BlueCross BlueShield of Delaware

P.O. Box 1991
Wilmington, DE 19899
1.800.572.4400

SMALL BUSINESS PROGRAM REQUIREMENTS
FOR GROUPS WITH 1–50 EMPLOYEES

This summary presents a brief overview of the program and is not a contract. All exclusions and limitations continue to apply. For more complete information about benefits, see your benefits handbook or contact your marketing representative.

ABOUT BCBSD'S SMALL BUSINESS PROGRAM

Blue Cross Blue Shield of Delaware (BCBSD) established the Diamond State Group Insurance Trust (DSGIT) to make our health insurance programs available to eligible employers in the State. To enroll and participate in the coverages available through the DSGIT, employers sign a Member Company Agreement. The Agreement states how the program operates and the basic terms and requirements for continued participation under the program. Employers who are enrolling for the first time, or who are returning, will enter into the Agreement as part of the application process.

The following provisions apply to the DSGIT program:

- The Trust Agreement and the insurance policy are available for inspection during normal business hours at BCBSD offices in Wilmington, DE.
- The principal duty of the Trustee is to hold the insurance policy that provides the insurance coverage.
- The Trustee is not the insurer.
- The insurance coverage, the determination of benefits and payments, and any other duties related to the coverage are the sole obligations of, and will be fulfilled by, BCBSD in accordance with the terms of the group policy, as well as BCBSD's underwriting and standard operating procedures.
- Neither the Trustee nor BCBSD are acting as sponsors of any employee benefit plan as defined by ERISA.

Employers seeking or renewing coverage through the DSGIT agree to abide by the program requirements, including:

- Compliance with the requirements to be an eligible member company, employee, dependent or retired employee under the plan;
- Compliance with the participation requirements (i.e., the percentage of employees required to be enrolled) to be eligible for coverage under the plan;
- Agreeing to allow BCBSD to periodically review payroll, personnel and other business records to confirm compliance with the eligibility requirements; and
- Acknowledging that if an employer or enrollee is confirmed to be ineligible, that the employer will be responsible to BCBSD for the difference between premiums and claims paid under the coverage.

These Member Company Agreement provisions will continuously apply for as long as an Employer obtains insurance coverage from BCBSD through the DSGIT.

ABOUT PREEXISTING CONDITIONS

What is a preexisting condition?

A preexisting condition is any condition that an employee or a dependent had BEFORE the effective date of coverage. These conditions include any disease, disorder, illness, or injury.

Note: Individuals under 19 will not be subject to a preexisting condition waiting period. Pregnancies are not considered preexisting conditions.

Federal and state law establish a 6-month "Look Back" period for preexisting conditions. This is the period to which we "look back" to determine if an individual received care or treatment or if a health care provider made a diagnosis or advised the individual about treatment or recommended treatment for any condition noted above. Individuals received "treatment" if they:

- Took prescription drugs, or
- Had lab tests, or
- Had imaging services, or
- Saw a medical provider.

Timing of enrollment sets the dates for the "Look Back" period:

Timely Enrollee: The 6-month period prior to the date of hire into an employee class eligible for coverage.

Late Enrollee: The 6-month period prior to the coverage effective date.

Special Enrollee: The 6-month period prior to the coverage effective date.

What is a preexisting waiting period? It is the time an individual has to wait before benefits begin to cover a preexisting condition. The timing of enrollment also affects the length of the waiting period.

When does BCBSD begin paying benefits for preexisting conditions?

The following preexisting condition waiting periods apply to employees and their dependents:

Timely Enrollees: 12 months from the date of hire into an employee class eligible for coverage. If an employer has an eligibility waiting period, then the preexisting condition waiting period starts at the same time as the eligibility waiting period. To be considered a timely enrollee an employee must apply for coverage within 30 days of completing the group's eligibility waiting period. Otherwise the employee is considered a late enrollee.

Late Enrollees: 12 months after the date of coverage. Late enrollees can apply for coverage when the contribution waiting period is satisfied, if it is longer than the eligibility waiting period, or at an annual reopening on the anniversary date of your company's program.

Special Enrollees: 12 months after the date of coverage.

Exception: There is no preexisting condition waiting period for individuals and dependents under 19:

Certificates of Coverage

Federal law requires that employers provide employees and their dependents with a Certificate of Coverage when they lose coverage under this plan. The Certificate will show the most recent 18-month period during which the employee or dependents had coverage. It will provide proof of coverage so that they can get credit toward any

preexisting condition waiting period that the new plan has.

