1300 Health Insurance General Provisions

1308 Small Employer Health Insurance [Formerly Regulation 72]

1.0 Statement of purpose

1.1 This Regulation is intended to implement the provisions of 18 **Del.C.** Ch. 72, Small Employer Health Insurance. The general purposes of 18 **Del.C.** Ch. 72 and this Regulation are to provide for the availability of health insurance coverage to small employers, regardless of their health status or claims experience; to regulate insurer rating practices and establish limits on differences in rates between health benefit plans; to ensure renewability of coverage; to establish limitations on underwriting practices, eligibility requirements and the use of preexisting condition exclusions; to provide for development of "basic" and "standard" health insurance plans to be offered to all small employers; to provide for establishment of a reinsurance program; to direct the basis of market competition away from risk selection and toward the efficient management of health care; and to improve the overall fairness and efficiency of the small group health insurance market.

1.2 18 **Del.C.** Ch. 72 and this Regulation are intended to promote broader spreading of risk in the small employer marketplace. 18 **Del.C.** Ch. 72 and this Regulation are intended to regulate all health benefit plans sold to small employers, whether sold directly or through associations or other groupings of small employers. Carriers that provide health benefit plans to small employers are intended to be subject to all of the provisions of 18 **Del.C.** Ch. 72 and this Regulation.

2.0 Definitions

2.1 As used in this Regulation:

“Associate member of an employee organization" means any individual who participates in an employee benefit plan (as defined in 29 U.S.C. Section 1002(1)) that is a multi-employer plan (as defined in 29 U.S.C. Section 1002(37A)), other than the following:

- An individual (or the beneficiary of such individual) who is employed by a participating employer within a bargaining unit covered by at least one of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained; or
- An individual who is a present or former employee (or a beneficiary of such employee) of the sponsoring employee organization, of an employer who is or was a party to at least one of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained, or of the employee benefit plan (or of a related plan).

"New entrant" means an eligible employee, or the dependent of an eligible employee, who becomes part of an employer group after the initial period for enrollment in a health benefit plan.

"Risk characteristic" means the health status, claims experience, duration of coverage, or any similar characteristic related to the health status or experience of a small employer group or of any member of a small employer group.

"Risk load" means the percentage above the applicable base premium rate that is charged by a small employer carrier to a small employer to reflect the risk characteristics of the small employer group.

3.0 Applicability and scope

3.1

3.1.1 Except as provided in sections 1.1 and 14.0, this Regulation shall apply to any health benefit plan, whether provided on a group or individual basis, which:

3.1.1.1 Meets the conditions set forth in 18 **Del.C.** §7203;

3.1.1.2 Provides coverage to one or more employees of a small employer located in this state, without regard to whether the policy or certificate was issued in this state; and

3.1.1.3 Is in effect on or after the effective date of 18 **Del.C.** Ch. 72.

3.1.2 The provisions of 18 **Del.C.** Ch.72 and this Regulation shall not apply to an individual health insurance policy issued prior to the effective date of 18 **Del.C.** Ch. 72.

3.2

3.2.1 A carrier that provides individual health insurance policies to one or more of the employees of a small employer shall be considered a small employer carrier and shall be subject to the provisions of 18 **Del.C.** Ch. 72 and this Regulation with respect to such policies if the small employer contributes directly or indirectly to the premiums for the policies and the carrier is aware or should have been aware of such contributions.

3.2.2 In the case of a carrier that provides individual health insurance policies to one or more employees of a small employer, the small employer shall be considered to be an eligible small employer as defined in 18 **Del.C.** §7207(a)(3) and the small employer carrier shall be subject to 18 **Del.C.** §7207(a)(2) (relating to guaranteed issue of coverage) if:

3.2.2.1 The small employer has at least two (2) employees, and

3.2.2.2 The small employer contributes directly or indirectly to the premiums charged by the carrier, including, but not limited to the following conditions:

3.2.2.2.1 any portion of the premium or benefits is paid by or on behalf of the employee;

3.2.2.2.2 the health benefit plan is administered by the small employer;

3.2.2.2.3 an eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium;

3.2.2.2.4 the health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of Section 162, Section 125, or Section 106 of the United States Internal Revenue Code.

3.3 The provisions of 18 **Del.C.** Ch. 72 and this Regulation shall apply to a health benefit plan provided to a small employer or the employees of a small employer without regard to whether the health benefit plan is offered under or provided through a group policy or trust arrangement of any size sponsored by an association of discretionary group.

3.4 An individual health insurance policy shall not be subject to the provisions of 18 **Del.C.** Ch. 72 and this Regulation solely because the policyholder elects a deduction under Section 162(1) of the Internal Revenue Code.

3.5

3.5.1 If a small employer is issued a health benefit plan under the terms of 18 **Del.C.** Ch. 72, the provisions of 18 **Del.C.** Ch. 72 and this Regulation shall continue to apply to the health benefit plan in the case that the small employer subsequently employs more than twenty-five (25) eligible employees. A carrier providing coverage to such an employer shall, within sixty (60) days of becoming aware that the employer has more than twenty-five (25) eligible employees but no later than the anniversary date of the employer's health benefit plan, notify such employer that the protections provided under 18 **Del.C.** Ch. 72 and this Regulation shall cease to apply to the employer if such employer fails to renew its current health benefit plan or elects to enroll in a different health benefit plan.

3.5.2

3.5.2.1 If a health benefit plan is issued to an employer that is not a small employer as defined in 18 **Del.C.** Ch. 72, but subsequently the employer becomes a small employer (due to the loss or change of work status of one or more employees), the terms of 18 **Del.C.** Ch. 72 shall not apply to the health benefit plan. The carrier providing a health benefit plan to such an employer shall not become a small employer carrier under the terms of 18 **Del.C.** Ch. 72 solely because such carrier continues to provide coverage under the health benefit plan to the employer.

