CareFirst
Family of health care plans

SMALL GROUP ELIGIBILITY GUIDELINES

Small employer (1–50 FTEs) group eligibility guidelines for CareFirst BlueCross BlueShield products sold in Maryland, Washington, D.C. and Northern Virginia

Revised as of 12/2024

WELCOME!

To: CareFirst BlueCross BlueShield (CareFirst) Distributors

This manual was developed to assist you in selling all CareFirst products sold in Maryland, Washington, D.C. and Northern Virginia.

Here you'll find information about new and renewing sales, as well as grandfathered products.

Again this year, we have streamlined the information by combining the Maryland and Washington, D.C./ Northern Virginia Group Eligibility Manuals and updating the content accordingly.

The information provided is based on CareFirst's interpretation of state and federal legislation, in addition to CareFirst sales and underwriting policies and guidelines. Additional details for sections of this manual can be found in **Partner News**, or by asking your dedicated CareFirst small market new business consultant or broker executive.

This manual provides you with the basics to successfully prospect and sell to any small group account in Maryland, Washington, D.C. and Northern Virginia, as well as help you to retain and renew that business. Please review all sections carefully—guidelines may vary based on the product(s) sold.

As our appointed and contracted distributors, you are required to adhere to our established policies and guidelines. If you have any questions about the information in this manual, contact your dedicated general producer (GP) and/or full-service producer (FSP), or your CareFirst small market new business consultant or broker executive.

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MARYLAND

CAREFIRST PRODUCT OFFERINGS

CareFirst, Inc. is made up of several affiliates that are licensed separately and viewed as separate carriers by the Insurance Divisions (MD/DC/VA).

Our primary licensed affiliates are as follows:

- CareFirst of Maryland, Inc. (CFMI)
- Group Hospitalization and Medical Services, Inc. (GHMSI)
- CareFirst BlueChoice, Inc.

Note: A broker can determine in which legal entity a prospect/group is quoted by the plan code noted on the proposal (listed under the product name):

- B in the 5th position = GHMSI
- C in the 5th position = BlueChoice
- M in the 5th position = CFMI
- T in the 5th position = TDN
- CareFirst BlueChoice, Inc.

Note: For a complete list of product offerings by jurisdiction, please refer to the most current **Small Group ACA product portfolio** available by logging in to the **broker portal**. Under the *Resources* tab, click *Product Resources*, then *Product Portfolios*.

STATE-DEFINED GEOGRAPHIC REGIONS

- Effective January 1, 2016, CareFirst treats the four geographic regions in Maryland as one rating region so it can remain competitive in the small group market.
- Effective January 1, 2017, all dental products in Maryland are rated the same, regardless of rating region.
- State geographic rating differences by region are only applicable to vision coverage.
- Effective Jan 1, 2023—all grandfathered plans in the small group market have been terminated.

Baltimore Metropolitan Area	D.C. Metropolitan Area	Western Maryland	Eastern and Southern Maryland
Anne Arundel County	Montgomery County	Allegany County	Calvert County
Baltimore City	Prince George's County	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

CALENDAR YEAR VERSUS CONTRACT YEAR BENEFIT PERIODS

Effective January 1, 2015, for new and renewing business:

Medical

- First day of the month effective date only
- Contract year benefit period only
- All ACA small group renewals must elect contract year benefits either at renewal, or in conjunction with an approved off-cycle benefit change
- No deductible credit or carryover is allowed for ACA medical products

Dental/vision (freestanding)

- First day of the month effective date only*—contract or calendar year benefit period allowed
- All BlueDental Plus/BlueDental EPO/BlueDental Basic/Traditional/Preferred dental products have deductible credit and deductible carryover as a core benefit for both calendar year/contract year benefit periods

* Effective June 1, 2017, 15th day of the month effective date was eliminated.

DEDUCTIBLES AND OUT-OF-POCKET (OOP) MAXIMUMS—SEPARATE VERSUS AGGREGATE

The *2025 Notice of Benefits and Parameters* requires carriers to limit an individual's out-of-pocket (OOP) contributions to a maximum of $9,450 for non-HSA plans and $8,050 for HSA plans. When the OOP maximum is set up separately, an individual on a family plan can meet their individual maximum out-of-pocket (MOOP) limit before the family OOP is met. This results in 100% claim coverage for that individual. Product portfolios and benefit summaries illustrate whether an aggregate or separate deductible and/or OOP limit applies.

The separate and aggregate status of a plan refers to the aggregation of dollars toward meeting the deductible and out-of-pocket maximum for plans with more than one member.

- **Separate:** Each member can satisfy their own deductible by meeting the individual deductible. In addition, eligible expenses for all covered family members can be combined to satisfy the family deductible. However, an individual family member cannot contribute more than the individual deductible toward meeting the family deductible. Once the family deductible has been met, that satisfies the deductible for all covered family members. The out-of-pocket maximum can be met the same way.
- **Aggregate:** The deductible can be met entirely by one member of the family by combining eligible expenses of two or more covered family members. There is no individual deductible with family coverage. The family deductible must be met before CareFirst pays benefits for any services subject to the deductible for any family member. The out-of-pocket maximum can be met the same way.

Note: Any type of coverage that is not individual coverage is considered family coverage for the purpose of determining the deductible and out-of-pocket maximum.

All in- and out-of-network deductible and OOP maximums are separate. They do not contribute to each other.

HSA IRS requirement for family coverage

For family coverage with HSA compatible plans, no individual can meet the deductible until the federally mandated high deductible plan minimum of $3,200 is met.

OOP PPACA (Patient Protection and Affordable Care Act) Requirement

No individual is required to pay more than the self-only maximum out-of-pocket amount toward the deductible under federal law.

DETERMINATION OF GROUP SIZE—ACA-COMPLIANT

ACA-compliant small group

Effective January 1, 2014, product eligibility and group size is determined based on the full-time equivalent (FTE) calculation that uses a 30-hour work week and 120-hour work month.

This calculation includes full-time employees working 30 or more hours per week, as well as seasonal, and aggregates the part-time employees.

This calculation is used to determine the average number of all employees, not just the number of covered lives, who worked for the company in the calendar year prior to the new sale or renewal effective date.

If an employer did not exist in the preceding calendar year, the determination of whether the employer is a small group is based on the average number of employees the employer is reasonably expected to employ on business days in the current calendar year.

Employers are encouraged to use federal guidance in conjunction with accountants and/or legal counsel when determining their group size.

The current **FTE form** is available on the **broker portal**.

Importance of submitting timely FTE counts

All groups are required to complete an **FTE form**, available on the employer and broker portals. Brokers and employers are encouraged to submit updated FTE worksheets for year-end 2023 and for all 2024 renewing groups as quickly as possible to ensure their 2024 renewals are issued in the appropriate market size segment. Estimates of year-end 2023 FTEs are acceptable for groups renewing in the first quarter of 2024. If we learn that the FTE size does not match the market size that was stated in the renewal, corrected rates and plans will be issued for the appropriate segment.

Refer to Broker Sales Flash 12/22/2015—Clarification on Guaranteed Renewability.

GROUP ELIGIBILITY FOR SMALL GROUP BENEFITS (INCLUDES HUSBAND/WIFE AND FAMILY-OWNED BUSINESSES)

ACA-compliant: *Small Employer* means an employer headquartered in Maryland that, during the preceding calendar year, employed an average of 50 employees or less as determined by the FTE calculation. The group must be defined as a single employer under IRS code 414(b), (c), (m) or (o).

At least one full-time, currently employed and eligible employee must be enrolled under the group's coverage at all times. The employee cannot be the owner, the owner's spouse or a dependent.

ON-SHOP: the employee cannot be the owner, the owner's spouse, a dependent or an extended family member of any age.

OFF-SHOP: a dependent could satisfy the requirement of the one full-time common-law employee as long as they are a W-2 employee that is reflected on the wage and tax and they are not claimed as a dependent on the parents tax return.

Exception: please note that ONLY during the ACA annual open enrollment is the full-time W-2 common-law employee(s) allowed to waive coverage with only the owner(s) allowed to enroll in medical coverage.

ACA-compliant groups must be headquartered in Maryland; however, certain exceptions may be allowed (see below).

Per Blue Cross Blue Shield Association (BCBSA) guidelines:

- For a 1–50 group headquartered in Maryland or a 1–50 group headquartered in Maryland with an office in another state that is **not** a separate purchasing entity location, all employees should be underwritten in Maryland.
- For a 1–50 group headquartered in Maryland with an office in another state that is a separate purchasing entity location, employees working in Maryland can be underwritten in Maryland and employees in another state can be underwritten in that state.
- A 1–50 group headquartered out of state can buy an HMO or indemnity product if the branch office is a separate purchasing entity.

Minimum participation requirements

ACA requirements: The group must enroll and maintain enrollment of at least 75% of all eligible employees. For participation purposes, all eligible employees are included in the participation calculation, except for:

- Those with spousal coverage under a public or private plan of health insurance, or another employer's health benefit arrangement (including Medicare, Medicaid and Tricare) that provides benefits similar to or exceeding the benefits provided under the group contract.
- Those who are under the age of 26 who are covered under a parent's health benefit plan.
- Those who do not live or work in the CareFirst BlueChoice service area, when that is the only CareFirst affiliate being offered by the group.
- For groups purchasing OFF-SHOP, those who are able to receive a federal subsidy through individual coverage on the public Exchange. For groups purchasing ON-SHOP, anyone who is enrolled in an individual policy that meets minimum essential coverage requirements on the public Exchange. The employee must also provide verification that they are currently receiving a subsidy. To obtain subsidy verification the member (or broker) can log on to the Maryland Health Exchange at **https://marylandhealthconnection.gov** to obtain this information. Once logged into the site, the member can locate this information from the home page message center. They should look for their Successful Enrollment Notice that will include their subsidy information as well as the effective date. This is the form that should be provided along with their waiver of enrollment form that will allow us to consider them as a valid waiver. If for any reason the member is unable to locate the form, they should call MHBE directly at 855-642-8572 for assistance to obtain this documentation.
- Participation requirements are waived for a small employer enrolling between November 15 and December 15 of any calendar year, with an effective date of January 1 for Medical only. (These requirements are outlined in the Group Contract Application.) These dates may be adjusted based on applicable Federal and/or State mandates. Participation still applies to dental/vision, if offered. While participation requirements are waived during this time, meeting group eligibility is still required.
- To calculate participation, take the total number of eligible employees, minus all legitimate waivers, and then multiply this number by the participation rate (.75%). Now apply normal rounding rules (.5 or greater, round up). Example: 10 eligible employees minus 3 spousal waivers = 7 (x) .75 = 5.25 or 5 must enroll to meet participation.

ACA/1099 employees

Under ACA, 1099 employees are NOT considered eligible employees, however, if they meet the IRS definition for a "Common Law Employee" then they could be covered under the group plan. The group is required to have at least one full-time, currently employed eligible W2 employee enrolling with coverage that is not the owner, or owner's spouse. 1099 employees are not considered as W2 employees, unless the group defines them as such. Please note that CareFirst does not make the determination as to whether the employees are considered Common Law Employees. This would be up to the group and/or their legal counsel or accountant.

1099s versus Common Law Employees—enrolling eligible employees

- Independent contractors, such as subcontractors who receive a 1099 are not eligible employees
- The IRS has issued guidance on when individuals are to be treated as either an employee or independent contractor. Group's should consult with their attorney or accountant for guidance if they have questions relative to offering coverage to 1099s

- An independent contractor MAY be classified as an employee based upon the specifics of the relationship
- ACA definition of employee is based on "common law" standard
- Common law definition of "employee" requires a fact-intensive review focusing on control and direction of the 1099 individual providing services
- This will apply in MD/DC and VA (1099s formerly not allowed in DC/VA)

If the group determines the employee(s) are common law employees, CareFirst will require a certification signed by the CFO or CEO or head Partner of the Account that establishes the member as a common law employee under the IRS definition. The Group would need to provide a letter that begins with the following language: "The undersigned hereby certifies under penalty of perjury that the following information is true and correct (State that the person is a common law employee under the IRS definition and the reasons therefore), and, the letter must be signed by the Officer of the Company.

http://www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Employee-Common-Law-Employee

Employer contribution

There is no minimum employer contribution requirement for OFF-SHOP small groups; however, groups are encouraged to contribute a minimum of 50% of the individual rate. Please note ON-SHOP, the small group tax credit requires 50 percent individual premium contribution.

Sole proprietorships, partnerships or corporations

ACA requirements: Partner/owner-only groups are not eligible under ACA for group coverage. Under ACA regulations, there must be at least one full-time, common-law employee enrolled (cannot be the owner, the owner's spouse or a dependent).

A company insured with CareFirst must be an active entity with a federal tax ID, engaged in a trade or business, (unless HB 857 or HB988).

Non-profit organizations

ACA requirements: Non-profit groups of one eligible employee working 20 hours or more (but less than 30 hours) have been removed. Any existing groups in this category will be renewed but cannot make a benefit change.

- New ACA non-profit groups may be written as long as there is at least one full-time, common-law employee who is not the owner or owner's spouse and is eligible on day one, working at least 30 hours a week.

Required documentation: The group must provide CareFirst with the Letter of Determination, also known as Form 501(c)(3), provided by the IRS, which identifies 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).

MEDICARE RETIREES AND ELIGIBLES

ACA-compliant products: Any active employee with Medicare must enroll as an active employee under the member-level rating methodology.

Under ACA-compliant products, retirees currently enrolled may remain enrolled on the group plan as long as the group does not make a benefit change that requires a new group contract application.

Coverage is not extended to retirees who are not currently enrolled or seeking group benefits.