Employees have the right to ask their prior employer for a Certificate of Coverage so that they can get credit under their new plan. Individuals have up to 24 months following loss of coverage to request the Certificate.

Many employers have designated BCBSD as the administrator to issue Certificates of Coverage for them. Please call us at the number listed in the front of this booklet if you have questions about HIPAA administration.

Credit for Preexisting Condition Waiting Periods

Preexisting condition waiting periods may be reduced by the number of days of coverage under a prior plan. Employees will receive credit towards the preexisting condition waiting period if they enrolled in this new plan within 63 days after the prior "creditable coverage" ended.

Start of 63-day period: The day after prior "creditable coverage" ended.

End of 63-day period: Whichever is the earlier of 63 days or:

For Timely Enrollees: The date of hire into an employee class eligible for coverage.

For Special Enrollees and Late Enrollees: The effective date of coverage.

Creditable Coverage refers to the coverage (which meets the legal guidelines) that an employee had immediately before joining this plan.

Examples of "creditable coverage" include:

- A group plan through an employer (includes government-sponsored plans such as the Federal Employees Plan), or
- An individual plan, or
- Carveout plans where this plan is secondary to Medicare, or
- Part A or Part B of Medicare, or
- Medicaid, or

ABOUT ELIGIBILITY

There are two kinds of eligibility rules for participation in the BCBSD health care program: one for member companies and one for your employees as participants. This section provides a summary of both. Please refer to your Account Administration Manual for full details.

Member Company Eligibility Requirements

To participate in the BCBSD health care programs for small businesses, your company must:

- Conduct a full-time business which is principally domiciled within the State of Delaware.
- Possess licensing: For-Profit Companies — a business license or professional license. Non-Profit Companies — a valid declaration of tax-exempt status and a Federal Taxpayer ID number from the IRS.
- Have 50 or fewer eligible full-time employees (as defined by BCBSD). The majority must be employed in Delaware.
- Have and maintain payroll and personnel records (hours worked, wages, and salaries paid) in accordance with state and federal law and regulations, and agree to make such records available to BCBSD upon request.
- Comply with all applicable underwriting guidelines.

Your company must also meet the following percentage of **Participation Requirements** for health benefits (and traditional dental or vision benefits— if offered by your company):

Eligible Employees	Minimum Percentage of Who Must Enroll
1 to 5	100%
6 to 9	100%, less one employee
10 to 50	75%

To determine the above percentage, your company must count as eligible all persons who have completed your eligibility waiting period in the classes you have selected, unless they are covered under their spouse's program, are eligibly enrolled on their parent's health care plan, or have other qualifying coverage.

Eligibility for Employees

To be eligible for the BCBSD health care programs, each of your employees must satisfy at least one of the two requirements below. They must be either:

Active full-time employees who work for the company for a minimum of 30 hours per week, at not less than minimum wage, for at least 9 months out of a 12 month period.

Company owners, officers, or directors who participate in the daily operation of your company and receive a full-time salary equivalent to at least 30 hours a week at not less than minimum wage. If the company covers all other part-time employees, part-time owners, officers or directors may be covered if salaried and working at least 20 hours a week.

When BCBSD determines a company's health rating category and percentage of participation requirements, we include all classes of personnel who are eligible for coverage under your company's policy for health benefits.

Eligibility for Dependents

Legally married spouse of an employee.

A child will qualify for coverage by meeting all the criteria for one of the categories below:

A child who is born to you or your spouse; or adopted by you or your spouse, or placed in your home for adoption; or someone for whom health care coverage is the employee's responsibility under the terms of a qualified medical child support order (a copy of the order must be on file with and accepted by BCBSD). He/she must also be under age 26 — eligibility for a covered child extends only through the last day of the month in which the child becomes age 26.

An over-age disabled dependent child who is someone who meets all criteria for a "child," except age, listed above. The child must be unmarried, covered as a dependent by a parent as of the date the child reaches the maximum dependent child age and receiving more than 50 percent of support by his/her parent. The child must have a disability that occurred prior to reaching the maximum dependent child age, and is expected to last more than 12 months or is terminal in nature, and, is so severe the child is incapable of self-support. The child must not eligible for coverage under another health plan or Medicare or Medicaid (unless federal or state law requires otherwise). In addition, a Disabled Child Application form must be completed and approved by BCBSD. In deciding whether the applicable requirements have been met, and approving the Disabled Child Application, BCBSD shall be the sole judge.