3.5.2.2 A carrier providing coverage to an employer described in section 3.5.2.1 shall, within sixty (60) days of becoming aware that the employer has twenty-five (25) or fewer eligible employees, notify such employer of the options and protections available to the employer

under 18 **Del.C.** Ch. 72, including the employer's option to purchase a small employer health benefit plan from any small employer carrier.

3.6

3.6.1

3.6.1.1 If a small employer has employees in more than one state, the provisions of 18 **Del.C.** Ch. 72 and this Regulation shall apply to a health benefit plan issued to the small employer if:

3.6.1.1.1 the majority of eligible employees of such small employer are employed in this state; or

3.6.1.1.2 if no state contains a majority of the eligible employees of such small employer, the primary business location of the small employer is in this state.

3.6.1.2 In determining whether the laws of this state or another state apply to a health benefit plan issued to a small employer described in section 3.6.1.1, the provisions of such paragraph shall be applied as of the date the health benefit plan was issued to the small employer for the period that such health benefit plan remains in effect.

3.6.2 If a health benefit plan is subject to 18 **Del.C.** Ch. 72 and this Regulation, the provisions of 18 **Del.C.** Ch. 72 and this Regulation shall apply to all individuals covered under such health benefit plan, whether they reside in this state or in another state.

3.7 A carrier that is not operating as a small employer carrier in this state shall not become subject to the provisions of 18 **Del.C.** Ch. 72 and this regulation solely because a small employer that was issued a health benefit plan in another state by such carrier moves to this state.

4.0 Establishment of classes of business

4.1 A small employer carrier that establishes more than one class of business pursuant to the provisions of 18 **Del.C.** §7204 shall maintain on file for inspection by the Commissioner the following information with respect to each class of business so established:

4.1.1 A description of each criterion employed by the carrier (or any of its agents) for determining membership in the class of business;

4.1.2 A statement describing the justification for establishing the class as a separate class of business and documentation that the establishment of the class of business is intended to reflect substantial differences in expected claims experience or administrative costs related to the reasons set forth in 18 **Del.C.** §7204; and

4.1.3 A statement disclosing which, if any, health benefit plans are currently available for purchase in the class and any significant limitations related to the purchase of such plans.

4.2 A carrier may not directly or indirectly use group size as a criterion for establishing eligibility for a health benefit plan or for a class of business.

5.0 Transition for assumptions of business from another carrier

5.1

5.1.1 A small employer carrier shall not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering a small employer in this state unless:

5.1.1.1 The transaction has been approved by the Commissioner of the state of domicile of the assuming carrier;

5.1.1.2 The transaction has been approved by the Commissioner of the state of domicile of the ceding carrier; and

5.1.1.3 The transaction otherwise meet the requirements of this section.

5.1.2 A carrier domiciled in this state that proposes to assume or cede the entire insurance obligation and/or risk of one or more small employer health benefit plan from another carrier shall make a filing for approval with the Commissioner at least sixty (60) days prior to the date of the proposed assumption. The Commissioner may approve the transaction if the Commissioner finds that the transaction is in the best interests of the individuals insured under the health benefit plan to be

transferred and is consistent with the purposes of 18 **Del.C.** Ch. 72, and this Regulation. The Commissioner shall not approve the transaction until at least thirty (30) days after the date of the filing; except that, if the ceding carrier is in hazardous financial condition, the Commissioner may approve the transaction as soon as the Commissioner deems reasonable after the filing.

5.1.3

5.1.3.1 The filing required under section 5.1.2 shall:

5.1.3.1.1 Describe the class of business (including any eligibility requirements) of the ceding carrier from which the health benefit plans will be ceded;

5.1.3.1.2 Describe whether the assuming carrier will maintain the assumed health benefit plans as a separate class of business (pursuant to section 5.3 or will incorporate them into an existing class of business (pursuant to section 5.4. If the assumed health benefit plans will be incorporated into an existing class of business, the filing shall describe the class of business of the assuming carrier into which the health benefit plans will be incorporated;

5.1.3.1.3 Describe whether the health benefit plans being assumed are currently available for purchase by small employers;

5.1.3.1.4 Describe the potential effect of the assumption (if any) on the benefits provided by the health benefit plans to be assumed;

5.1.3.1.5 Describe the potential effect of the assumption (if any) on the premiums for the health benefit plans to be assumed; and

5.1.3.1.6 Describe any other potential material effects of the assumption on the coverage provided to the small employers covered by the health benefit plans to be assumed.

5.1.3.1.7 Include any other information required by the Commissioner.

5.1.3.2 A small employer carrier required to make the filing under section 5.1.2 shall also make an informational filing with the Commissioner of each state in which there are small employer health benefit plans that would be included in the transaction. The informational filing to each state shall be made concurrently with the filing made under section 5.1.2 and shall include at least the information specified in section 5.1.3.1 for the small employer health benefit plans in that state.

5.1.4 A small employer carrier shall not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering a small employer in this state unless it complies with the following:

5.1.4.1 The carrier has provided notice to the Commissioner at least sixty (6) days prior to the date of the proposed assumption. The notice shall contain the information specified in section 5.1.3 for the health benefit plans covering small employers in this state.

5.1.4.2 If the assumption of the class of business would result in the assuming small employer carrier being out of compliance with the limitations related to premium rates contained in 18 **Del.C.** §7205(a)(1), the assuming carrier shall make a filing with the Commissioner seeking suspension of the application of 18 **Del.C.** §7205(a)(1).