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 work day in each of 20 or more calendar weeks in the current or preceding calendar year. **All active members are 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 be moved from one TEFRA/Non-TEFRA designation to another. CMS put this in place to avoid groups moving between designations repeatedly. Groups are responsible for determining their designation and should get assistance from their accountant if there is confusion.

AFFILIATED COMPANIES

Under ACA regulations, certain affiliated employers with common ownership (or who are part of a controlled group) must aggregate their employees to determine group size and the full-time equivalency (FTE) calculation. CareFirst looks to the employer and its counsel for this certification.

To determine the number of eligible employees, affiliated companies (or those eligible to file a consolidated federal income tax return) will 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.

If the companies are not eligible to file a consolidated return, they must provide proof of common ownership and common control to be considered for writing as one group. Common ownership means one person or entity having more than 50% ownership in both companies. When there is proof that one entity owns another in excess of 50% (but less than 80%), which establishes ownership, CareFirst may request the company provide additional information, including a certification, in order to determine whether or not the owner exerts control over the owned entity or entities. Maryland law states that groups under common control must be counted together to determine whether the group is a small group. Corporations, LLCs, partnerships, and sole proprietorships are all subject to this rule.

View the **Affiliated Companies/Common Ownership Certification**.

Parent Company	Tax Filing Method	Legislative Interpretation
Corporations	If the corporation has **80% ownership or more in the other businesses**, they have the choice of filing separate returns OR a consolidated tax return. If the corporation has **less than 80% ownership in the other businesses**, they must file separate tax returns.	Either way, the corporation is eligible to file consolidated returns. Therefore, **they are considered one employer**. Since they are not eligible to file consolidated tax returns, **there must be sufficient proof that there are affiliated companies under common ownership and common control in order to be written as one group**. Common ownership is one person or entity having more than 50% ownership in both companies. When there is proof that one entity owns another in excess of 50% (but less than 80%), establishing ownership, CareFirst may request the company provide additional information, including a certification, in order to determine whether or not the owner exerts control over the owned entity or entities. Corporations, LLCs, partnerships and sole proprietorships are all subject to this rule.

Parent Company	Tax Filing Method	Legislative Interpretation
Sole Proprietors	Must file separate tax returns.	Since they are not eligible to file consolidated tax returns, **there must be sufficient proof they are affiliated companies under common ownership and common control in order to be written as one group**. Common ownership is one person or entity having more than 50% ownership in both companies. When there is proof that one entity owns another in excess of 50% (but less than 80%), establishing ownership, CareFirst may request the company provide additional information, including a certification, in order to determine whether or not the owner exerts control over the owned entity or entities. Corporations, LLCs, partnerships and sole proprietorships are all subject to this rule.
Partnerships	Must file separate tax returns.	Since they are not eligible to file consolidated tax returns, **there must be sufficient proof they are affiliated companies under common ownership and common control in order to be written as one group**. Common ownership is one person or entity having more than 50% ownership in both companies. When there is proof that one entity owns another in excess of 50% (but less than 80%), establishing ownership, CareFirst may request the company provide additional information, including a certification, in order to determine whether or not the owner exerts control over the owned entity or entities. Corporations, LLCs, partnerships and sole proprietorships are all subject to this rule.

Note:

- **Companies may have different names and different employer tax ID numbers and still have common ownership by way of affiliation. Therefore, ownership should be verified using the Affiliated Companies/ Common Ownership Certification form.**
- The **Affiliated Companies/Common Ownership Certification** form should be completed by a group applying for coverage that has affiliated companies, subsidiaries, or enough common ownership to apply for coverage under one entity.
- Understanding a groups' affiliation/common ownership is important as it can impact a groups' Federal Employer size (FTE) which determines market segment and rating.
- Groups that are affiliated or have enough common ownership under control group rules to be considered one employer have the option to be written together or separately subject to the combined FTE.

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/DUI 15/16). This quarterly document, filed with the state of Maryland, lists all compensated employees for unemployment tax purposes. It is with this document that CareFirst determines the total number of eligible employees. When the DLLR/DUI 15/16 is submitted, the account should list the 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: The most current Wage and Tax Statement (DLLR/OUI 15/16) filed with the state of Maryland is required on all new accounts, including those transferring from one company within CareFirst to another (CFMI, GHMSI or BlueChoice). CareFirst requires a duplicate copy of the DLLR/DUI 15/16 be sent to the state. W-4s are required for employees not appearing on the Wage and Tax Statement unless they are an owner. The owner's name and social security number should be written on the bottom of the Wage and Tax Statement and identified with the number of hours worked per week and eligibility status.

Payroll registers in lieu of a DLLR/DUI 15/16

Payroll registers will be accepted in lieu of the Maryland Wage and Tax Statement when the payroll register is filed as an amendment. This option should only be used on an exception basis when the Maryland Wage and Tax Statement (DLLR/DUI 15/16) is unavailable. If a payroll register is provided, it must be generated by a payroll service such as EasyPay or ADP. It cannot be generated by desktop computer software.

Newly formed companies

If an employer did not exist in the preceding calendar year, the determination of whether the employer is a small employer is based on the average number of employees that employer is reasonably expected to employ on business days in the current calendar year.

The group must have at least one full-time, common-law employee eligible enrolled on day one. The employee cannot be the owner or owner's spouse to be a viable small group.

If the newly formed company does not have a DLLR/DUI 15/16, they should submit a notarized letter on company letterhead listing their employees, their working hours per week and their eligibility status. W-4s must be submitted for each employee, as well as the business formation documents. The application for the DLLR/DUI 15/16 should also be submitted, if available. The group must also submit a current full-time equivalent (FTE) calculation to verify their group size.

Specific group configurations and eligibility

The following people are not considered employees when determining group size and eligibility:

A. Leased employees
B. Sole proprietors
C. Partners in a partnership
D. S Corporation shareholders with less than 2% or more stock ownership.
E. Family members or household dependents of those mentioned in A, B, C and D.
F. Real estate agents and direct sellers working strictly on commission

(See Federal Regulations 26 CFR § 54.4980H.)

Segment migrations between small group and 51+

Renewals will be released 60–120 days in advance of the effective date using the group's FTE calculation, based on the prior calendar year.

Groups are required to keep this number current with CareFirst to apply the rating calculations required for the number of FTEs in the group.

Groups with new federal tax ID numbers

A new federal 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 the original group be termed and the new entity written as a new group. This may affect existing groups who currently offer a high deductible plan.

Groups moving from ON-SHOP to OFF-SHOP, or OFF-SHOP to ON-SHOP

Existing groups that move between ON-SHOP and OFF-SHOP or are rewritten/reapplying (with no change in tax id) during the ACA annual OE are not considered new businesses to CareFirst. However, the paperwork process to make the change follows our standard new business paperwork process—so a new group number will be assigned. The coordination of this process is handled by the renewal representative.

TAX DOCUMENTATION

The following information was provided by state legislation (for self-employed individuals) and the Maryland Office of Unemployment Insurance to determine which tax documents are available to verify eligibility of an employer group and its employees.

Tax documentation—ACA groups

Type of Business	DLLR/DUI 15/16 required if employees are	DLLR/DUI 15/16 not required if employees are	If no DLLR/DUI 15/16 required, submit instead
Corporation Must have at least one common-law FTE who is not the owner or owner's spouse, who is eligible on day one and works 30 hours or more/week	Most will have a formal Wage and Tax (DLLR/DUI 15/16)		Form 1120, Form 1120-S or Articles of Incorporation showing owners of business
In most cases, corporations will have a formal Wage and Tax (DLLR/DUI 15/16) Statement. Refer to the Enrolling Eligible Employees section.			
Non-Profit Organization Must have at least one common-law FTE who is not the owner or owner's spouse, who is eligible on day one and works 30 hours or more/week			IRS Form 501(c)(3) a.k.a. Letter of Determination w/ notarized letter on company letterhead, listing employees, hours per week/eligibility status; in lieu of 501(c), Charter Document w/ notarized letter
Sole Proprietorship Must have at least one common-law FTE who is not the owner or owner's spouse, who is eligible on day one and works 30 hours or more/week	Owner's non-dependent children (over age 21) working full-time and other employees working full or part-time		Signed Schedule C/F

Type of Business	DLLR/DUI 15/16 required if employees are	DLLR/DUI 15/16 not required if employees are	If no DLLR/DUI 15/16 required, submit instead
Partnership Must have at least one common-law FTE who is not the owner or owner's spouse, who is eligible on day one and works 30 hours or more/week	Spouse, owner's children and other employees	Partners	Form 1065 and signed K-1 forms for each partner

For corporations, sole proprietorships and partnerships, there must be at least one common-law FTE who is not the owner, owner's spouse or dependent child who is eligible on day one, working at least 30 hours a week.

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

ENROLLING ELIGIBLE EMPLOYEES

Eligible employees in ACA-compliant products

- Those eligible are full-time employees who work, on average, at least 30 hours per week. Owners and partners may or may not be enrolled depending on the wording of the insurance policy and/or the filed group application.
  - For additional guidance, please refer to **irs.gov**.
  - The group should work with its legal counsel and/or accountant as necessary to confirm eligibility of its members when it provides enrollment information. CareFirst may perform audits to confirm eligibility.
- Former employees and their dependents that fall under COBRA or MD Continuation provisions are eligible for coverage.
- Groups may also choose to offer benefits to part-time employees as long as the part-time employees have a normal workweek of at least 17.5 hours and are not full-time employees. If the part-time employee works less than 17.5 hours in a normal workweek, they are not eligible for coverage. Part-time eligibility can be added at any time by completing a new group contract application. (**Note**: Under ACA, part-time employees count toward participation. New groups whose enrolling subscribers are only made up of part-time employees will not be accepted.)
- Groups may also offer coverage to domestic partners of eligible employees. Domestic partnership coverage may be added at any time by completing a new group contract application.
- Groups must offer benefits to all eligible employees or to all employees in an additional designated class (part-time, domestic partners, etc.).

Note: All employees working more than 30 hours per week and who otherwise meet the requirements of eligible employee under the MD regulations, as well as their eligible dependents, must be offered all product options (excluding certain classes of employees or offering certain products to specific employees or classes of employees, not allowed under MD Code Section 15-1210).

For ACA-compliant business, eligible employees may enroll:

- As a new hire, after satisfying any employer waiting period.
- During a small employer's annual open enrollment.

- Within 31 days of a lifestyle change as defined by the Health Insurance Portability and Accountability (HIPAA) special enrollment period. This applies to those who initially declined coverage.
  - Refer to the eligibility schedule within the group's contract to determine the member's effective date of coverage.
- If they are full-time employees under the age of 18, as long as they provide proof of employment and hours worked via a current DLLR/DUI 15/16. If a DLLR/DUI 15/16 is unavailable, a payroll statement or notarized letter indicating the number of hours the employee works must be submitted.

MD special enrollment period for pregnancy life event—effective january 1, 2020

Effective January 1, 2020, for any new or renewing small group and individual plans, carriers must provide a special enrollment period (SEP) for pregnancy. MD HB127 allows individuals who become pregnant to enroll in a health benefit plan. This mandate establishes a 90-day duration for the special enrollment period beginning on the date a pregnancy is confirmed by a health care practitioner. Coverage will begin on the first day of the month in which pregnancy is confirmed.

Effective date and impacted business:

- Effective January 1, 2020, this applies to new business and upon renewal for existing business
- 2-50 groups headquartered in Maryland
- Consumer individual residing in Maryland (except Medicare Supplement)

If you have any questions, please contact your broker sales representative.

Uniformed Services Employment and Re-employment Rights Act (USERRA)

If an employee leaves their job to perform military service, the employee has the right to elect to continue their group coverage (including any dependents for up to 24 months) while in the military. Even if continuation of coverage was not elected during the member's military service, the member has the right to be reinstated in their group coverage when re-employed, without any waiting periods or pre-existing condition exclusions (except for service-connected illnesses or injuries).

Enrollment in BlueChoice products (exception BlueChoice Advantage/ HealthyBlue Advantage)

All enrolling members must work or reside in the BlueChoice service area at the time of enrollment in order to enroll in a BlueChoice product. The member must choose a primary care provider (PCP).

WAITING PERIOD FOR NEW EMPLOYEES

ACA requires that all groups have no more than a 90-day waiting period. For this reason, groups are contractually offered one of the following waiting period options as stated in the ACA small group contract applications. ***Note**: When the maximum 90-day waiting period is selected coverage begins on the 91st day.*

Coverage for a new eligible employee will be effective on the first day of the month following the date of employment or eligibility, whichever is later, unless otherwise specified below:

- On the date of employment or eligibility, whichever is later.
- On the first day of the month following 30 days of employment or eligibility, whichever is later.
- On the first day of the month following 60 days of employment or eligibility, whichever is later.
- On the day following ___ days of employment or eligibility, whichever is later (day range cannot exceed a total of ninety (90) days).
- On the day following the completion of the group's waiting period. The group's waiting period for professional employees is ___ days from the date of employment or eligibility, whichever is later, and for non-professional employees is ___ days from the date of employment or eligibility, whichever is later (day ranges cannot exceed a total of ninety (90) days).
- On the first day of the month following the completion of the group's waiting period. The group's waiting period for professional employees is ___ days from the date of

employment or eligibility, whichever is later, and for non-professional employees is ___days from the date of employment or eligibility, whichever is later (day ranges cannot exceed a total of sixty (60) days to ensure compliance with applicable law).

In all cases, the waiting period options are stated in a specific number of days. Actual calendar days must be counted.

- The 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.
- Waiting periods can be changed as needed off-renewal to accommodate business needs.
- 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 and the employee has met the new waiting period by the date of the change, the employee is effective on the effective date of the waiting period change.
  - If the new waiting period is shorter than the prior one and the employee has not met the new waiting period by the date of the change, the new waiting period is applied to the employee's original hire date.
- Day one of a waiting period begins the day of hire.
- New employees must complete 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.
- If a group is not offering benefits to part-time employees, but a part-time employee moves to full-time status and is eligible for benefits, the employer can apply the part-time hours worked to the new hire waiting period as long as the employer applies that decision to all similar situations.