About Coverage For Optional Classes of Employees

Employers may also offer coverage to any or all of the following classes of personnel, so long as the Employer's written personnel policy makes such provision:

Active Part-Time Employees who work at least 20 hours a week with a salary reflective of part-time employment at not less than minimum wage. Your company must contribute at least 50% of their health insurance premium rate.

Full-Time Independent Contractors who work the same number of hours for your company as other full-time employees. Part-time independent contractors can be covered if the company covers all other part-time employees. The salary requirement is the same as defined for Full-Time Employees or Part-Time Employees.

Seasonal Employees who work full-time at least 30 hours a week for at least 9 months of the year.

Disabled Employees— BCBSD requires that disabled employees meet the following criteria:

1. Must have been covered by your company's health benefits program prior to the disability, and be receiving the same level of employer contribution to the group health premium as active employees.
2. Must be receiving disability compensation (e.g., Workers Compensation) under the terms of your group disability program. Payment of the employee's health care premium alone does not constitute compensation. Once the employee's eligibility for disability compensation ends, they must be terminated from your group health benefits program unless they have returned to the prior level of active employment with your company. This requirement is waived for short term disabilities not exceeding eight weeks.

   If disability compensation and BCBSD coverage are continued beyond eight weeks, as provided above, BCBSD coverage may not be continued beyond:

   - an additional eighteen weeks (26 total weeks) of uninterrupted disability.
   - the date the employee resigns or is terminated by the employer
   - the date the employee is no longer prevented by disability from returning to work

   At the end of the earliest of the above, the employee's group health benefits must be terminated, even if the employee continues to be eligible for disability compensation. If your company is not subject to COBRA, non-group direct pay health benefits are offered provided BCBSD is notified immediately once the disabled employee's eligibility for group health benefits ends (as defined in preceding information).
3. If your company is subject to federal COBRA regulations, and offers qualified employees continuing coverage in accordance with the regulation, BCBSD will waive our requirement that an employee must be receiving disability compensation.

Retirees who retired from your company, and:

1. Were eligible for and covered by your company's health care program while they were active employees (you must furnish proof of their prior employment), and
2. Satisfy your company's written health benefits policy for age and length of service requirement (at least 55 and 5, respectively) for receiving health care benefits.

Note: Dental or vision rider benefits are not available to retirees.

Former Owners may continue coverage with your company as retirees provided they retired at the time of sale, were covered under your company's policy during their term of ownership and satisfy the eligibility requirements for retirees under your company's health care policy.

Note: As retirees, former owners are not eligible for dental or vision rider benefits.

BCBSD will not insure groups consisting solely of optional classes (e.g., part-time, retiree, etc.) of enrollees.

CLASSES NOT ELIGIBLE FOR COVERAGE

The following classes of individuals are not eligible for coverage:

1. Surviving spouses.
2. Any other class of enrollee not specified in this application unless specifically agreed to in writing by BCBSD Underwriting.

DENTAL AND VISION BENEFIT ENROLLMENT INFORMATION

- Dental and vision benefits are not available to retirees or former owners.
- Your company can add dental or vision coverage at any time. We must receive your company's application by the 15th of the month to start coverage on the 1st of the following month.
- Your company can cancel dental or vision coverage only on the anniversary date of your health care program. Otherwise your company will lose health care coverage. If your company cancels coverage, your company cannot rejoin the dental or vision plan for one year. Employees can drop coverage only on the anniversary date of your program.
- Your company can offer either Traditional Dental, or BlueDental DHMO and DPPO.

  For Traditional Dental: To offer family dental coverage, 75% of employees who are eligible for dental coverage and who have eligible dependents must enroll their dependents in the plan. Once an employee cancels coverage he or she cannot rejoin Traditional Dental through the same employer until a subsequent annual reopening on the anniversary date of your company's program.

  BCBSD does not provide "stand alone" dental coverage. If a person has medical coverage with BCBSD or another carrier, they are eligible for BCBSD Traditional dental. If they are eligible for medical coverage but decline it, they are not eligible for BCBSD Traditional dental.