5.1.4.3 An assuming carrier seeking suspension of the application of 18 **Del.C.** §7205(a)(1) shall not complete the assumption of the class of business unless the Commissioner grants the suspension requested pursuant to section 5.1.3.2.

5.1.4.4 Unless a different period is approved by the Commissioner, a suspension of the application of 18 **Del.C.** §7205(a)(1) shall, with respect to and assumed class of business, be for no more than fifteen (15) months and, with respect to each individual small employer, shall last only until the anniversary date of such employer's coverage (except that the period with respect to an individual small employer may be extended for a period of up to twelve (12) months if such small employer's anniversary date occurs within three (3) months of the date of assumption of the class of business).

5.2

5.2.1 Except as provided in section 5.1.2, a small employer carrier shall not cede or assume the entire insurance obligation and/or risk for a small employer health benefit plan unless the transaction

includes the ceding to the assuming carrier of the entire class of business which includes such health benefit plan.

5.2.2 A small employer carrier may cede less than an entire class of business to an assuming carrier if:

5.2.2.1 One or more small employers in such class have exercised their right under contract or state law to reject (either directly or by implication) the ceding of their health benefit plans to another carrier. In such instance, the transaction shall include each health benefit plan in the class of business except those health benefit plans for which a small employer has rejected the proposed cession; or

5.2.2.2 After a written request from the transferring carrier, the Commissioner determines that the transfer of less than the entire class of business is in the best interests of the small employers insured in such class of business.

5.3 Except as provided in section 5.4, a small employer carrier that assumes one or more health benefit plans from another carrier shall maintain such health benefit plans as a separate class of business.

5.4 A small employer carrier that assumes one or more health benefit plans from another carrier may exceed the limitation contained in 18 **Del.C.** §7204(b) (relating to the maximum number of classes of business a carrier may establish) due solely to such assumption for up to a period of fifteen (15) months after the date of the assumption, provided that the carrier complies with the following provisions:

5.4.1 Upon assumption of the health benefit plans, such health benefit plans shall be maintained as a separate class of business. During the fifteen (15) month period following the assumption, each of the assumed small employer health benefit plans shall be transferred by the assuming small employer carrier into a single class of business operated by the assuming small employer carrier. The assuming small employer carrier shall select the class of business into which the assumed health benefit plans will be transferred in a manner such that the transfer results in the least possible change to the benefits and rating method of the assumed health benefit plans.

5.4.2 The transfers authorized in section 5.4.1 shall occur with respect to each small employer on the anniversary date of the employer's coverage, except that the period may be extended for a period that is no greater than twelve (12) months for small employers whose anniversary dates occur within three (3) months of the date of assumption of the class of business.

5.4.3 A small employer carrier making a transfer pursuant to section 5.4.1 may alter the benefits of the assumed health benefit plans to conform to the benefits currently offered by the carrier in the class of business into which the health benefits plans have been transferred.

5.4.4 The premium rate for an assumed small employer health benefit plan shall not be modified by the assuming small employer carrier until the health benefit plan is transferred pursuant to section 5.4.1. Upon such transfer, the assuming small employer carrier shall calculate a new premium rate for the health benefit plan from the rate manual established for the class of business into which the health benefit plan is transferred. In making such calculation, the risk load applied to the health benefit plan shall be no higher than the risk load applicable to such health benefit plan prior to the assumption.

5.5 During the fifteen (15) month period provided in this subsection, the transfer of small employer health benefit plans from the assumed class of business in accordance with this subsection shall not be considered a violation of the first sentence of 18 **Del.C.** §7204(e).

5.6 An assuming carrier may not apply eligibility requirements (including minimum participation and contribution requirements) with respect to an assumed health benefit plan (or with respect to any health benefit plan subsequently offered to a small employer covered by such an assumed health benefit plan) that are more stringent than the requirements applicable to such health benefit plan prior to the assumption.

5.7 The Commissioner may approve a longer period of transition upon application of a small employer carrier. The application shall be made within sixty (60) days after the date of assumption of the class of business and shall clearly state the justification for a longer transition period.

5.8 Nothing in this Section or in 18 **Del.C.** Ch. 72 is intended to:

5.8.1 Reduce or diminish any legal or contractual obligation or requirement, including any obligation provided in 18 **Del.C.** Ch. 9, Reinsurance, of the ceding or assuming carrier related to the transaction;

5.8.2 Authorize a carrier that is not admitted to transact the business of insurance in this state to offer or insure health benefit plans in this state; or

5.8.3 Reduce or diminish the protections related to an assumption reinsurance transaction provided in 18 **Del.C.** Ch. 9, or otherwise provided by law.

6.0 Restrictions relating to premium rates

6.1

6.1.1 A small employer carrier shall develop a separate rate manual for each class of business. Base premium rates and new business premium rates charged to small employers by the small employer carrier shall be computed solely from the applicable rate manual developed pursuant to this subsection. To the extent that a portion of the premium rates charged by a small employer carrier is based on the carrier's discretion, the manual shall specify the criteria and factors considered by the carrier in exercising such discretion.

6.1.2

6.1.2.1 A small employer carrier shall not modify the rating method used in the rate manual for a class of business until the change has been approved as provided in this paragraph. The Commissioner may approve a change to a rating method if the Commissioner finds that the change is reasonable, actuarially appropriate, and consistent with the purposes of 18 **Del.C.** Ch. 72 and this Regulation.