Termination and rehire

- If an employee is rehired within 30 days of their termination date, benefits will be reinstated without a wait period. This is subject to the group's new hire waiting period. Benefits will become effective using the appropriate effective date rule following the rehire date.
- If an employee is rehired more than 30 days after their termination date, benefits will be reinstated with a wait period. Benefits will become effective using the group's wait period and effective date rule following the rehire date.

The following list includes examples that assume the group maintains a first-of-the-month rule following a 30-day wait period:

- A termination date of January 15, 2025 with a rehire date of February 1, 2025. The rehire category is less than 30 days, so the benefit effective date is February 1, 2025.
- A termination date of January 15, 2025 with a rehire date of February 18, 2025. The rehire category is greater than 30 days, so the benefit effective date is April 1, 2025.

Open enrollment period

- When the group first offers coverage, there will be an open enrollment period for eligible employees. To be eligible, the employee must complete the new hire waiting period. During this time, the employee and their dependents may apply for coverage.
- The group will have an annual open enrollment period—the 31-day period immediately preceding the open enrollment effective date set forth in the group schedule.

Subscriber terminations

- Termination occurs on the last day of the month in which the subscriber's employment or eligibility ends.
- A spouse and dependents cannot terminate from the group coverage during the contract period unless the subscriber terminates.

- A subscriber can make a mid-year reduction or termination of coverage due to:
  - A reduction or elimination of coverage during the contract year
  - Significant increase or decrease in subscriber's cost without a less costly and similar alternative, including a change in job classification (full-time or part-time)
  - Entitlement to Medicare by the subscriber, spouse or dependent
- A subscriber can make a mid-year change to reduce or terminate coverage of the subscriber or dependent if one of the following qualifying life events occur:
  - Legal marital status change
  - Employment status change
  - Dependent status change
  - Residence change (HMO members only)
- Groups are responsible for disenrolling their employee under the following conditions:
  - Employee no longer meets the eligibility requirements for health benefits coverage
  - Employee is no longer employed by the group

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, foster child or grandchild if legal custody has been granted to the subscriber. Eligible dependents may enroll:

- Along with newly hired employee.
- During the 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 under another group plan.

Proof of employment and hours worked via a current DLLR/DUI 15/16 must be provided when full-time employees are enrolled under the age of 18. If a DLLR/DUI 15/16 is not available, a payroll statement or notarized letter indicating the number of hours the employee works must be submitted.

Dependent children who meet the definition of a dependent child under the group contract will now be covered to the last day of the month of their 26th birthday.

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, they cannot be enrolled with the employee's membership.

Full-time students

Beginning with renewals effective October 10, 2010, federal law allows for dependent children (full-time or part-time students) to be covered on the parents' group policy until the end of the month of their 26th birthday.

Disabled dependents

- Eligibility may continue past age 26 for unmarried dependents who are mentally/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 CareFirst Individual Under 65 division.
- CareFirst may request proof of mental or physical incapacity at any time.

Domestic partner dependents

Effective September 1, 2004, domestic partner dependent renewals and new business are available at the employer's discretion. Coverage may also be added off-cycle with no rate or renewal date impact.

- It is 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.
- Requirements for eligibility are monitored by the employer and may be audited by CareFirst after the initial enrollment.

Requirements for domestic partner eligibility

- 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.
- The subscriber and the domestic partner are the same or opposite sex, are both at least eighteen (18) 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 share a common primary residence and have submitted documentary evidence of cohabitation that is satisfactory to the group.
- The subscriber and domestic partner are financially interdependent for at least six consecutive months prior to application and submit documentary evidence of interdependence that is satisfactory to the group. They must both sign 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.
- Qualifying life events allowing the subscriber to reduce or terminate coverage include termination of a domestic partnership or the death of the subscriber's domestic partner.

MULTIPLE OPTION OFFERINGS

For ACA-compliant groups, up to three medical products can be offered to a small group.

ACA-compliant groups

- 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 for each option.
  - The minimum enrollment requirements do not apply to a small employer who submits an application between November 15 and December 15 of any calendar year for a January 1 effective date (Medical only. Participation still applies to dental/vision, if offered).
- All employee segments must be offered all product options. "Classing out" of employees is not allowed.
- The options offered must be differentiated by the product offered and may not be limited to a "referral only" differential.
- **Groups offering one medical plan** can offer a BlueDHMO or BlueDental EPO plan combined with either a Traditional, Preferred, BlueDental Plus or BlueDental Basic

plan. Participation is combined; however, BlueDHMO, if offered, requires that a minimum of two eligibles enroll.

- **Groups offering two or three medical plans** can offer up to two dental plans. The two dental plans must be selected from different product types:
  - The six different product types are: Traditional, Preferred, BlueDental Plus, BlueDental EPO, BlueDental Basic and BlueDHMO. (**Note**: BlueDental EPO and BlueDHMO cannot be offered together.)
  - Exception: Any two employer-sponsored BlueDental Plus plans may be sold together.
  - Participation is combined; however, BlueDHMO, if offered, requires that a minimum of two eligibles enroll.
- BlueVision Plus: Groups may only elect one vision plan, regardless of the number of medical plans offered.

MOVEMENT BETWEEN PRODUCTS

CareFirst is comprised of several companies from which our various products originate. These include CFMI, GHMSI and BlueChoice. Although the products offered through these companies 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 due to CareFirst's structure. For purposes of broker compensation, however, movement between our family of products is considered migrated (existing) business and is not applicable under our new sales bonus.

Brokers should also be mindful of the account installation renewal paperwork submission dates when moving business between CareFirst legal entities.

SMALL GROUP RATING—ACA

All ACA rating is guarantee issue and groups are rated based on a per member basis. This means each member is rated based on their age. This methodology is used for all new group quotes and renewals.

For families, each member will be rated individually, and these rates will be combined to form a family premium.

- For children under the age of 21, only the rate for the three oldest children will be counted.
- For dependents age 21–25, the rate for each dependent will be counted.
- Washington, D.C. rates for ages 0–20 are the same, rates for 21–27 are the same, and the rates for >27 differ.
- Virginia rates for ages 0-14 are the same and the rates for >14 differ.
- Rates vary each year beginning at age 25.

For ACA member-level rated dental plans:

- For Virginia children under the age of 21, only the rate for the three oldest children will be counted.
- For Washington, D.C., all children are counted.
- For dependents age 21-25, the rate for each dependent will be counted.
- Rates for ages 0-20 are the same and the rates for 21+ are the same.

Rates may only vary by the following factors:

- Geography
- CareFirst has chosen not to rate for tobacco use

For ACA, the Rx benefit is part of the medical option and the rate is combined with the medical rate.

Metal Level: The ACA uses a "metal level" rating model. The metal levels represent a range of actuarial values or "AVs" that reflect the percentage of expected health care costs (both medical and Rx) a specific health plan will cover for the standard population.

ACA health plans fall into the following metal levels:

- Bronze (58%-62%; can go up to 65% if plan qualified as an "expanded" benefit design)
- Silver (66%-72%)
- Gold (76%-82%)
- Platinum (86%-92%)

All standard CareFirst product offerings will have a 60% AV or better.

All other dental plans are tier rated, as well as our vision and grandfathered products.

Subscribers with both Medicare Parts A and B receive a member rate based on their age.

The Retiree Rider is not available for renewal or sale to ACA groups. Retirees currently enrolled may remain on the group plan if the group extends coverage to them.

Composite rating

Note: Currently limited to one medical plan under CareFirst.

CareFirst will use the composite rating methodology provided by the Maryland Insurance Administration to offer four-tier composite rating with Off-Exchange products sold in Maryland. Employers may not use composite rates for plans purchased on the SHOP Exchange.

Composite rates are only available for a single medical plan for subscribers who are actively employed by the group. Final composite rates will be determined after the initial look-back period which occurs at the end of the effective date month. Starting with January 1, 2021 effective dates, COBRA and MD Continuation of Coverage subscribers are excluded from the final composite rate recalculation.

Groups will be notified if there are changes in the rate recalculation contingent upon final enrollment changes.

NEW BUSINESS

Physical address

All new accounts must provide their physical address on the new sales paperwork. The physical address allows us to verify the account eligibility and provides us with an address for priority deliveries, including contracts. In addition, the physical address of all subscribers is required prior to enrollment.

County code

The physical address and county code used for rating purposes must be the headquarters location for the group, not a branch office. If there is a question, CareFirst reserves the right to investigate the actual headquarters of the business through use of the internet and business listings.

Effective date

As of December 1, 2015, 15th of the month effective dates are no longer allowed for new medical groups in Maryland.

Initial premium requirement

CareFirst requires a binder payment equivalent to the first month's premium on all new business, including FSP business, in order for the new account to be processed.

Note: A binder payment is not required when new medical coverage is being added to existing dental/vision freestanding coverage.

ACA-compliant groups must be headquartered in Maryland. Exceptions to this rule are listed below.

Per BCBSA guidelines:

- For a 1–50 group headquartered in Maryland or a 1–50 group headquartered in Maryland with an office in another state that is **not** a separate purchasing entity location, all employees should be underwritten in Maryland.
- For a 1–50 group headquartered in Maryland with an office in another state that is a separate purchasing entity location, employees working in Maryland can be underwritten in Maryland and employees reporting to the separate purchasing entity in the other state can be underwritten in that state.
- A 1–50 group headquartered out of state can buy an HMO or indemnity product if the branch office in Maryland is a separate purchasing entity.

RENEWAL BUSINESS

ACA-compliant product renewals

- Groups that have all ACA-compliant plan renewals will be provided with a renewal representing the closest matched ACA plans from the current ACA-compliant product portfolio upon renewal. Plans represented in the renewal will be the closest matched plan to their existing ACA-compliant plans and are member-level rated.

- Small market renewals will be based on the current FTE count that CareFirst has on record upon the issue date of the renewal.
  - If the FTE form is received after the small market renewal is released and the count shows greater than 50 FTEs, the small market renewal released is no longer valid. The group must then move to the large group market upon the group's renewal effective date.
  - If the FTE form is provided before the issuance of the small market renewal and the FTE is greater than 50, the group will not be issued a small market renewal and will be provided with a 51+ market quote.
  - If the FTE count of a 51+ group falls below 50, the group will be issued a small group market quote.
- Census change requests do not apply to ACA-compliant products.
- Business migrating between CFMI/GHMSI BluePreferred and BlueChoice is considered existing business, even though new group paperwork may be required and is not considered new business for purposes of CareFirst's new business bonus schedule.
- Broker of record transfer letters are required when the non-incumbent broker migrates any CareFirst account from one CareFirst company to another.
- Mid-contract year benefit changes include any change initiated by the account to alter the ACA-compliant product selection and does not include CareFirst initiated product changes (such as migration to a new product portfolio). Benefit changes must be received prior to renewal deadlines according to the effective date of the benefit change.
- Requests for benefit changes to existing products or movement between products offered by the same CareFirst entity will not be approved within 90 days prior to the account's current renewal date. *Exception: when groups are adding new medical.*
- Accounts that want to make off-renewal benefit changes may on the first of the month after their renewal or new sale.
- The effective date of the medical benefit change will become the new renewal date. Any deductibles and out-of-pocket maximums will reset on the new effective date.
- Under a contract year benefit period, Preferred, Traditional and BlueDental dental products and vision products can be added to the group short plan year without affecting the medical renewal date. The ancillary products will renew with the next medical renewal.
- When adding or changing products at renewal or off cycle, a signed proposal and any contract and supporting documents must be provided. **Note**: You are also required to submit an updated group contract application (GCA), **FTE form** and **Medicare Secondary Payer (MSP) form**.
- Termination of either medical or ancillary (but not both) must be done as a benefit change and not a termination to avoid terminating both products.
- Maryland groups whose jurisdiction has changed to Virginia or Washington, D.C. may renew under the Maryland contract; however, if a benefit change is requested, the change must take place within the proper jurisdiction.

Benefit changes with a jurisdiction change at renewal

- Benefit changes must be received prior to the deadline.
  - If a group is located in Virginia and moves to Maryland or Washington, D.C., the group can keep their current Virginia benefits regardless of medical product. The group cannot change their benefits unless they accept Maryland or Washington, D.C. benefits.
  - If group is located in Washington, D.C. and moves to Virginia (within our service area) or Maryland, the group should coordinate with the DC Health Link (DCHL).

REQUEST FOR ANNIVERSARY DATE CHANGE

A written request (in letter format) must be provided to Small Group Underwriting for any change of group anniversary date, including the following:

- Group name and number.
- Statement of the following: "The group would like to move to MM/DD/YYYY renewal from a MM/DD/YYYY renewal."
- Statement noting that the group understands their rates will change effective MM/DD/YYYY, and this may result in an increase in premium.
- Letter must be signed by the group administrator.

GROUP TERMINATIONS

Out-of-area company headquarters and employees—If CareFirst determines that employees no longer work or reside in the CareFirst Service Area and the company headquarters is not located in the service area upon renewal, we will no longer offer group coverage.

Zero enrollment in ACA plans—If CareFirst determines that a group does not have at least one eligible employee enrolled in the entire group, the group will be terminated one day prior to the renewal effective date. If the group believes the information is incorrect or if the group is planning to add employees to the current group plan effective upon renewal, the broker will work with the group to renew or change the plan and provide proof of enrollment of eligible employee(s).

Please refer to the below links when calculating your group's FTE count.

Internal Revenue Service (IRS)

DENTAL BENEFITS

CareFirst offers a comprehensive dental portfolio, including voluntary and employer-sponsored Traditional, Preferred (PPO), BlueDental Plus, BlueDental EPO, BlueDental Basic and BlueDHMO plans.

