Bend Chamber of Commerce Group Eligibility and Underwriting Guidelines

Group Eligibility

- Groups must be domiciled in Oregon.
- Groups must maintain membership in good standing with the Bend Chamber and/or their local chamber. Groups located outside of Bend must either:
    - Be a member of their local chamber and an Associate Member of the Bend Chamber; or
    - Be a full member of the Bend Chamber.
- Coverage is available to groups with 2 or more eligible employees and a minimum of 2 enrolled employees. At least one employee must be a common-law (W-2/payrolled) employee. The most recent IRS Form 132 is required for verification. Businesses operated soley by a husband and wife are not eligible unless there is at least one other full-time employee.

Medical Rules:

- Groups with 2-9 enrolled subscribers may offer up to two medical/Rx plans.
- Groups with 10 or more enrolled subscribers may offer up to three medical/Rx plans.
- Refer to the Medical Plan Pairing Spreadsheet for approved combinations.
- Large groups (51+ eligible employees) with 10 or more enrolled subscribers that elect both Moda and Kaiser may offer up to two Moda plans and one Kaiser plan.
- At least 60% of all employees must live, reside, or physically work within the Moda Health service area.

Dental Rules:

- Standalone dental coverage is available to groups with 5 or more enrolled subscribers.
- The High, Mid and Low Delta Dental plans are available to groups with 2 or more enrolled subscribers who are enrolled in a Bend Chamber medical plan.
- The Delta Dental Super plan is available to groups with 5 or more enrolled subscribers.
- To offer two Delta Dental plans, in addition to the Willamette Dental plan, groups must have 5 or more enrolled subscribers.
- Orthodontia Coverage is available to groups with 10 or more enrolled subscribers.
- Dental enrollment does not need to match medical enrollment.

Vision Rules:

- If the optional vision rider is selected, it must be offered with all plans, except HSA plans.

Group Requirements

Employer Contributions

- Employers must contribute at least 50% of the employee-only premium for the lowest cost medical and dental plan.
- Dependent premium contribution discounts are available to groups with at least one enrolled dependent at plan inception or renewal.

Employee Eligibility

- Employers may establish employee eligibility between 17.5 and 40 hours per week.
- Large groups may not set eligibility requirements above 30 hours per week.
- Leased employees, independent contractors, temporary employees, seasonal employees, and individuals not treated as employees for employment tax purposes are not eligible for enrollment and may not be counted toward participation requirements.
- Employees who decline coverage when first eligible must wait until the next open enrollment period unless they experience a qualifying event.
- Retirees, including early retirees, are not eligible for coverage unless required as a public or quasi-public employer.
- Employees who reside in Hawaii are not eligible for coverage.

Participation Requirements

- A minimum of 90% participation is required for all eligible employees who are not waiving coverage due to other qualifying coverage for medical plans.
- A minimum of 75% participation of all eligible employees is required for dental plans.
- The following waivers do not count against participation:
    - Coverage through another group health plan
    - Government-sponsored coverage
- The following waivers do count against participation:
    - Individual coverage
    - Shared Care coverage
    - No coverage

Waiting periods

- Employers may choose one of the following waiting periods:
    - Date of Hire (first month's coverage and premium prorated)
    - First of the month coinciding with or following date of hire
    - First of the month following 30 days
    - First of the month following 60 days
    - 91st day of employment (first month's coverage and premium prorated)

Controlled Groups

- If a controlled group (as defined in section 414 of the Internal Revenue Code) is determined to be a large employer, each affiliated employer will be considered a large group.

Additional Rules

- Employee-only contracts are not available.
- All selected product lines must share the same anniversary date.
- Additional lines of coverage may be added off anniversary; however, all policies will renew on a common anniversary date.

Other Provisions

Underwriting & Rate Approval

- Moda Health reserves the right to adjust rates for a new group if any information differs from the original quote. Final rates will be determined by final enrollment. If initial census differs from final enrollment rates will change.
- Coverage may be declined if the group does not meet established underwriting guidelines.
- Released proposals are illustrations only and do not constitute a contract, guarantee of coverage or final rate approval. The rates and benefits are for general information and discussion purposes only and not valid unless approved by the Bend Chamber carriers. The rate quote is not an offer or a guarantee of coverage. Moda Health reserves the right to modify rates in the event plan benefits must be modified because of any change, modification or clarification in law, including the Affordable Care Act. If coverage is applied for and accepted, actual rates may vary depending on final enrollment, plan benefits, effective date and other possible adjustments.

HSA Funding

- For HSA-qualified plans, employer funding may not exceed 50% of the plan deductible.

Medicare & COBRA

- All groups will be considered primary over Medicare when Medicare eligibility is based on age.
- All groups are subject to COBRA requirements.

Carrier Requirements

- Products are offered on a sole-carrier basis.
- For groups with 51+ enrolled subscribers, Moda Health will allow a split-carrier (slice) arrangement with Kaiser Permanente for medical coverage, subject to underwriting approval. In these situations, a minimum of 51% of enrolled medical members must be enrolled with Moda Health.

Broker of Record (BOR)

- BOR Changes may be submitted at any time.
- The BOR change becomes effective based on the date reflected in the request. However, commissions are paid to the new broker beginning on the group's next renewal date.
- Upon receipt of a new BOR, we will work with the new broker and provide group information as requested.
- In cases involving broker termination by the carrier or JBP, the BOR may be approved effective the first of the month following receipt of the BOR.

Letter of Authorization

- An LOA does not replace the current Broker of Record.
- An LOA provides limited access to group information for the authorized agent.

Employer Contribution Changes

- Contribution changes may be submitted at any time and become effective the first of the month following receipt of the request.
- Contribution changes submitted after renewal release will be accepted for re-rating purposes.
- To be reflected in the renewal, contribution changes must be fully processed and updated in the carrier's system before renewal implementation.
- If not processed in time, the contribution change will be factored into the group's next renewal.