6.1.2.2 A carrier may modify the rating method for a class of business only with prior approval of the Commissioner. A carrier requesting to change the rating method for a class of business shall make a filing with the Commissioner at least sixty (60) days prior to the proposed date of the change. The filing shall contain at least the following information:

6.1.2.2.1 The reasons the change in rating method is being requested;

6.1.2.2.2 A complete description of each of the proposed modifications to the rating method;

6.1.2.2.3 A description of how the change in rating method would affect the premium rates currently charged to small employers in the class of business, including an estimate from a qualified actuary of the number of groups or individuals (and a description of the types of groups or individuals) whose premium rates may change by more than ten percent (10%) due to proposed change in rating method (not including general increases in premium rates applicable to all small employers in a health benefit plan);

6.1.2.2.4 A certification from a qualified actuary that the new rating method would be based on objective and credible data and would be actuarially sound and appropriate; and

6.1.2.2.5 A certification from a qualified actuary that the proposed change in rating method would not produce premium rates for small employers that would be in violation 18 **Del. C.** §7205.

6.1.2.3 For the purpose of this section, a change in rating method shall mean:

6.1.2.3.1 A change in the number of case characteristics used by a small employer carrier to determine premium rates for health benefit plans in a class of business;

6.1.2.3.2 A change in the manner or procedures by which insureds are assigned into categories for the purpose of applying a case characteristic to determine premium rates for health benefit plans in a class of business;

6.1.2.3.3 A change in the method of allocating expenses among health benefit plans in a class of business; or

6.1.2.3.4 A change in a rating factor with respect to any case characteristic if the change would produce a change in premium for any small employer that exceeds ten percent (10%).

6.1.2.4 For the purpose of section 6.1.2.3.1, a change in a rating factor shall mean the cumulative change with respect to such factor considered over a twelve (12) month period. If a small employer carrier changes rating factors with respect to more than one case characteristic in a twelve (12) month period, the carrier shall consider the cumulative effect of all such changes in applying the ten percent (10%) test under section 6.1.2.3.1.

6.2

6.2.1 The rate manual developed pursuant to section 6.1.1 shall specify the case characteristics and rate factors to be applied by the small employer carrier in establishing premium rates for the class of business.

6.2.2 A small employer carrier may not use case characteristics other than those specified in 18 **Del.C.** §7202(g) without the prior approval of the Commissioner. A small employer carrier seeking such an approval shall make a filing with the Commissioner for a change in rating method under section 6.1.2.1.

6.2.3 A small employer carrier shall use the same case characteristics in establishing premium rates for each health benefit plan in a class of business and shall apply them in the same manner in establishing premium rates for each such health benefit plan. Case characteristics shall be applied without regard to the risk characteristics of a small employer.

6.2.4 The rate manual developed pursuant to section 6.1.1 shall clearly illustrate the relationship among the base premium rates charged for each health benefit plan in the class of business. If the new business premium rate is different than the base premium rate for a health benefit plan, the rate manual shall illustrate such difference.

6.2.5 Differences among base premium rates for health benefit plans shall be based solely on the reasonable and objective differences in the design and benefits of the health benefit plans and shall not be based in any way on the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan. A small employer carrier shall apply case characteristics and rate factors within a class of business in a manner that assures that premium differences among health benefit plans for identical small employer groups vary only due to reasonable and objective differences in the design and benefits of the health benefit plans and are not due to the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan.

6.2.6 The rate manual developed pursuant to section 6.1.1 shall provide for premium rates to be developed in a two step process. In the first step, a base premium rate shall be developed for the small employer group without regard to any risk characteristics of the group. In the second step, the resulting base premium rate may be adjusted by a risk load, subject to the provisions of 18 **Del.C.** §7205 to reflect the risk characteristics of the group.

6.2.7

6.2.7.1 Except as provided in section 6.2.7.2, a premium charged to a small employer for a health benefit plan small employer carrier shall not include a separate application fee, underwriting fee, or any other separate fee or charge.

6.2.7.2 A carrier may charge a separate fee with respect to a health benefit plan (but only one fee with respect to such plan) provided the fee is no more than five dollars ($5.00) per month per employee and is applied in a uniform manner to each health benefit plan in a class of business.

6.2.8 A small employer carrier shall allocate administrative expenses to the basic and standard health benefit plans on no less favorable a basis than expenses allocated to other health benefit plans in the class of business. The rate manual developed pursuant to section 6.1.1 shall describe the method of allocating administrative expenses to the health benefit plans in the class of business for which the manual was developed.

6.2.9 Each rate manual developed pursuant to section 6.1.1 shall be maintained by the carrier for a period of six (6) years. Updates and changes to the manual shall be maintained with the manual.

6.2.10 The rate manual and rating practices of a small employer carrier shall comply with any guidelines issued by the Commissioner.

6.3 If group size is used as a case characteristic by a small employer carrier, the highest rate factor associated with a group size classification shall not exceed the lowest rate factor associated with such a classification by more than twenty (20%) percent.

6.4 The restrictions related to changes in premium rates in 18 **Del.C.** §§7205 (a)(3) and 7205 (a)(7) shall be applied as follows:

6.4.1 A small employer carrier shall revise its rate manual each rating period to reflect changes in base premium rates and changes in new business premium rates.

6.4.2

6.4.2.1 If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate is less than or the same as the percentage change in the base premium rate, the change in the new business premium rate shall be deemed to be the change in the base premium rate for the purposes of 18 **Del.C.** §§7205 (a)(3)(c) and 7205 (a)(7)(a).

6.4.2.2 If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate exceeds the percentage change in the base premium rate, the health benefit plan shall be considered a health benefit plan into which the small employer carrier is no longer enrolling new small employers for the purposes of 18 **Del.C.** §§7205 (a)(3) and 7205 (a)(7) of Chapter 72.