For a complete list of product offerings by jurisdiction, please refer to the most current Small Group ACA Product Portfolio available by logging in to the Broker Portal. Under the *Resource*s tab, click *Product Resources*, then *Product Portfolios*.

VISION BENEFITS

Through our partnership with Davis Vision,* CareFirst offers a comprehensive vision portfolio including employer-sponsored and voluntary BlueVision Plus options.

There are currently twenty-two vision plans available. BlueVision Plus Options A–P offer newer, richer benefits than BlueVision Plus Options 1–6.

For a complete list of product offerings by jurisdiction, please refer to the most current Small Group ACA Product Portfolio available by logging in to the Broker Portal. Under the *Resource*s tab, click *Product Resources*, then *Product Portfolios*.

GROUP CONTRACT APPLICATION MATRIX

ACA Maryland OFF-SHOP products

CFMI—For groups headquartered in counties other than Prince George's and Montgomery.

GHMSI—For groups headquartered in Prince George's or Montgomery Counties.

Note: No retiree coverage is available under ACA.

Below are the most current versions of the Group Contract Applications (GCA) that are posted on the broker portal at the time of this update. At the time of sale or renewal, always refer to the broker portal for the most recent version of the GCA or the prior version, if applicable.

	Medical Product(s) Sold	Sold with (Yes) or without (No) Traditional/Preferred Dental, BlueDental Plus/ BlueDental EPO/BlueDental Basic and/or BlueVision Plus Employer-Sponsored/ Voluntary	Required Group Applications
Section A	**BlueChoice HMO Product(s) MD OFF-SHOP (One product or any combination in Section A)**		
	BlueChoice HMO Referral BlueChoice HMO Referral HSA/HRA BlueChoice HMO BlueChoice HMO HSA/HRA BlueChoice Plus Opt-Out	NO—Dental/Vision YES—Use CFMI/GHMSI Point-of-Enrollment (POE) Applications. This is the only application that you will need to complete.	If no, use: **MD/CFBC/SE/HMO-BCOO/ GCA (R. 1/19)** If yes for GHMSI, use: **MD/SE/POE/GCA (R.1/19)** If yes for CFMI, use: **CFMI/SE/POE/GCA (R. 1/19)**
Section B	**Point-of-Service Product(s) MD OFF-SHOP (One product or any combination in Section B)**		
	BlueChoice Plus BlueChoice Plus HSA/HRA HealthyBlue Plus BlueChoice Advantage BlueChoice Advantage HSA/ HRA	Yes or No—The CFMI/ GHMSI POS group contract application covers the Traditional/Preferred Dental, BlueDental Plus/BlueDental EPO/BlueDental Basic and/or BlueVision Plus, if sold.	If yes or no for GHMSI, use: **MD/SE/POS/GCA (R. 1/19)** If yes or no for CFMI, use: **CFMI/SE/POS/GCA (R. 1/19)**
Section C	**Maryland CareFirst BluePreferred Product(s) OFF-SHOP (One product or any combination in Section C)**		
	BluePreferred PPO BluePreferred PPO HSA/HRA	Yes or No—The CFMI/ GHMSI PPO group contract application covers the Traditional/Preferred Dental, BlueDental Plus/BlueDental EPO/BlueDental Basic and/or BlueVision Plus, if sold.	If yes or no for GHMSI, use: **MD/CF/SE/PPO/GCA (R. 1/19)** If yes or no for CFMI, use: **CFMI/SE/PPO/GCA (R. 1/19)**

	Medical Product(s) Sold	Sold with (Yes) or without (No) Traditional/Preferred Dental, BlueDental Plus/ BlueDental EPO/BlueDental Basic and/or BlueVision Plus Employer-Sponsored/ Voluntary	Required Group Applications
Point-of-Enrollment Group Contract Application (POE)			
Note: Any time you sell multiple ACA medical products together from Sections A, B and C, with or without Traditional/Preferred Dental, BlueDental Plus/BlueDental EPO/BlueDental Basic and/or BlueVision Plus, you can use one of the following POE applications for all products sold. This is the **only** application you will need to complete. You will also use the POE application when you are adding Traditional/Preferred Dental, BlueDental Plus/BlueDental EPO/BlueDental Basic and/or BlueVision Plus to any Section A product, or a combination of Section A medical products. For GHMSI, use **MD/SE/POE/GCA (R. 1/19)** For CFMI, use **CFMI/SE/POE/GCA (R. 1/19)**			
Section D	**Freestanding Traditional/Preferred Dental, BlueDental Plus/BlueDental EPO/BlueDental Basic and/or BlueVision Plus** **Note:** Use only when there is a) No CareFirst medical plan or b) When the group has ON-SHOP medical and you are selling OFF-SHOP dental and/or BlueVision Plus. **2–50 and 51+ Freestanding (not certified ACA benchmark plans)**		
	BlueDental Plus BlueDental EPO BlueDental Basic Preferred Dental Traditional Dental		For GHMSI, use: **MD/GHMSI DN-VS ONLY GRP APP (R. 1/13) (MD GHMSI DN-VS ONLY 10/16) (for plans effective prior to 5/1/19)** **MD/GHMSI/DN-VS ONLY/ GCA (R.11/18) (DENT-VIS 5/19) (for plans effective 5/1/19 and after)** For CFMI use: **CFMI/DN-VS ONLY GCA (R. 1/13) (CFMI DN-VS ONLY 10/16) (for plans effective prior to 5/1/19)** **CFMI/DN-VS ONLY/GCA (R.11/18) (DENT-VIS 5/19) (for plans effective 5/1/19 and after)**
Section E	**Blue DHMO**—A separate group contract application is always required when you sell BlueDHMO, with or without medical.		
	BlueDHMO $0 BlueDHMO $10		**MD/TDN/DHMO/GCA (10/15)**

WASHINGTON, D.C. & NORTHERN VIRGINIA

CAREFIRST PRODUCT OFFERINGS

CareFirst, Inc. is made up of several affiliates that are licensed separately and viewed as separate carriers by the Insurance Divisions (Maryland/ Washington, D.C./Virginia).

Our primary affiliates are as follows:

- CareFirst of Maryland, Inc. (CFMI)
- Group Hospitalization and Medical Services, Inc. (GHMSI)
- CareFirst BlueChoice, Inc.

Note: A broker can determine in which legal entity a prospect/group is quoted by the plan code noted on the proposal (listed under the product name).

- B in the 5th position = GHMSI
- C in the 5th position = BlueChoice
- M in the 5th position = CFMI
- CareFirst BlueChoice, Inc.

Note: For a complete list of product offerings by jurisdiction, please refer to the most current **Small Group ACA product portfolio** available on the **broker portal**. Under the *Resources* tab, click *Product Resources*, then *Product Portfolios*.

STATE-DEFINED GEOGRAPHIC REGIONS

CareFirst's marketing sales area includes Maryland, Washington, D.C. and the Commonwealth of Virginia, the cities of Alexandria and Falls Church, the counties of Arlington and the portion of Fairfax east of Route 123, including the incorporated limits of Fairfax City and the town of Vienna in their entirety.

Note: Use the Blue Cross Blue Shield website, **bcbs.com**, to determine the appropriate Blue Cross Blue Shield plan.

City/County/Town	ZIP Codes				
Virginia ZIP codes within the service area					
Alexandria	22300 22301 22302 22303 22304	22305 22306 22307 22308 22309	22310 22311 22312 22313 22314	22315 22320 22321 22331 22332	22333 22334 22336
Arlington	22201 22202 22203 22204 22205 22206 22207	22209 22210 22211 22212 22213 22214 22215	22216 22217 22218 22219 22222 22223 22225	22226 22227 22229 22230 22234 22240 22241	22242 22243 22244 22245 22246
Fairfax City	22031	22032	22034	22036	
Fairfax City	22116				

City/County/Town	ZIP Codes				
Fairfax	22003 22009 22015	22027 22031 22032	22034 22035 22036	22037 22038 22060	22067 22081 22082
	22106 22109 22116 22118	22119 22121 22122 22150	22151 22152 22153 22156	22158 22159 22160 22161	22199
	22303 22306	22307 22308	22309 22310	22312 22312	
Falls Church	22040 22041	22042 22043	22044 22046	22047	
Vienna	22183	22184	22185		
Counties/ZIP codes split by Route 123					
Fairfax	22030	22039	22079		
Fairfax	22101 22102	22124 22180	22181 22182	22191 22192	
Prince William	22125	22191	22192		

WASHINGTON, D.C. MARKET RULES

Beginning January 1, 2015, any small employer group offering group health benefits must purchase or renew on the DC Health Link (SHOP). District-based small businesses that purchased health insurance directly from an insurance company now renew through DC Health Link (DCHL).

Small businesses that have all of the below are eligible to purchase insurance coverage through DCHL:

- A valid federal tax identification number (EIN).
- 1-50 full-time equivalent employees (FTEs) not including owner(s).
- Offer coverage, at a minimum, to all full-time employees working at least 30 hours per week.
- Either:
  - A principal business address in Washington, D.C. and offering coverage to all full-time employees, or
  - Offer coverage to all full-time employees whose primary workplace is located in Washington, D.C.

Although self-employed individuals and sole proprietors are not eligible to purchase coverage as a business, they can purchase individual and family health insurance coverage through DCHL.

For more information on DCHL, please visit their **website**.

Medical

- First of month effective date only—contact or calendar year benefit period allowed.

Dental/vision (freestanding)

- First of month effective date only*—contract or calendar year benefit period allowed.
- All BlueDental Plus/BlueDental Basic/ BlueDental EPO/Traditional/Preferred dental products have deductible credit and deductible carryover as a core benefit for both calendar year/contract year benefit periods.

* Effective June 1, 2017, 15th day of the month effective date was eliminated.

DEDUCTIBLES AND OUT-OF-POCKET (OOP) MAXIMUMS—SEPARATE VERSUS AGGREGATE

The *2024 Notice of Benefits and Parameters* requires carriers to limit an individual's out-of-pocket (OOP) contributions to a maximum of $9,450 for non-HSA plans and $8,050 for HSA plans. When the OOP maximum is set up separately, an individual on a family plan can meet their individual maximum out-of-pocket (MOOP) limit before the family OOP is met—resulting in 100% claim coverage for that individual. Product portfolios and benefit summaries illustrate whether an aggregate or separate deductible and/or OOP limit applies.

The separate and aggregate status of a plan refers to the aggregation of dollars toward meeting the deductible and out-of-pocket maximum for plans with more than one member.

- **Separate:** Each member can satisfy their own deductible by meeting the individual deductible. Eligible expenses for all covered family members can also be combined to satisfy the family deductible. However, an individual family member cannot contribute more than the individual deductible amount toward meeting the family deductible. Once the family deductible is met, the deductible is satisfied for all covered family members. The out-of-pocket maximum can be met the same way.
- **Aggregate:** The deductible can be met entirely by one member of the family by combining eligible expenses of two or more covered family members. There is no individual deductible with family coverage. The family deductible must be met before CareFirst pays for any benefits subject to the deductible for any member. The out-of-pocket maximum can be met the same way.

Note: Any type of coverage that is not individual coverage is considered family coverage for the purpose of determining the deductible and out- of-pocket maximum.

All in- and out-of-network deductible and OOP maximums are separate and do not contribute to each other.

HSA IRS requirement for family coverage

For family coverage with HSA compatible plans, no individual can meet the deductible until the federally mandated high deductible plan minimum of $3,200 is met.

OOP PPACA (Patient Protection and Affordable Care Act) requirement

No individual is required to pay more than the self-only maximum out-of-pocket amount toward the deductible under federal law.

GROUP ELIGIBILITY FOR ACA-COMPLIANT SMALL GROUP BENEFITS

Small Employer means an employer headquartered in Virginia or Washington, D.C. that, during the preceding calendar year, employed an average of no more than 50 employees. The group must be defined as a single employer under IRS code 414(b), (c), (m) or (o). At least one full-time, currently employed eligible employee (not the owner or owner's spouse) must be enrolled under the group's coverage at all times.

Virginia expanded its definition of small employer in 2018 and again in 2019 to provide that the following described person is considered an "Employee" for the purpose of determining whether an entity qualifies as a small group.

1. The person performed any service for payment under a written or oral contract for hire on behalf of a corporation or an LLC and the person meets the following requirements as applicable:
   a) The person is a shareholder or an immediate family member of a shareholder of the Corporation; or
   b) The person is a member ("owner") of the LLC.
2. The person is a self-employed individual or immediate family member of the self-employed individual. "Self-employed individual" under VA law is an individual who derived a substantial portion of his income from a trade or business

(i) operated by the individual as a sole proprietor,

(ii) through which the individual has attempted to earn taxable income, and

(iii) for which he or she has filed the appropriate Internal Revenue Service Form 1040, Schedule C or F, for the previous taxable year.

NOTE: The Virginia law does not extend small group eligibility to a proprietorship owned jointly by a husband and wife unless it has at least one full time common law employee.

DETERMINATION OF GROUP SIZE—ACA-COMPLIANT

ACA-compliant small group: Effective January 1, 2014, product eligibility and group size will be determined based on the full-time equivalent (FTE) calculation that uses a 30-hour work week and 120-hour work month.

This calculation includes full-time employees working 30 or more hours per week, as well as seasonal employees, and aggregates the part-time employees.

This calculation is used to determine the average number of all employees—not just the number of covered lives—who worked for the company in the calendar year prior to the new sale or renewal effective date.

If an employer was not in existence throughout the preceding calendar year, the determination of whether the employer is a small group is based on the average number of employees the employer is reasonably expected to employ on business days in the current calendar year.

Employers are encouraged to use federal guidance in conjunction with accountants and/or legal counsel when determining their group size.