  For BlueDental DHMO and DPPO Benefits: Your company can offer DHMO and DPPO even if only one employee selects dental coverage. There are no employee percentage of participation requirements. Employees can drop coverage only on the anniversary date of your company's program. Once an employee cancels coverage, he or she cannot rejoin the dental plan through the same employer until a subsequent annual reopening on the anniversary date of your company's program.

  For Vision: An employee must choose the same level of coverage for vision as chosen for medical (i.e. employee only, employee and spouse, etc.) Once an employee cancels vision coverage, he or she cannot rejoin the vision plan through the same employer until a subsequent annual reopening on the anniversary date of your company's program.

OTHER IMPORTANT ELIGIBILITY INFORMATION

1. State law requires that eligible employees and/or their dependents who choose not to enroll in your company's health benefits program must complete a *Waiver of Coverage*. A copy of this form must be retained by your company, and the original sent to BCBSD.
2. Payment of an employee's health insurance premium alone does not constitute compensation.
3. When individuals are employed by, or associated through ownership or holding office with more than one business entity, they must be enrolled for coverage through the entity which represents their primary source of occupational income and the activity where they spend most of their time. BCBSD makes the determination where distinctions are unclear.
4. When an enrollee, spouse or dependent becomes eligible for Medicare, they must apply for and retain both Parts A and B of Medicare unless they are subject to TEFRA, DEFRA or OBRA regulations which require their group health plan to be primary. BCBSD will not provide primary or under-age-65-type benefit programs to persons eligible for primary reimbursement under Medicare.
5. It is the Member Company's responsibility to ensure that its enrollment practices are in compliance with state and federal law. The Member Company is encouraged to consult with its legal counsel regarding the applicability of such federal laws as OBRA, TEFRA/DEFRA, and other Medicare Secondary Payer laws.

PARTICIPATION REQUIREMENTS

In determining whether the applicable percentage is met, all personnel in the eligible classes are counted as eligible except individuals:

- Covered under their spouses' employer's health and/or dental / and/or vision rider benefits plan;
- Eligible and covered under their parents' employer's health and/or dental and/or vision rider benefits plan;
- Who have not satisfied the Member Company's eligibility waiting period;
- Who have qualifying existing coverage under:
  - Medicare (Parts A and B), Medicaid, or Medicare Advantage
  - Other employer-based health benefits similar to or exceeding benefits under the State of Delaware's definition of a Basic Health Plan,
  - An individual health insurance plan similar to or exceeding benefits under the State of Delaware's definition of a Basic Health Plan, providing that coverage has been in effect continuously for at least one year (this includes all BCBSD non-group policies),
  - Who are not in a class of personnel which is eligible for BCBSD coverage such as temporary or casual employees.

A Member Company may not terminate, reduce the hours or otherwise alter an employee's work arrangements for the primary purpose of making that person ineligible for health insurance benefits in order to satisfy percentage participation requirements.

BCBSD considers commonly-owned and/or closely-affiliated companies as one entity for purposes of calculating the percentage participation requirement. Common ownership exists when one or more individuals or companies have controlling interest in two or more separate business entities. Close affiliation exists where there are indications of overlapping ownership of similar or interdependent entities, or where employees or facilities are shared. BCBSD reserves the right to make these determinations.

ABOUT ELIGIBILITY & RECORDS

Periodically, we will require your company to certify that your company and your employees meet our eligibility requirements. To confirm eligibility, your company will need to retain and, when requested, make available to us applicable records, tax returns, payroll and personnel records. BCBSD honors the confidentiality of all records, and, if requested, will provide a signed Confidentiality Agreement.

ABOUT MEDICAL UNDERWRITING

Medical underwriting allows us to set rates that are fair and equitable by basing them on the health risk of your employees. Periodically we may ask you and all your covered employees to complete a new questionnaire to re-evaluate your company's rating category.

We reserve the right to change our renewal procedures and we will give you advance notice of any major changes. Rules for coverage are subject to adjustment each year.

ABOUT RATES

Premium rates are established for each small employer and may be adjusted annually based on a variety of factors, including: claims costs and the small employer's composite age, composite health status, size and region.

ABOUT COVERAGE ENDING

Coverage is renewable annually. Coverage for a company will end if (1) BCBSD chooses not to renew all Small Business coverage or (2) your company:

- Terminates its relationship with BCBSD
- Fails to pay premiums
- No longer qualifies as an eligible member company with BCBSD (for example, the company may no longer meet participation or domicile requirements)
- Commits fraud or misrepresents information related to eligibility requirements