6.4.2.3 If, for any rating period, the change in the new business premium rate for a health benefit plan differs from the change in the new business premium rate for any other health benefit plan in the same class of business by more than twenty (20%) percent, the carrier shall make a filing with the Commissioner containing a complete explanation of how the respective changes in new business premium rates were established and the reason for the difference. Such filing shall be made within thirty (30) days of the beginning of such rating period.

6.4.2.4 A small employer carrier shall keep on file for a period of at least six (6) years the calculations used to determine the change in base premium rates and new business premium rates for each health benefit plan for each rating period.

6.5

6.5.1 Except as provided in sections 6.4.2.1 through 6.4.2.4, a change in premium rate for a small employer shall produce a revised premium rate that is no more than the following:

6.5.1.1 the base premium rate for the small employer (as shown in the rate manual as revised for the rating period), multiplied by

6.5.1.2 one (1) plus the sum of:

6.5.1.2.1 the risk load applicable to the small employer during the previous rating period, and

6.5.1.2.2 fifteen (15%) percent (prorated for periods of less than one year).

6.5.2 In the case of a health benefit plan into which a small employer carrier is no longer enrolling new small employers, a change in premium rate for a small employer shall produce a revised premium rate that is no more than the following:

6.5.2.1 the base premium rate for the small employer (given its present composition and as shown in the rate manual in effect for the small employer at the beginning of the previous rating period), multiplied by

6.5.2.2 one (1) plus the lesser of:

6.5.2.2.1 the change in the base rate or (ii) the percentage change in the new business premium for the most similar health benefit plan into which the small employer carrier is enrolling new small employers, multiplied by (c) one (1) plus the sum of:

6.5.2.2.1.1 the risk load applicable to the small employer during the previous rating period and

6.5.2.2.1.2 fifteen (15%) percent (prorated for periods of less than one year).

6.5.3 In the case of a health benefit plan described in 18 **Del.C.** §7205(a)(6), if the current premium rate for the health benefit plan exceeds the ranges set forth in 18 **Del.C.** §7205 (a), the formulae set forth in sections 6.5.1 and 6.5.2 will be applied as if the fifteen (15%) percent adjustment provided in section 6.5.1.2.2 and Paragraph (2)(c)(ii) (?) were a zero (0) percent adjustment.

6.5.4 Notwithstanding the provisions of section 6.5.1 and 6.5.2, a change in premium rate for a small employer shall not produce a revised premium rate that would exceed the limitations on rates provided in 18 **Del.C.** §7205(a)(2).

6.6

6.6.1 A representative of a Taft Hartley trust (including a carrier upon the written request of such a trust) may file in writing with the Commissioner a request for the waiver of application of the provisions of 18 **Del.C.** §7205 (a) with respect to such trust.

6.6.2 A request made under section 6.5.1 shall identify the provisions for which the trust is seeking the waiver and shall describe, with respect to each such provision, the extent to which application of such provision would:

6.6.2.1 adversely affect the participants and beneficiaries of the trust; and

6.6.2.2 require modifications to one or more of the collective bargaining agreements under or pursuant to which the trust was or is established or maintained.

6.6.2.3 A waiver granted under 18 **Del.C.** Ch. 72 shall not apply to an individual who participates in the trust because such individual is an associate member of an employee organization or the beneficiary of such an individual.

7.0 Requirement to insure entire groups

7.1

7.1.1 A small employer carrier that offers coverage to a small employer shall offer to provide coverage to each eligible employee and to each dependent of an eligible employee. Except as provided in section 7.1.2 and 7.1.3, the small employer carrier shall provide the same health benefit plan to each such employee and dependent.

7.1.2 A small employer carrier may offer the employees of a small employer the option of choosing among one or more health benefit plans, provided that each employee may choose any of the offered plans. Except as provided in 18 **Del.C.** §7207 (c) (with respect to exclusions for preexisting conditions) the choice among benefit plans may not be limited, restricted or conditioned based upon the risk characteristics of the employees or their dependents.

7.2

7.2.1 A small employer carrier shall require each small employer that applies for coverage, as part of the application process, to provide a complete list of eligible employees as defined in 18 **Del.C.** §§7202 (m) and 7202 (n). The small employer carrier shall require the small employer to provide appropriate supporting documentation (such as the W-2 Summary Wage and Tax Form) to verify the information required under this paragraph.

7.2.2 A small employer carrier shall secure a waiver with respect to each eligible employee and each dependent of an eligible employee who declines an offer of coverage under a health benefit plan provided to a small employer. A small employer carrier may issue a health benefit plan to a small employer that excludes an eligible employee or the dependent of an eligible employee only if:

7.2.2.1 The excluded individual does not have a risk characteristic or other attribute that would cause the carrier to make a decision with respect to premiums or eligibility for a health benefit plan that is adverse to the small employer, or

7.2.2.2 The excluded individual can demonstrate that he or she has waived coverage for other legitimate reasons, such as that found in 18 **Del.C.** §7207 (c)(4)c.

If unwillingness to make a premium contribution is the reason stated for waiver of coverage under section 7.2.2.1, the small employer carrier shall take affirmative steps to

verify the voluntary nature of the waiver. The waiver shall be signed by the eligible employee (on behalf of such employee or the dependent of such employee) and shall certify that the individual who declined coverage was informed of the availability of coverage under the health benefit plan. The waiver form shall require that the reason for declining coverage be stated on the form and shall include a written warning of the penalties imposed on late enrollees. Waivers shall be maintained by the small employer carrier for a period of six (6) years.