The current **FTE form** is available on the **broker portal**.

DETERMINATION OF GROUP SIZE—GRANDFATHERED

Grandfathered small group: Existing small group accounts enrolled under the pre-ACA guidelines (either prior calendar year or prior quarter) can remain in their current grandfathered product. However, if they choose to make a benefit change, they must move to an ACA-compliant plan and meet the group eligibility requirements under ACA.

Small Group Reform Eligible	Small Group Reform Ineligible
All full-time employees (including those in probationary period). However, the 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 (17.5–30 hours)
Full-time independent contractor—1099 employees (discretion of employer)	Seasonal employee
	COBRA ex-employee or dependent
	Retiree or dependent
	Board members

Independent contractors (grandfathered groups): Independent contractors (e.g., 1099 employees) working full-time (30 or more hours per week) may be considered eligible at the employer's discretion.

If the employer elects to cover part-time employees, 1099s meeting the definition of part-time (working more than 17.5 hours per week but less than 30 hours per week) may enroll. If the employer has elected to extend coverage to this segment of employees, coverage must be offered to all 1099 employees.

If the employer elects to offer benefits to this population, all benefits offered to other employees must be offered to the 1099 employees. The enrolled group can only consist of 1099 employees if there is an employer relationship where the employer and any other full-time eligible employee(s) have waived coverage.

Note: The 75% participation requirement must be met.

The below chart shows an example of a group of one owner and one full-time 1099 independent contractor who have been offered benefits.

Enrolling	Viable Group?
Owner and full-time 1099 independent contractor	Yes
Owner only—Full-time 1099 is waiving coverage with other group-sponsored insurance (HB857)	Yes
Full-time 1099 only—Owner is waiving coverage with other group-sponsored insurance	Yes

ACA GUARANTEED RENEWABILITY

On October 30, 2013, CMS addressed guaranteed renewability, confirming that employers are guaranteed the ability to renew coverage. However, when choosing to renew a non-grandfathered plan, the new coverage must comply with the full-time equivalent employee market size segment rules. CMS has recently advised that, pursuant to 45 C.F.R. 147.106(h), guaranteed renewability rights do not permit employer groups to continue in non-grandfathered coverage that they would otherwise be ineligible for, per federal law (see also CMS' 2015 Final Letter to FFM Issuers).

A group cannot stay in a market segment if their FTE count does not reflect that segment size, even if they do not make a benefit change. There are no exceptions to this rule. Groups with an FTE of one or zero will not be offered a renewal. Grandfathered plans can be renewed in the same market size segment, regardless of changes in FTEs.

Examples:

- A Washington, D.C. employer group had more than 50 FTEs and now has less than 50. This employer must renew into an ACA-compliant small group product.
- In Virginia the same rules apply.

Groups with a mixture of grandfathered and non-grandfathered plans may have plans renewing in different market size segments and would therefore receive two different renewals. As noted above, grandfathered plans can be renewed as is, remaining in the same market segment. If the group qualifies to retain grandfathered status and the FTE is over 50, the grandfathered plan can remain in small group and rated accordingly. However, the ACA plan must move to the 51+ segment.

Importance of submitting timely FTE counts

All groups are required to complete an FTE form, available on the employer and broker portals. Brokers and employers are encouraged to submit updated FTE worksheets for year-end 2023 and for all 2024 renewing groups as quickly as possible to ensure 2024 renewals are issued in the appropriate market size segment. Estimates of year-end 2023 FTEs are acceptable for groups renewing in the first quarter of 2024. If we find the FTE size does not match the market size stated in the renewal, corrected rates and plans will be issued for the appropriate segment.

Refer to Broker Sales Flash December 22, 2015—Clarification on Guaranteed Renewability.

GROUP ELIGIBILITY FOR GRANDFATHERED SMALL GROUP BENEFITS

There must be at least one contract in the service area and the group must be headquartered and physically located (P.O. Box is not sufficient) in Washington D.C., Maryland or Northern Virginia—East of Route 123, including the City of Fairfax and Town of Vienna—to be covered under a small group product.

Enrolled groups that drop to less than two full-time employees should contact their broker, general producer (GP), full-service producer (FSP) or sales representative to obtain information.

Minimum participation requirements: ACA-compliant products

The group must enroll and maintain enrollment of at least 75% of all eligible employees for medical coverage and for each ancillary product purchased, if offered (or 100% if the employer pays the entire individual coverage premium). The ancillary products are dental and vision benefits. If at any time there is less than 75% enrolled in these products, CareFirst reserves the right to rescind the proposal, revise the rates or terminate the product below the requirement.

The group cannot enroll in their HMO programs (other than CareFirst BlueChoice) more than 25% of the total number of employees enrolled in all health programs offered through the group. The group cannot continue to enroll new employees in their staff model HMO.

For participation purposes, all eligible employees are included in the participation calculation, except for:

- Those with spousal coverage under a public or private plan of health insurance, or another employer's health benefit arrangement (including Medicare, Medicaid and CHAMPUS) that provides benefits similar to or exceeding the benefits provided under the group contract.
- Those under the age of 26 who are covered under a parent's health benefit plan.
- Those who do not live or work in the CareFirst BlueChoice service area, when it is the only CareFirst affiliate offered by the group.
- Those who get a federal subsidy through enrollment on the public Exchange.

These requirements are waived for a small employer enrolling between November 15 and December 15 of any calendar year with an effective date of January 1. These dates are subject to change based on applicable Federal and/or State mandates.

Minimum participation requirements: grandfathered products

The requirements in this section do not apply to Virginia small groups electing coverage under Virginia Essential or Standard Health Benefit Plans.

The group must enroll and maintain enrollment (unless otherwise approved by CareFirst/CareFirst BlueCross BlueShield) as stated below:

If Point of Enrollment or BlueChoice Opt-Out Plus Open Access is selected, this must be the sole health plan offered by the group to its employees.

Groups must enroll and maintain enrollment of 75% of all employees eligible for medical coverage and for each ancillary product purchased, if offered (or 100% if the employer pays the entire individual coverage premium). The ancillary products are dental and vision benefits. If at any time there are less than 75% enrolled in any of the medical or ancillary products, CareFirst reserves the right to rescind the proposal, revise the rates, terminate the product that does not meet the 75% requirement, or refuse to renew the product that does not meet the 75% requirement. Voluntary dental requires 35% participation or 10 enrolled, whichever is less. Voluntary vision has no participation requirement.

The group cannot enroll in their HMO programs (other than CareFirst BlueChoice) more than 25% of the total number of employees enrolled in all health programs offered through the group. The group cannot continue to enroll new employees in their staff model HMO.

The following employees should be excluded from the above counts:

- Employees who have coverage under their spouse's or parent's group coverage, CHAMPUS, Medicare as primary under TEFRA, or their prior employer's plan under COBRA.
- Employees enrolled in other company coverage or covered under any company affiliate.

At least two employees must be employed full-time and enrolled under the group's coverage at all times.

Note: Those employees with complementary to Medicare coverage do not count toward the two-employee minimum enrollment requirement.

Enrolled groups that drop to less than two full-time employees should contact their sales representative to arrange for individual direct pay coverage.

If at any time total enrollment increases or decreases by 10% or more, the company reserves the right to rescind the proposal, revise the rates, terminate the contract or refuse to renew the contract.

The basis for determining whether an enrollment increase or decrease has occurred will be the total enrollment:

- On the effective date or contract renewal date versus the total enrollment proposed at the time the rates were developed, and
- On the first day of any month during the contract period versus the total enrollment proposed at the time the rates were developed.

The company may change the applicable premium rates at any time by giving no less than thirty (30) days prior written notice to the group. If, however, the proposed premium rate increase exceeds 35% of the annual premium charged, the company will give the group prior written notice of no less than sixty (60) days.

Sole proprietorships, partnerships or corporations

Under ACA requirements, there must be at least one full-time "common law" employee enrolled who is not an owner or their spouse. Any existing groups of this nature will be migrated to an ACA-compliant product and cannot make a benefit change.

Grandfathered business will be renewed with no benefit change.

A company insured with CareFirst must be an active entity with a federal tax ID, engaged in a trade or business and have at least two eligible employees.

Virginia expanded its definition of small employer in 2018 and again in 2019 to provide that the following described person is considered an "Employee" for the purpose of determining whether an entity qualifies as a small group.

1. The person performed any service for payment under a written or oral contract for hire on behalf of a corporation or an LLC and the person meets the following requirements as applicable:

   a) The person is a shareholder or an immediate family member of a shareholder of the Corporation; or

   b) The person is a member ("owner") of the LLC.

2. The person is a self-employed individual or immediate family member of the self-employed individual. "Self-employed individual" under VA law is an individual who derived a substantial portion of his income from a trade or business

   (i) operated by the individual as a sole proprietor,

   (ii) through which the individual has attempted to earn taxable income, and

   (iii) for which he or she has filed the appropriate Internal Revenue Service Form 1040, Schedule C or F, for the previous taxable year.

Employer contribution

To be eligible for group coverage, the employer must contribute an amount equal to at least 50% of the cost of the individual coverage for enrolled employees.

RETIREES, PART-TIME EMPLOYEES AND FULL-TIME EMPLOYEES WITH OTHER COVERAGE: GRANDFATHERED PRODUCTS ONLY

The group can elect to provide coverage for the following:

- Part-time employees working at least 17.5 hours a week for more than six months each year. (Those working less than these required time periods are ineligible.)
- Retirees who have retired prior to the effective date of this coverage. (Available only if covered under the group's prior health coverage.) Proof will be required, which may include a copy of prior carrier's contract and most recent billing statement.
- Retirees who retire on or after the effective date of this coverage. (Available only if covered under the group's prior health coverage.)
- All employees who terminated employment due to disability prior to the effective date of this coverage for a period of not more than two years. If for a shorter period of time, please indicate_____. (Available only if covered under the group's prior health coverage.)

MEDICARE RETIREES AND ELIGIBLES

ACA-compliant products: Any active employee with Medicare must enroll as an active employee under the member level rating methodology.

Under ACA-compliant products, retirees currently enrolled may remain enrolled on the group plan as long as the group does not make a benefit change that requires a new group contract application.

Coverage will not be extended to retirees not currently enrolled and seeking group benefits.

Grandfathered business: Effective March 1, 2011, in conjunction with the CFMI migration, CareFirst introduced a Retiree Rider for CFMI/GHMSI BluePreferred business only. This rider is not available to BlueChoice grandfathered business.

CareFirst offers a small group Medicare secondary individual rate to active employees with Medicare Parts A and B, in non-TEFRA accounts for grandfathered products only.

TEFRA versus 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. **All active members are 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 be moved from one TEFRA/Non-TEFRA designation to another. CMS 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.

AFFILIATED COMPANIES

Under ACA regulations, certain affiliated employers with common ownership, or who are parts of a controlled group, must aggregate their employees for determining group size for the full-time equivalency (FTE) calculation. CareFirst looks to the employer and its counsel for this certification.

To determine the number of eligible employees, companies which are affiliated companies (or are eligible to file a consolidated federal income tax return) are 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.

If the companies are not eligible to file a consolidated return, they must provide proof of common ownership and common control in order to be considered for writing as one group. Common ownership is one person or entity having more than 50% ownership in both companies. When there is proof that one entity owns another in excess of 50% but less than 80%, establishing ownership, CareFirst may request the company provide additional information, including a certification, in order to determine whether or not the owner exerts control over the owned entity or entities.

The **Affiliated Companies/Common Ownership Certification** form is available on the **broker portal**. If you have any questions, please reach out to your CareFirst small market consultant.

Parent Company	Tax Filing Method	Legislative Interpretation
Corporations	If the corporation has **80% ownership or more in the other businesses**, they have the choice of filing separate returns or a consolidated tax return. If the corporation has **less than 80% ownership in the other businesses**, they must file separate tax returns.	Either way, the corporation is eligible to file consolidated returns. Therefore, **they are considered one employer**. Since they are not eligible to file consolidated tax returns, **there must be sufficient proof that there are affiliated companies under common ownership and common control in order to be written as one group**. Common ownership is one person or entity having more than 50% ownership in both companies. When there is proof that one entity owns another in excess of 50% (but less than 80%), establishing ownership, CareFirst may request the company provide additional information, including a certification, in order to determine whether or not the owner exerts control over the owned entity or entities. Corporations, LLCs, partnerships and sole proprietorships are all subject to this rule.
Sole Proprietors	Must file separate tax returns.	Since they are not eligible to file consolidated tax returns, **there must be sufficient proof they are affiliated companies under common ownership and common control in order to be written as one group**. Common ownership is one person or entity having more than 50% ownership in both companies. When there is proof that one entity owns another in excess of 50% (but less than 80%), establishing ownership, CareFirst may request the company provide additional information, including a certification, in order to determine whether or not the owner exerts control over the owned entity or entities. Corporations, LLCs, partnerships and sole proprietorships are all subject to this rule.

Parent Company	Tax Filing Method	Legislative Interpretation
Partnerships	Must file separate tax returns.	Since they are not eligible to file consolidated tax returns, **there must be sufficient proof they are affiliated companies under common ownership and common control in order to be written as one group**. Common ownership is one person or entity having more than 50% ownership in both companies. When there is proof that one entity owns another in excess of 50% (but less than 80%), establishing ownership, CareFirst may request the company provide additional information, including a certification, in order to determine whether or not the owner exerts control over the owned entity or entities. Corporations, LLCs, partnerships and sole proprietorships are all subject to this rule.

Note:

- **Companies could have different names and different employer tax ID numbers and still have either common ownership by way of affiliation. Therefore, ownership should be verified using the Affiliated Companies/Common Ownership Certification form.**
- The **Affiliated Companies/Common Ownership Certification** form should be completed by any group that is applying for coverage that has affiliated companies, subsidiaries or enough common ownership to apply for coverage under one entity.