7.2.2.3

7.2.2.3.1 A small employer carrier shall not issue coverage to a small employer that refuses to provide the list required under section 7.2.1 or a waiver required under section 7.2.2.

7.2.2.3.2

7.2.2.3.2.1 A small employer carrier shall not issue coverage to a small employer if the carrier, or a producer for such carrier, has reason to believe that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to the individual's risk characteristics.

7.2.2.3.2.2 A producer shall notify a small employer carrier, prior to submitting an application for coverage with the carrier on behalf of a small employer, of any circumstances that would indicate that the small employer has induced or pressured an eligible employee (or the dependent of an eligible employee) to decline coverage due to the individual's risk characteristics.

7.2.2.4

7.2.2.4.1 New entrants to a small employer group shall be offered an opportunity to enroll in the health benefit plan currently held by such group. A new entrant that does not exercise the opportunity to enroll in the health benefit plan within the period provided by the small employer carrier may be treated as a late enrollee by such carrier, provided that the period provided to enroll in the health benefit plan extends at least thirty (30) days after the date the new entrant is notified of his or her opportunity to enroll. If a small employer carrier has offered more than one health benefit plan to a small employer group pursuant to section 7.1.2, the new entrant shall be offered the same choice of health benefit plans as the other members of the group.

7.2.2.4.2 A small employer carrier shall not apply a waiting period, elimination period or other similar limitation of coverage (other than an exclusion for preexisting medical conditions consistent with 18 **Del.C.** §7207 (c)(2) with respect to a new entrant that is longer than sixty (60) days.

7.2.2.4.3 New entrants to a group shall be accepted for coverage by the small employer carrier without any restrictions or limitations on coverage related to the risk characteristics of the employees or their dependents, except that a carrier may exclude coverage for preexisting medical conditions, subject to the provisions provided in 18 **Del.C.** §7207 (c).

7.2.2.4.4 A small employer carrier may assess a risk load to the premium rate associated with a new entrant, consistent with the requirements of 18 **Del.C.** §7205. The risk load shall be at the same risk load charged to the small employer group immediately prior to acceptance of the new entrant into the group.

7.2.2.5

7.2.2.5.1

7.2.2.5.1.1 In the case of an eligible employee (or dependent of an eligible employee) who, prior to the effective date of 18 **Del.C.** §7207(a), was excluded from coverage or denied coverage by a small employer carrier in the process of providing a health benefit plan to an eligible small employer (as defined in 18 **Del.C.** §7207 (a)(3)), the small employer carrier shall provide an opportunity for the eligible employee (or dependent of such eligible employee) to enroll in the health benefit plan currently held by the small employer.

7.2.2.5.1.2 A small employer carrier may require an individual who requests enrollment under this subsection to sign a statement indicating that such individual sought coverage under the group contract (other than as a late enrollee) and that such coverage was not offered to the individual.

7.2.2.5.2 The opportunity to enroll shall meet the following requirements:

7.2.2.5.2.1 The opportunity to enroll shall begin March 31, 1992, and shall last for a period of at least three (3) months.

7.2.2.5.2.2 Eligible employees and dependents of eligible employees who are provided an opportunity to enroll pursuant to this subsection shall be treated as new entrants. Premium rates related to such individuals shall be set in accordance with section 7.2.2.4.1.

7.2.2.5.2.3 The terms of coverage offered to an individual described in section 7.2.2.5.1.1 may exclude coverage for preexisting medical conditions if the health benefit plan currently held by the small employer contains such an exclusion, provided that such exclusion period shall be reduced by the number of days between the date the individual was excluded or denied coverage and the date coverage is provided to such individual pursuant to this subsection.

7.2.2.5.2.4 A small employer carrier shall provide written notice at least forty-five (45) days prior to the opportunity to enroll provided in section 7.2.2.5.1.1 to each small employer insured under a health benefit plan offered by such carrier. The notice shall clearly describe the rights granted under this subsection to employees and dependents who were previously excluded from or denied coverage and the process for enrollment of such individuals in the employer's health benefit plan.

8.0 Consideration of industry

8.1 Except as provided in section 8.2 and 8.3, a small employer carrier may not consider the trade or occupation of the employees of a small employer or the industry or type of business in which the small employer is engaged in determining whether to issue or continue to provide coverage to the small employer.

8.2 A small employer carrier may use industry as a case characteristic in establishing premium rates, subject to 18 **Del.C.** §7205 (a)(6).

8.3 A small employer carrier may consider trade, occupation or industry as part of the eligibility criteria for a class of business, subject to 18 **Del. C.** §7207 (a)(2)b.

9.0 Application to reenter state

9.1 A carrier that has been prohibited from writing coverage for small employers in this state pursuant to 18 **Del.C.** §7206(b) may not resume offering health benefit plans to small employers in this state until the carrier has made a petition to the Commissioner to be reinstated as a small employer carrier and the petition has been approved by the Commissioner. In reviewing a petition, the Commissioner may ask for such information and assurances as the Commissioner finds reasonable and appropriate.

9.2 In the case of a small employer carrier doing business in only one established geographic service area of the state, if the small employer carrier elects to nonrenew a health benefit plan under 18 **Del.C.** §7206 (a)(6), the small employer carrier shall be prohibited from offering health benefit plans to small employers in any part of the service area for a period of five (5) years. In addition, the small employer carrier shall not offer health benefit plans to small employers carrier in any other geographic area of the state without the prior approval of the Commissioner. In considering whether to grant approval, the Commissioner may ask for such information and assurances as the Commissioner finds reasonable and appropriate.