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/DUI 15/16). This quarterly document, filed with the applicable state, lists all compensated employees for unemployment tax purposes. It is through this document that CareFirst determines the total number of eligible employees. When the DLLR/DUI 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/DUI 15/16) statement filed with the applicable state is required on all new accounts, including those transferring from one company within CareFirst to another (CFMI, GHMSI and BlueChoice). CareFirst requires a duplicate copy of the DLLR/DUI 15/16 sent to the state. W-4s are required for those employees not appearing on the Wage and Tax Statement unless they are an owner. The owner's name and social security number should be written on the bottom of the Wage and Tax Statement and identified as such with the number of hours worked per week and eligibility status.

Payroll registers in lieu of a DLLR/DUI 15/16

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

Newly-formed companies

If an employer did not exist throughout the preceding calendar year, the determination of whether the employer is a small employer is based on the average number of employees that employer is reasonably expected to employ on business days in the current calendar year.

The group must have at least one full-time, common-law employee that is eligible on day one and who is not the owner or owner's spouse to be a viable small group.

If the newly-formed company does not have a DLLR/DUI 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-4s must be submitted for each employee as well as the business formation documents. The application for the DLLR/DUI 15/16 should also be submitted, if available. The group must also submit a current full-time equivalent (FTE) calculation to verify their group size.

Specific group configurations and eligibility

The following people are not considered employees when determining group size and eligibility:

A. Leased employees
B. Sole proprietors
C. Partners in a partnership
D. S Corporation shareholders with less than 2% or more stock ownership.
E. Family members or household dependents of those mentioned in A, B, C and D.
F. Real estate agents and direct sellers working strictly on commission

(See Federal Regulations 26 CFR § 54.4980H.)

Segment migrations between small group and 51+

Renewals will be released 60–120 days in advance of the effective date using the group's FTE calculation based on the prior calendar year.

Groups are required to keep this number current with CareFirst to apply rating calculations required for the number of FTEs in the group.

Groups with new federal tax ID numbers

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

Groups moving from ON-SHOP to OFF- SHOP, or OFF-SHOP to ON-SHOP

Existing groups that move between ON-SHOP and OFF-SHOP are not considered new businesses to CareFirst. However, the paperwork process to make the change follows our new business paperwork process and a new group number will be assigned. The coordination of this process is also handled by the renewal representative.

TAX DOCUMENTATION

Tax documentation—grandfathered groups

Type of Business	DLLR/DUI 15/16 required if employees are	DLLR/DUI 15/16 not required if employees are	If no DLLR/DUI 15/16 required, submit instead
Self-Employed Individuals			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
Self-Employed Licensed Professionals such as attorneys, physicians (LLP "Limited Liability Partnership" excluded)			Articles of (Professional) Incorporation and Letter of Good Standing from licensing group
Non-Profit Organization (one eligible employee working 20 hours/week)			IRS Form 501(c)(3) a.k.a. Letter of Determination w/ notarized letter on company letterhead, listing employees, hours per week/eligibility status

Note: The above types are no longer eligible for coverage under ACA regulations. If they are grandfathered and continue to meet the grandfathering requirements, they may renew with no benefit change.

Tax documentation—ACA groups

Type of Business	DLLR/DUI 15/16 required if employees are	DLLR/DUI 15/16 not required if employees are	If no DLLR/DUI 15/16 required, submit instead
Corporation Must have at least one common-law FTE who is not the owner or owner's spouse, who is eligible on day one and works 30 hours or more/week	Most will have a formal Wage and Tax (DLLR/OUI 15/16)		Form 1120, Form 1120-S or Articles of Incorporation showing owners of business
In most cases, corporations will have a formal Wage and Tax (DLLR/DUI 15/16) Statement. Refer to the Enrolling Eligible Employees section.			
Non-Profit Organization Must have at least one common-law FTE who is not the owner or owner's spouse, who is eligible on day one and works 30 hours or more/week			IRS Form 501(c)(3) a.k.a. Letter of Determination w/ notarized letter on company letterhead, listing employees, hours per week/eligibility status; in lieu of 501(c), Charter Document w/ notarized letter
Sole Proprietorship Must have at least one common-law FTE who is not the owner or owner's spouse, who is eligible on day one and works 30 hours or more/week	Owner's non-dependent children (over age 21) working full time and other employees working full or part time		Signed Schedule C/F
Partnership Must have at least one common-law FTE who is not the owner or owner's spouse, who is eligible on day one and works 30 hours or more/week	Spouse, owner's children and other employees	Partners	Form 1065 and signed K-1 forms for each partner

For corporations, sole proprietorships and partnerships, there must be at least one common-law FTE who is not the owner or owner's spouse and is eligible on day one, working at least 30 hours a week.

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

HUSBAND/WIFE BUSINESSES

ACA requirements: Groups of only a husband and wife are not eligible for coverage. There must be at least one full-time common-law employee that is eligible on day one other than the owner and spouse.

ENROLLING ELIGIBLE EMPLOYEES

Eligible employees in ACA-compliant products

- An eligible employee is full-time and works, on average, at least 30 hours per week. Owners and partners may or may not be enrolled depending on the wording of the insurance policy and/or the filed group application.
  - For additional guidance, please refer to **irs.gov**.
  - The group should work with its legal counsel and/or accountant as necessary to confirm eligibility of its members when it provides enrollment information. CareFirst may perform audits to confirm eligibility.
- Former employees and their dependents that fall under COBRA or any applicable state's Continuation provisions are eligible for coverage.
- Groups may also choose to offer benefits to part-time employees as long as the part-time employee has a normal work week of at least 17.5 hours. If the part-time employee works less than 17.5 hours in a normal work week, they are not eligible for coverage. Part-time eligibility can be added at any time by completing a New Group contract application. (**Note**: Under ACA, part-time employees count toward participation. New groups whose enrolling subscribers are only made up of part-time employees will not be accepted.)
- Groups may also offer coverage to domestic partners of eligible employees. Domestic partnership coverage may be added at any time by completing a New Group contract application.
- Groups must offer benefits to all eligible employees or to all employees in an additional designated class (part-time, domestic partners, etc.).

Eligible employees in grandfathered products

A **full-time employee** works on a full-time basis with 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. **Groups cannot limit their coverage of employees to only those who work a greater number of hours than the legislated 30 hours per week (such as only offering benefits to employees working 40 hours per week or more).** 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, for whom compensation is reported to the Internal Revenue Service by Form W-2 and the State of Virginia Department of Labor, Licensing and Regulation by VA form 6. This includes employees who are not United States citizens but meet the standard eligibility criteria noted above.

Note: All employees working in excess of 30 hours per week and who otherwise meet the requirements of an eligible employee under DC/VA regulations, as well as their eligible dependents, must be offered all product options. Excluding certain classes of employees or offering certain products to specific employees or classes of employees is not allowed under DC/VA law.

For both grandfathered and ACA-compliant business, eligible employees may enroll:

- As a new hire, after satisfying any employer waiting period.
- During the small employer's annual open enrollment.
- 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.
  - Refer to the Eligibility Schedule within the group's contract to determine the members effective date of coverage.

- If they are full-time employees under the age of 18, as long as they provide proof of employment and hours worked via a current DLLR/DUI 15/16. If a DLLR/DUI 15/16 is not available, a payroll statement or notarized letter indicating the number of hours the employee works must be submitted.

Uniformed Services Employment and Re-employment Rights Act (USERRA)

If an employee leaves their job to perform military service, the employee has the right to elect to continue their group coverage, including any dependents, for up to 24 months while in the military. Even if continuation of coverage was not elected during the member's military service, the member has the right to be reinstated in their group coverage when re-employed, without any waiting periods or pre-existing condition exclusions (except for service-connected illnesses or injuries).

Enrollment in BlueChoice products (except BlueChoice Advantage/HealthyBlue Advantage)

All enrolling members must work or reside in the BlueChoice service area at the time of enrollment in order to enroll in a BlueChoice product. Selection of a primary care provider (PCP) is also required.

COBRA (CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986)

COBRA is legislation that includes a requirement for groups with 20 or more employees to offer extended health insurance coverage at the member's expense to members and eligible dependents who leave the group or are otherwise no longer eligible for the group's coverage. All applicants eligible for COBRA should complete an individual enrollment application and a COBRA application. The COBRA application should be completed by the applicant and the group administrator. These forms are available in the *For Brokers* section on the CareFirst website.

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, foster child or grandchild if legal custody has been granted to the subscriber. Eligible dependents may enroll:

- Along with the newly hired employee.
- During the 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 under another group plan.

Proof of employment and hours worked via a current DLLR/DUI 15/16 must be provided when full-time employees are enrolled under the age of 18. If a DLLR/DUI 15/16 is not available, a payroll statement or notarized letter indicating the number of hours the employee works must be submitted.

Dependent children who meet the definition of a dependent child under the group contract will now be covered to the last day of the month of their 26th birthday.

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. They cannot be enrolled on the employee's membership.

Full-time students

Beginning with renewals effective October 1, 2010, federal law allows for dependent children, full-time or part-time, to be covered on the parents' group policy until the end of the month of their 26th birthday.

Primary care dependents (Washington, D.C.-based groups)

- The child must be the subscriber's grandchild, niece or nephew.
- The child must be under the subscriber's "primary care" (the subscriber provides food, clothing and shelter for the child on a regular and continuous basis during the time that the District of Columbia public schools are in regular session), and
- If the child's legal guardian is someone other than the subscriber, the child's legal guardian cannot be covered under an accident or sickness policy.

Disabled dependents

- Eligibility may continue past age 26 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 CareFirst Individual Under 65 division.
- CareFirst may request proof of mental or physical incapacity at any time.

Domestic partner dependents

Effective September 1, 2004, domestic partner dependent renewals and new business are available at the employer's discretion. Coverage may also be added off-cycle with no rate or renewal date impact.

- It is 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.
- Requirements for eligibility are monitored by the employer and may be subject to CareFirst audit after the initial enrollment.

Requirements for domestic partner eligibility

- 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.
- The subscriber and the domestic partner are the same sex or the opposite sex and both are at least 18 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 share a common primary residence and have submitted documentary evidence of such cohabitation that is satisfactory to the group.
- The subscriber and domestic partner are financially interdependent for at least six consecutive months prior to application and submit documentary evidence of it 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.

- The qualifying life events allowing the subscriber to reduce or terminate coverage are the termination of a domestic partnership or the death of the subscriber's domestic partner.

MULTIPLE OPTION OFFERINGS

For both grandfathered and ACA-compliant groups, up to three medical products can be offered to a small group.

ACA-compliant groups

- 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.
  - The minimum enrollment requirements do not apply to a small employer who submits an application between November 15 and December 15 of any calendar year for a January 1 effective date (Medical only—participation still applies to dental/vision, if offered).
- All employee segments must be offered all product options. "Classing out" of employees is not permitted.
- The options offered must be differentiated by the product offered and cannot be limited to a "referral only" differential.
- **Groups offering one medical plan** can offer a BlueDHMO or BlueDental EPO plan combined with either a Traditional, Preferred, BlueDental Plus or BlueDental Basic plan. Participation is combined; however, BlueDHMO, if offered, requires that a minimum of two eligibles enroll.
- **Groups offering two or three medical plans** can offer up to two dental plans. (**Note**: BlueDental EPO and BlueDHMO cannot be offered together.) The two dental plans must be selected from different product types:
  - The six different product types are: Traditional, Preferred, BlueDental Plus, BlueDental EPO, BlueDental Basic and BlueDHMO.
  - Exception: Any two employer-sponsored BlueDental Plus plans may be sold together.
  - Participation is combined; however, BlueDHMO, if offered, requires that a minimum of two eligibles enroll.
- BlueVision Plus: Groups may only elect one vision plan, regardless of the number of medical plans offered.

Grandfathered groups

- 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.
- The employer may apply multiple waiting periods to defined segments of employees within the same account. (See **Waiting Period for New Employees**.)
- 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.
- 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 (Traditional, Preferred PPO or DHMO).
- If one (1) medical option is offered, a Traditional or 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.

MOVEMENT BETWEEN PRODUCTS

CareFirst is comprised of several companies from which our various products originate. These include CFMI, GHMSI and BlueChoice. Although the products offered through these companies 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. For purposes of broker compensation, however, movement between our family of products is considered migrated (existing) business, and is therefore not applicable under our new sales bonus.

Brokers should also be mindful of the account installation **renewal** paperwork submission dates when moving business between our legal entities.

SMALL GROUP RATING—ACA

All ACA rating is guarantee issue and groups are rated based on a per member basis. This means each member is rated based on their age. This methodology is used for all new group quotes and for any non-grandfathered renewals.

For families, each member will be rated individually. These rates will be combined to form a family premium:

- For children under the age of 21, only the rate for the three oldest children will be counted.
- For dependents age 21–25, the rate for each dependent will be counted.
- Washington, D.C. rates for ages 0–20 are the same, rates for 21–27 are the same, and the rates for >27 differ.
- Virginia rates for ages 0-14 are the same and the rates for >14 differ.
- Rates vary each year beginning at age 25.

For ACA member-level rated dental plans:

- For Virginia children under the age of 21, only the rate for the three oldest children will be counted.

For Washington D.C., all children are counted.

- For dependents age 21-25, the rate for each dependent will be counted.
- Rates for ages 0-20 are the same and the rates for 21+ are the same.

Rates may only vary by the following factors:

- Geography
- CareFirst has chosen not to rate for tobacco use

For ACA, the Rx benefit is part of the medical option and the rate is combined with the medical rate.

Metal level: The ACA uses a "metal level" rating model. The metal levels represent a range of actuarial values or "AVs" that reflect the percentage of expected health care costs, both medical and Rx, a specific health plan will cover for the standard population.

ACA health plans fall into the following metal levels:

- Bronze (58%–62%—can go up to 65% if plan qualified as an "expanded" benefit design)
- Silver (66%–72%)
- Gold (78%–82%)
- Platinum (88%–92%)

All standard CareFirst product offerings will have a .60AV or better.

All other dental plans are tier rated, as well as our vision and grandfathered products.

Subscribers with both Medicare Parts A and B receive a member rate based on their age.

The Retiree Rider is not available for renewal and sale to ACA groups. Retirees currently enrolled may remain on the group plan if the group extends coverage to them.

Virginia composite rating

Note: Currently limited to one medical plan under CareFirst.

CareFirst will use the composite rating methodology to offer four-tier composite rating with Off-Exchange products sold in Virginia.

Employers may not use composite rates for plans purchased on the SHOP Exchange. Composite rates are only available for a single medical plan. Final composite rates will be determined after the initial look-back period which occurs at the end of the effective date month. Groups will be notified if there are changes in the rate recalculation contingent upon final enrollment changes.

Rating grandfathered products

BluePreferred and BlueChoice plans use average age rating.

Grandfathered BlueChoice and BluePreferred plans

- Under the BluePreferred options and at the employer's election, retirees and their dependents may be offered health benefits through the Retiree Rider by choosing "yes" on the rating proposal HB8 question.
- Retirees are not included in the group eligible count, nor are they counted toward participation.
- Actives and retirees age 65 or older (=>65) with Medicare Parts A and B are excluded from the average age calculation. All other active and retirees are rated using their actual age. If a group currently offering the Retiree Rider dissolves, there is no COBRA benefit.
- Non-TEFRA: An employer can offer coverage to their active Medicare-eligible employees by choosing "yes" on the other insurance HB8 question on the group application.
- TEFRA: Active Medicare eligibles are always offered benefits. The HB8 election of "yes" to other insurance does not apply to them.
- TEFRA: Active Medicare eligibles are included in the Non-Medicare census at their actual age and billed based on their actual age. Active employees with Medicare Parts A and B in a TEFRA group have the group coverage as primary and are counted toward the eligible employee and minimum participation counts.
- Non-TEFRA: The Medicare eligibles' ages will be excluded from the census when enrolled in Medicare Parts A and B. If the spouse enrolls but does not have Medicare Parts A and B, the spouse's actual age will be used in the census.
- The Medicare rate has only the individual tier coverage level.

All grandfathered products

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

- 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.

Grandfathered Medicare only enrollment

- Groups with an under 65 enrollment of zero and at least one active Medicare complementary enrollee cannot be termed.
- Groups should be terminated if the under 65 enrollment drops to zero and the enrollment in Medicare complementary consists only of retirees.

NEW BUSINESS

Beginning January 1, 2014, any Washington, D.C. employer group not currently offering group health benefits that then elects to offer group health benefits must purchase those benefits through the DC Health Link (SHOP).

Physical address

All new accounts must provide their physical address on the new sales paperwork. The physical address allows us to verify the account eligibility and provides us with an address for priority deliveries, including contracts. In addition, the physical address of all subscribers is required prior to enrollment.

County code

The physical address and county code used for rating purposes must be the headquarters location of the group, not a branch office. If there is a question, CareFirst reserves the right to investigate the actual headquarters of the business through use of the internet and business listings.

Initial premium requirement

CareFirst requires a binder payment equivalent to the first month's premium on all new business, including FSP business, in order for the new account to be processed.

***Note**: A binder payment is not required when new medical coverage is being added to existing dental/ vision freestanding coverage .*

RENEWAL BUSINESS

ACA-compliant product renewals

- Groups that have all ACA-compliant plan renewals will be provided with a renewal representing the closest matched ACA plans from the current ACA-compliant product portfolio upon renewal. Plans represented in the renewal will be the closest matched plan to their existing ACA-compliant plans and are member-level rated.
- Small market renewals will be based on the current FTE count that CareFirst has on record upon the issue date of the renewal:
  - If the FTE form is received after the small market renewal is released and the count shows greater than 50 FTEs, the small market renewal released is no longer valid. The group must then move to the large group market upon the group's renewal effective date.
  - If the FTE form is provided before the issuance of the small market renewal and the FTE is greater than 50, the group will not be issued a small market renewal and will be provided with a 51+ market quote.
  - If the FTE count of a 51+ group falls below 50, the group will be issued a small group market quote.
- Groups that are mixed with small group market grandfathered plan(s) will be issued a small group market renewal for their grandfathered plans and large group for their ACA-compliant plan(s) depending on their FTE count. If you need additional advice regarding a hybrid renewal, please discuss with your broker executive.
- Census change requests do not apply to ACA-compliant products.
- Business migrating between CFMI/GHMSI BluePreferred and BlueChoice is considered existing business, even though new group paperwork may be required and is not considered new business for purposes of CareFirst's new business bonus schedule.
- Broker of record transfer letters are required when the non-incumbent broker migrates any CareFirst account from one CareFirst company to another.
- Mid-contract year benefit changes are changes initiated by the account to alter the ACA-compliant product selection and does not include CareFirst-initiated product changes (such as migration to a new product portfolio). Benefit changes must be received prior to renewal deadlines according to the effective date of the benefit change.
- Requests for benefit changes to existing products or movement between products offered by the same CareFirst entity 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.
- The effective date of the medical benefit change will become the new renewal date. Any deductibles and out-of-pocket maximums will reset upon the new effective date.
- Under a contract year benefit period, Preferred, Traditional and BlueDental dental products and vision products can be added to the group short plan year without affecting the medical renewal date. The ancillary products will renew with the next medical renewal.
- When adding or changing products at renewal or off cycle, a signed proposal and contract/supporting documents must be provided. Please note that you are also required to submit an updated group contract application (GCA), FTE form and **Medicare Secondary Payer (MSP) form**.

- Termination of either medical or ancillary (but not both) must be done as a benefit change—not a termination—to avoid termination of both products.
- Maryland groups whose jurisdiction has changed to Virginia/Washington, D.C. may renew under the Maryland contract; however, if a benefit change is requested, the change must be handled in the proper jurisdiction.

Grandfathered product renewals

If the group has received a renewal that includes tier-rated benefits, CareFirst has identified one or more of the medical products as grandfathered. The group can keep the current benefits and rate structure. For a small group health plan to be considered grandfathered, it must have an effective date on or before March 23, 2010, have at least one enrollee, and have maintained continuous enrollment since then. **Grandfathered plans that reach zero enrollment will be terminated immediately.**

- Existing groups that designate product(s) as grandfathered may renew coverage with CareFirst; however, if a plan change is made, the plan loses grandfathering under the ACA, and the plan ends. Based on their FTE calculation, they must move into an ACA-compliant product if their FTE is 50 or less (or to a product offered in the 51–199 market if the FTE calculation is over 50).
- All CareFirst grandfathered product renewals are rated based on the sum of the combined actual enrollment in all of the grandfathered product(s) offered. New enrollment applications are required when a plan change to another grandfathered product within the group is made.
- Groups with all grandfathered products may add an ACA-compliant product based on member-level rating of those enrolled in that ACA-compliant option. Groups may not have more than three product options total. If there is no enrollment in the grandfathered plan, the grandfathered plan will be terminated immediately.
- Existing groups that remain with grandfathered products must submit a completed Notice of Intent to Grandfather each year upon renewal.
- A group cannot maintain grandfathered status if it changes jurisdictions.

According to the ACA, any one of the following changes will end the grandfathered status of a health plan:

- Elimination of all (or substantially all) benefits to diagnose or treat a particular condition.
- Increase in a percentage cost-sharing requirement (such as raising an individual's coinsurance requirement from 20% to 25%).
- Increase in a deductible or out-of-pocket maximum by an amount that exceeds medical inflation plus 15%.
- Increase in a copayment by an amount that exceeds medical inflation plus 15% (or, if greater, $5 plus medical inflation).
- Decrease in an employer's contribution rate towards the cost of coverage by more than 5%.
- Imposition of annual limits on the dollar value of all benefits, specified amounts.

If you have made any of these changes since March 23, 2010, you must offer a new plan(s) that complies with the ACA requirements.

Grandfathered products, census change only

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/Average Factor Adjustment form. Census change only requests for these products can be made through the end of the month prior to renewal.

- Changing from a husband/wife or family contract to two individual contracts:
  - If a husband and wife (working for the same employer) wish to change membership category from husband and 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.

- Changing to the younger subscriber:
  - 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.

Requests for census changes to grandfathered plan renewals must be submitted directly to CareFirst Small Group Underwriting or through the general/full-service producer. These are limited to one request per group per renewal.

Grandfathered product renewals, county code changes

- The address and county code used for rating purposes must be the headquarters location of the group, not a branch office location. If there is a question, CareFirst reserves the right to investigate the actual headquarters of the business through use of the internet and business listings.
- Incorrect address and county codes released on a grandfathered renewal:
  - To facilitate a recalculation of the renewal rate, the address and county code must be updated to CareFirst's internal systems. Contact either your CareFirst renewal representative or general/full-service producer to request this type of change. Please note that a change in rates is only allowed at the group's renewal or in conjunction with an off-cycle benefit change.

Benefit changes with a jurisdiction change at renewal

- Benefit changes must be received prior to deadline.
  - If a group is located in Virginia and moves to Maryland or Washington, D.C., the group can keep the current Virginia benefits (regardless of medical product). The group cannot change their benefits unless they accept Maryland/Washington, D.C. benefits.
  - If the group is located in Washington, D.C. and moves to Virginia (within our service area) or Maryland, the group should coordinate such efforts through the Washington DC exchange.

REQUEST FOR ANNIVERSARY DATE CHANGE

Written request (in letter format) must be provided to Small Group Underwriting for any change of group anniversary date, including the following:

- Group name and number.
- A statement including "The group would like to move to MM/DD/YYYY renewal from a MM/DD/ YYYY renewal."
- A statement that the group understands that their rates will change effective MM/DD/YYYY, and this may result in an increase in premium.
- The letter must be signed by the group administrator.

MEDICARE ELIGIBILITY, RATING AND PARTICIPATION FOR GRANDFATHERED PRODUCTS ONLY

Grandfathered renewal rating: Medicare eligibles BlueChoice/BluePreferred

EE = employee, SP = spouse, CH = child

		Rate EE	Rate SP	Rate CH
1	EE is Medicare	Rate EE as Medicare if Non-TEFRA and enroll as Medicare; If TEFRA, use EE actual age and enroll as individual	N/A	N/A
2	EE is Medicare + SP	Rate EE as Medicare if Non-TEFRA and enroll as Medicare; If TEFRA, use EE actual age, and enroll as (individual/ adult)	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	Rate on employee only using their real age as EE is <65. Must enroll as (individual/adult)	N/A	N/A
4	EE is Medicare + SP is Medicare	Rate EE as Medicare if Non-TEFRA and enroll as Medicare; If TEFRA, use EE actual age and enroll as (individual/ adult)	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	Rate EE as Medicare if Non-TEFRA and enroll as Medicare; If TEFRA, use EE actual age, and enroll as individual/ child(ren)	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	Rate on employee only using their real age as EE is <65. Must enroll as individual/child(ren)	N/A	N/A
7	EE is Medicare + CH is Medicare	Rate EE as Medicare if Non-TEFRA and enroll as Medicare; If TEFRA, use EE actual age, and enroll as individual/ child(ren)	N/A	Rate child as Medicare if Non-TEFRA and enroll as individual; If TEFRA, child is not rated separately

		Rate EE	Rate SP	Rate CH
8	EE is Medicare + SP + CH	Rate on employee only using their real age; Must enroll as family	N/A	N/A
9	EE + SP is Medicare + CH	Rate on employee only using their real age; Must enroll as family	N/A	N/A
10	EE is Medicare + SP is Medicare + CH	Rate on employee only using their real age; Must enroll as family	N/A	N/A
11	EE + SP + CH is Medicare	Rate on employee only using their real age; Must enroll as family	N/A	N/A
12	EE is Medicare + two or more CH	Rate on employee only using their real age; Must enroll as family	N/A	N/A
13	EE is Medicare + SP + CH is	Rate on employee only using their real age; Must enroll as family	N/A	N/A
14	EE + SP is Medicare + CH is Medicare	Rate on employee only using their real age; Must enroll as family	N/A	N/A
15	EE is Medicare + SP is Medicare + CH is Medicare	Rate on employee only using their real age; Must enroll as family	N/A	N/A

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

DENTAL BENEFITS

CareFirst offers a comprehensive dental portfolio, including voluntary and employer-sponsored Traditional, Preferred (PPO), BlueDental Plus, BlueDental EPO, BlueDental Basic and BlueDHMO plans.

Renewal guidelines and short plan years

- Dental products 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 time.
- A group can replace their current employer sponsored dental with voluntary dental (or the reverse) prior to renewal, as long as it is not within 90 days of the renewal date.

For 2–50 grandfathered groups only

Existing grandfathered groups may maintain parallel dental benefits. All other groups can no longer offer parallel dental benefits to medical plans.

VISION BENEFITS

Through our partnership with Davis Vision, CareFirst offers a comprehensive vision portfolio including employer-sponsored and voluntary BlueVision Plus options.

There are currently eight vision plans available. BlueVision Plus Options A-D offer newer, richer benefits than BlueVision Plus Options 1–4.

Renewal guidelines and short plan years

- Short plan year changes to add BlueVision Plus or to change from employer-sponsored to voluntary (or the reverse) can be made (except 90 days prior to the account's renewal).
- Groups whose renewal is released with medical and BlueVision Plus but choose to terminate medical may re-write the vision on a freestanding basis.

For 2–50 grandfathered groups only

BlueVision Plus

- Grandfathered 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 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 grandfathered plans.