10.0 Qualifying previous and qualifying existing coverages

10.1 In determining whether a health benefit plan or other health benefit arrangement (whether public or private) shall be considered qualifying previous coverage or qualifying existing coverage for the purposes of 18 **Del.C.** §§7202 (r), 7207 (c)(2) and 18 **Del.C.** §7207 (c)(5), a small employer carrier shall interpret the Chapter no less favorably to an insured individual than the following:

10.1.1 A health insurance policy, certificate or other health benefit arrangement shall be considered employer-based if an employer sponsors the plan or arrangement or makes a contribution to the plan or arrangement.

10.1.2 A health insurance policy, certificate or other benefit arrangement shall be considered to provide benefits similar to or exceeding the benefits provided under the basic health benefit plan if the policy, certificate or other benefit arrangement provides benefits that:

10.1.2.1 Have an actuarial value (as considered for a normal distribution of groups) that is not substantially less than the actuarial value of the basic health benefit plan; or

10.1.2.2 Provides coverage for hospitalization and physician services that is substantially similar to or exceeds the coverage for such services in the basic health benefit plan.

10.1.3 In making a determination under this subsection, a small employer carrier shall evaluate the previous or existing policy, certificate or other benefit arrangement taken as a whole and shall not base its decision solely on the fact that one portion of the previous or existing policy, certificate or benefit arrangement provides less coverage than the comparable portion of the basic health benefit plan.

10.2 For the purposes of 18 **Del.C.** §7207(c)(2), an individual will be considered to have qualifying previous coverage with respect to a particular service if the previous policy, certificate or other benefit arrangement covering such individual met the definition of qualifying previous coverage contained in 18 **Del.C.** §7202(x) and provided any benefit with respect to the service.

10.3 A small employer carrier shall ascertain the source of previous or existing coverage of each eligible employee and each dependent of an eligible employee at the time such employee or dependent initially enrolls into the health benefit plan provided by the small employer carrier. The small employer carrier shall have the responsibility to contact the source of such previous or existing coverage to resolve any questions about the benefits or limitations related to such previous or existing coverage.

11.0 Restrictive riders

11.1 A restrictive rider, endorsement or other provision that would violate the provisions of 18 **Del.C.** §7207 (c)(5)(b) and that was in force on the effective date of this Regulation may not remain in force beyond the first anniversary date of the health benefit plan subject to the restrictive provision that follows the effective date of this Regulation. A small employer carrier shall provide written notice to those small employers whose coverage will be changed pursuant to this subsection at least thirty (30) days prior to the required change to the health benefit plan.

11.2 Except as permitted in 18 **Del.C.** §7207 (c)(2), a small employer carrier shall not modify or restrict a basic or standard health benefit plan in any manner for the purposes of restricting or excluding coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan.

11.3 Except as permitted in 18 **Del.C.** §7207 (c)(2), a small employer carrier shall not modify or restrict any health benefit plan with respect to any eligible employee or dependent, through riders, endorsements or otherwise, for the purpose of restricting or excluding coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan.

12.0 Rules related to fair marketing

12.1

12.1.1 A small employer carrier shall actively market each of its health benefit plans to small employers in this state. A small employer carrier may not suspend the marketing or issuance of the basic and standard health benefit plans unless the carrier has good cause and has received the prior approval of the Commissioner.

12.1.2 In marketing the basic and standard health benefit plans to small employers, a small employer carrier shall use at least the same sources and methods of distribution that it uses to market other health benefit plans to small employers. Any producer authorized by a small employer carrier to market health benefit plans to small employers in the state shall also be authorized to market the basic and standard health benefit plans.

12.2

12.2.1 A small employer carrier shall offer at least the basic and standard health benefit plans, as found in Appendix A and Appendix B of this Regulation, to any small employer that applies for or makes an inquiry regarding health insurance coverage from the small employer carrier. The offer shall be in writing and shall include at least the following information:

12.2.1.1 a general description of the benefits contained in the basic and standard health benefit plans and any other health benefit plan being offered to the small employer, and

12.2.1.2 information describing how the small employer may enroll in the plans. The offer may be provided directly to the small employer or delivered through a producer.

12.2.2

12.2.2.1 A small employer carrier shall provide a price quote to a small employer (directly or through an authorized producer) within ten (10) working days of receiving a request for a quote and such information as is necessary to provide the quote. A small employer carrier shall notify a small employer (directly or through an authorized producer) within five (5) working days of receiving a request for a price quote of any additional information needed by the small employer carrier to provide the quote.

12.2.2.2 A small employer carrier may not apply more stringent or detailed requirements related to application for enrollment for the basic and standard health benefit plans than are applied for other health benefit plans offered by the carrier.

12.2.3

12.2.3.1 If a small employer carrier denies coverage under a health benefit plan to a small employer on the basis of a risk characteristic, the denial shall be in writing and shall state with specificity the reasons for the denial (subject to any restrictions related to confidentiality of medical information). The written denial shall be accompanied by a written explanation of the availability of the basic and standard health benefit plans from the small employer carrier. The explanation shall include at least the following:

12.2.3.1.1 A general description of the benefits contained in each such plan;

12.2.3.1.2 A price quote for each such plan; and (iii) Information describing how the small employer may enroll in such plans.

The written information described in this subparagraph may be provided (within the time periods provided in section 12.2.2.1 directly to the small employer or delivered through an authorized producer.

12.2.3.2 The price quote required under section 12.2.3.1.2 shall be for the lowest-priced basic and standard health benefit plan for which the small employer is eligible.