BlueVision (Core Vision)

- BlueVision (Core Vision) is core to medical for grandfathered groups only. All other 2-50 groups do not have the BlueVision plan.
- BlueVision offers a comprehensive eye exam for a $10 copay and discounts on eyewear including lenses, frames and contacts once per benefit period (12-month period).
- BlueVision always has parallel enrollment to grandfathered groups.
- BlueVision is included as a core benefit, except in the following plan options:
  - BlueChoice HMO Open Access HRA Option 3 CORE
  - BlueChoice HMO Option 6 CORE (but may be purchased)
  - SPPP Option D CORE (but may be purchased)

WASHINGTON, D.C. AND NORTHERN VIRGINIA GROUP CONTRACT APPLICATION MATRICES

Any small employer group offering group health benefits must purchase or renew on the DC Health Link (SHOP). District-based small businesses that purchased health insurance directly from an insurance company now renew through DC Health Link. However, DC OFF-SHOP ancillaries can be purchased. See sections D, E and F for required group applications.

Below lists the most current versions of the Group Contract Applications (GCA) that are posted on the broker portal at the time of this update. At the time of sale or renewal, please be sure to refer to the broker portal for the most recent version of the GCA or the prior version, if applicable.

ACA Virginia OFF-SHOP products

Note: No retiree coverage is available under ACA.

	Medical Product(s) Sold	Sold with (YES) or without (NO) Traditional/Preferred Dental/BlueDental Plus/ BlueDental EPO/BlueDental Basic and/or BlueVision Plus Employer Sponsored/ Voluntary	Required Group Applications
Section A	**BlueChoice HMO Product(s) OFF-SHOP**		
	BlueChoice HMO Referral BlueChoice HMO Referral HSA/HRA BlueChoice HMO BlueChoice Plus Opt-Out	NO—VA/GRPAPP/HCR (1/14) (HMO) YES—Use Virginia Point-of-Enrollment (POE) Application listed. This is the only application that you will need to complete.	If no, use: **VA/GRPAPP/HCR (1/23) (HMO)** If yes, use: **VA/GRPAPP/HCR (1/23) (POE)**
Section B	**Virginia Point-of-Service Product(s) OFF-SHOP**		
	BlueChoice Plus BlueChoice Plus HSA/HRA BlueChoice Advantage BlueChoice Advantage HSA/HRA	YES or NO—The VA POS Group Contract Application covers the Traditional/ Preferred Dental and BlueVision Plus, if sold.	**VA/GRPAPP/HCR (1/23) (POS)**
Section C	**Virginia CareFirst BluePreferred Product(s) OFF-SHOP**		
	BluePreferred PPO BluePreferred PPO HSA/HRA	YES or NO—Virginia PPO Group Contract Application covers the Traditional/ Preferred Dental and BlueVision Plus, if sold.	**VA/GRPAPP/HCR (1/23) (PPO)**
Point-of-Enrollment Group Contract Application (POE)			
Note: Any time you are selling multiple ACA medical products together from Sections A, B and C, with or without Traditional/Preferred Dental/BlueDental Plus/BlueDental EPO/BlueDental Basic and/or BlueVision Plus, you can use one of the following POE Applications for all products sold. This is the **only** application that you will need to complete. You will also use the POE Application when you are adding Traditional/Preferred Dental/BlueDental Plus/BlueDental EPO/BlueDental Basic and/or BlueVision Plus to any Section A Product or a combination of Section A Medical Products. **VA/GRPAPP/HCR (1/23) (POE)**		

	Medical Product(s) Sold	Sold with (YES) or without (NO) Traditional/Preferred Dental/BlueDental Plus/ BlueDental EPO/BlueDental Basic and/or BlueVision Plus Employer Sponsored/ Voluntary	Required Group Applications
Section D	**Freestanding Traditional/Preferred Dental, BlueDental Traditional/Preferred and/or BlueVision Plus (not certified ACA benchmark plans)** Only use when there is no medical plan with CareFirst.		
	BlueDental Plus BlueDental EPO BlueDental Basic Preferred Dental Traditional Dental		Virginia: **VA/GHMSI/POE (1/13) (for plans effective prior to 5/1/19)** **VA/GHMSI/DN-VS ONLY/GCA (11/18) (DENT-VIS 5/19) (for plans effective 5/1/19 and after)** DC: **DC/GHMSI/POE (1/13) (for plans effective prior to 5/1/19)** **DC/GHMSI/DN-VS ONLY/GCA (R. 11/18) (DENT-VIS 5/19) (for plans effective 5/1/19 and after)**
Section E	**BlueDHMO**—A separate group contract application is always required when you sell BlueDHMO with or without medical.		
	BlueDHMO $0 BlueDHMO $10		Virginia: **VA/CFBC/DHMO/GCA (10/15)** DC: **DC/CFBC/DHMO/GCA (10/15)**

ADDITIONAL INFORMATION

CONTINUATION OF COVERAGE

Washington, D.C.

City Council passed an emergency act, the Continuation of Health Coverage Act of 2001, extending health benefits for covered members of a small employer group with fewer than 20 employees for a period of three months beyond termination of coverage. Eligible employees will have to pay the full cost of the policy during the extension, but the cost may not exceed 102% of the group rate. Eligible employees must elect the continuation of coverage benefit and provide payment to the employer within the required time frames. There are no additional forms to complete.

Virginia

Virginia continuation of health coverage extends health benefits for covered members of a small employer group with fewer than 20 employees for a period of 12 months beyond termination of coverage. Eligible employees will have to pay the full cost of the policy during the extension, but the cost may not exceed 102% of the group rate. Eligible employees must elect the continuation of coverage benefit and provide payment to the employer within prescribed time frames. A Selection Form for Continuation of Group Coverage is required.

Maryland

Maryland Continuation of Coverage enables members to continue their group's coverage for a limited period of time after they cease to be eligible in the group. There are additional forms to complete. Events that qualify for continuation of coverage include:

- Involuntary termination
- Surviving spouse
- Voluntary termination
- Divorce

The above is a general summary in condensed form of Maryland continuation coverage laws. A person may be eligible under more than one coverage (such as continuation or COBRA). If a person is eligible for more than one continuation of coverage, they will receive the continuation coverage that is most favorable at the time of application. A person may receive only one coverage at a time.

Duration Periods:

- Washington, D.C.—3 months
- Virginia—12 months
- Maryland—18 months

DOING BUSINESS WITH CAREFIRST

CareFirst products are sold through brokers who are contracted with us directly and/or through a general producer (GP) or full-service producer (FSP). It is important for all distributors selling CareFirst products to understand their role in the sales process to efficiently service our members. Please use the following details as a guideline for selling CareFirst products:

The role of the general producer (GP):

- Establish and maintain compliance with all regulatory requirements.
- Assist with the appointment of brokers.
- Provide brokers with rate quotes for new groups and alternative options for existing groups.
- Gather, review, and submit all paperwork required for new group enrollment, off-cycle benefit changes and renewals.
- Provide brokers with marketing/sales materials and literature.
- Distribute renewals to brokers and groups. Submit/upload complete and accurate paperwork to CareFirst through the Broker Express by the **deadlines established in the Account Installation (AI) Calendar (Producer Manual).**

- Assist brokers with benefits and eligibility questions.
- Assist with the Quote to Bill Process, including customer service, CareFirst Hub, enrollment and billing issues.
- Ensure their brokers receive CareFirst Broker News.

The general producer (GP) is also responsible for educating brokers and their staff on the requirements for new group and benefit change submissions. In addition, the GP is expected to hold broker training sessions on CareFirst products, enrollment eligibility requirements and other important topics. CareFirst Representatives also attend these sessions to assist and answer questions.

The role of the CareFirst broker sales representative is to educate the general producer (GP) and their staff on CareFirst products and procedures.

The role of the full-service producer (FSP):

- Establish and maintain compliance with all regulatory requirements.
- Assist with appointment of brokers.
- Provide brokers with rate quotes for new groups and alternative options for existing groups.
- Gather, review, and submit all paperwork required for new group enrollment, off-cycle benefit changes and renewals.
- Provide brokers with marketing/sales. materials and literature.
- Distribute renewals to brokers and groups.
- Submit complete and accurate paperwork to CareFirst through the Broker Express by the **deadlines established in the Account Installation (AI) Calendar (Producer Manual).**
- Assist brokers with benefits and eligibility questions.
- Ensure their brokers receive CareFirst Partner News.
- Bill and collect premiums for groups.
- Send termination notices to groups and brokers.
- Update and maintain enrollment records, service accounts and members regarding billing, enrollment and customer service issues.

The CareFirst broker sales representative is responsible for assisting the full-service producer with broker training sessions. In addition, they are responsible for training and educating the full-service producer on all changes and updates related to doing business with CareFirst.

The role of the CareFirst representative for the direct broker:

- Establish and maintain compliance with all regulatory requirements.
- Provide training on CareFirst products and policies.
- Provide training on the CareFirst Quote to Bill process.
- Assist in new sales and renewals.
- Assist with enrollment meetings (groups with 25 or more enrollees).
- Provide materials necessary to sell and renew CareFirst products.
- Maintain a positive relationship with all brokers.
- Assist with benefit and eligibility questions.

KEEPING YOU INFORMED

CareFirst BlueCross BlueShield strives to keep our broker community informed. Timely updates lead to better service of our accounts and members. Information and product updates are described below.

Partner News

CareFirst Partner News covers a variety of sales-related topics, including product updates, administrative matters and more. Partner News is distributed by email. In addition, **Partner News archives** are available on the **broker portal**. General/full-service producers are responsible for providing brokers with Partner News information. Direct brokers can contact their broker sales representative to be added to the distribution list to receive the Partner News directly from CareFirst.

Broker forums

Broker forums are held to keep brokers informed of CareFirst product initiatives and enhancements, pricing updates and other sales-related information. These forums are generally held on an annual basis and brokers are invited in advance.

Broker Council

The CareFirst Broker Council is comprised of approximately 20 experienced health insurance brokers representing Maryland, Washington, D.C. and Northern Virginia. New members are appointed to the Council each year. The Council meets quarterly and provides the opportunity for members of the Council to discuss issues and concerns in the broker community. The Broker Council represents CareFirst's entire distributor networks. We strongly encourage brokers to contact any member of the Broker Council with any questions, comments or concerns. To request a copy of the list of Council members, please contact your broker sales representative.

CONNECTING WITH CAREFIRST

GPS, FSPs or direct brokers doing business with our Maryland, Washington, D.C., and/or Northern Virgina locations can contact Broker Sales by emailing **BrokerServicesTeam@carefirst.com** or fax to 301-470-8049.

Brokers working with a GP or FSP should contact them directly.

Direct brokers only:

As part of the workflow process, all paperwork should be submitted through the Broker Express for new and renewing business. Please send the following requests to the above-stated email or fax number:

- Signed renewals
- Benefit booklet and group contract requests for existing groups (please allow 6–8 weeks for shipment)
- Group updates such as address changes, group administrator and enrollment eligibility
- Group cancellation letters

IMPORTANT CONTACTS

Broker customer service

888-4CF-BRKRS (423-2757)
BrokerServicesTeam@carefirst.com

Billing enrollment and ID card inquiries

Group Enrollment
202-479-2730

Group Enrollment Fax (including subsidy paperwork)
301-470-7604

Billing and Collections (Invoices)
888-232-2335

Group Conversion
888-567-9155

BluePreferred member services

Monday-Friday 7 a.m.–7 p.m.
Toll Free 800-321-3497
TTY 202-479-3546
Pre-Authorization—866-773-2884

BlueChoice member services

Monday-Friday 7 a.m.–7 p.m.
Toll Free 866-520-6099
TTY 800-828-3196
Pre-Authorization—866-773-2884

HealthyBlue member services

Monday-Friday 7 a.m.–7 p.m.
866-452-2217

Note: When writing to CareFirst BlueCross BlueShield, always include the member ID number and group number. Please address your correspondence to:

CareFirst BlueCross BlueShield
Attn: Mail Administrator
P.O. Box 14114
Lexington, KY 40512-4114

Vision—Davis Vision

800-783-5602

Dental benefits

866-891-2802

Pharmacy

800-241-3371

Out-of-area providers

800-810-2583

Health and Wellness

Blue365 discount program
855-511-BLUE (2583)

24-Hour Nurse Advice Line

800-535-9700

Mental health/substance abuse

800-972-0716

CareFirst switchboard

202-479-8000

Individual sales

410-356-8000/800-544-8703

Broker commission information/accounting

BrokerCompensationQuestions@carefirst.com

Broker contracting and compliance

855-541-3986
BCC@carefirst.com

BlueCard® provider information

800-810-BLUE (2583)

Broker Portal and Broker Express help desk

877-526-8390
SBUPortalSupport@carefirst.com

Member website

Members can check the status of their medical claims history, covered members, eligibility, benefits and email questions to customer service by logging in to **carefirst.com/myaccount**.

Due to changes in state and federal privacy rules, adult dependents will only have access to claims information about themselves.

REQUESTING A QUOTE

Brokers doing business with general or full-service producer

When requesting a proposal, please provide your GP/FSP with the following information about the prospective group regardless of group size:

- Name of company
- Headquarters location's physical address and all other locations
- Census information, including employee date of birth and covered spouse/dependents
- Product information
- Number, nature of business and SIC codes of employees located outside the service area
- Federal employer size
- Full-time equivalent (FTE) calculation

CareFirst direct brokers:

When requesting a proposal, please provide your broker representative with the following information about the prospective group regardless of group size:

- Name of company
- Headquarters location's physical address and all other locations
- Census information, including employee date of birth and covered spouse/dependents
- Product information
- Number of employees located outside the service area
- Federal employer size
- Full-time equivalent (FTE) calculation

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