12.3 A small employer carrier shall establish and maintain a toll-free telephone service to provide information to small employers regarding the availability of small employer health benefit plans in this state. Such service shall provide information to callers on how to apply for coverage from the carrier. Such information may include the names and phone numbers of producers located geographically proximate to the caller or such other information that is reasonably designed to assist the caller to locate an authorized producer or to otherwise apply for coverage.

12.4 The small employer carrier shall not require a small employer to join or contribute to any association or group as a condition of being accepted for coverage by the small employer carrier, except that, if membership in an association or other group is a requirement for accepting a small employer into a particular health benefit plan, a small employer carrier may require the small employer to be a member of the association or group as a condition of eligibility for the health benefit plan, subject to the requirements of 18 **Del.C.** §7207 (a)(2)(b).

12.5 A small employer carrier may not require, as a condition to the offer or sale of a health benefit plan to a small employer, that the small employer purchase or qualify for any other insurance product or service.

12.6

12.6.1 Carriers offering individual and group health benefit plans in this state shall be responsible for determining whether the plans are subject to the requirements of 18 **Del.C.** Ch. 72 and this Regulation. Carriers shall elicit the following information from applicants for such plans at the time of application:

12.6.1.1 Whether or not any portion of the premium will be paid by or on behalf of a small employer, either directly or through wage adjustments or other means of reimbursement; and

12.6.1.2 Whether or not the prospective policyholder, certificateholder or any prospective insured individual intends to treat the health benefit plan as part of plan or program under Section 162 (other than Section 162(1)), Section 125 or Section 106 of the United States Internal Revenue Code.

12.6.2 If a small employer carrier fails to comply with section 12 .6.1 such small employer carrier shall be deemed to be on notice of any information that could reasonably have been gained if the small employer carrier had complied with section 12.6.1.

12.7

12.7.1 A small employer carrier shall file annually the following information with the Commissioner related to health benefit plans issued by the small employer carrier to small employers in this state:

12.7.1.1 The number of small employers that were issued health benefit plans in the previous calendar year (separated as to newly issued plans and renewals);

12.7.1.2 The number of small employers that were issued the basic health benefit plan and the standard health benefit plan in the previous calendar year (separated as to newly issued plans and renewals and as to class of business);

12.7.1.3 The number of small employer health benefit plans in force in each county (or by zip code) of the state as of December 31 of the previous calendar year;

12.7.1.4 The number of small employer health benefit plans that were voluntarily not renewed by small employers in the previous calendar year;

12.7.1.5 The number of small employer health benefit plans that were terminated or nonrenewed (for reasons other than nonpayment of premium) by the carrier in the previous calendar year; and

12.7.1.6 The number of small employer health benefit plans that were issued to small employers that were uninsured for at least the three months prior to issue.

12.7.2 The information described in section 12.7.1 shall be filed no later than March 15 of each year.

13.0 Status of carriers as small employer carriers

13.1 Within 30 days after the effective date of 18 **Del.C.** Ch. 72, each carrier providing health benefit plans in this state shall make a filing with the Commissioner indicating whether the carrier intends to operate as a small employer carrier in this state under the terms of this Regulation.

13.2 Subject to section 13.3, a carrier shall not offer health benefit plans to small employers, or continue to provide coverage under health benefit plans previously issued to small employers in this state, unless the filing provided pursuant to section 13.1 indicates that the carrier intends to operate as a small employer carrier in this state.

13.3

13.3.1 If the filing made pursuant to section 13.1 indicates that a carrier does not intend to operate as a small employer carrier in this state, the carrier may continue to provide coverage under health benefit plans previously issued to small employers in this state only if the carrier complies with the following provisions:

13.3.1.1 The carrier complies with the requirements of 18 **Del.C.** Ch. 72 (other than 18 **Del.C.** §§ 7208, 7209, and 7210) with respect to each of the health benefit plans previously issued to small employers by the carrier.

13.3.2 The carrier provides coverage to each new entrant to a health benefit plan previously issued to a small employer by such carrier. The provisions of 18 **Del.C.** Ch. 72 (other than 18 **Del.C.** §§7208, 7209, and 7210) and this Regulation shall apply to the coverage issued to such new entrants.

13.3.3 The carrier complies with the requirements of 18 **Del.C.** Ch. 72 §3 and section 11.0 of this Regulation as they apply to small employers whose coverage has been terminated by the carrier and to individuals and small employers whose coverage has been limited or restricted by the carrier.

13.4 A carrier that continues to provide coverage pursuant to this subsection shall not be eligible to participate in the reinsurance program established under 18 **Del.C.** §7210.

13.5 If the filing made pursuant to 13.1 indicates that a carrier does not intend to operate as a small employer carrier in this state, the carrier shall be precluded from operating as a small employer carrier in this state (except as provided for in section 13.3) for a period of five (5) years from the date of such filing. Upon a written request from such a carrier, the Commissioner may reduce the period provided for in such sentence if the Commissioner finds that permitting the carrier to operate as a small employer carrier would be in the best interests of the small employers in the state.

14.0 Restoration of coverage

14.1

14.1.1 Except as provided in section 14.1.2, a small employer carrier shall, as a condition of continuing to transact business in this state with small employers, offer to provide a health benefit plan as described in section 14.3 to any small employer whose coverage was terminated or not renewed by such small employer carrier after January 9, 1992.

14.1.2 The offer required under section 14.1.1 shall not be required with respect to a health benefit plan that was not renewed if:

14.1.2.1 The health benefit plan was not renewed for reasons permitted in 18 **Del.C.** §7206 (a), or

14.1.2.2 The nonrenewal was a result of the small employer voluntarily electing coverage under a separate health benefit plan.

14.2 The offer made under section 14.1 shall occur not later than thirty (30) days after a carrier indicates its intention to operate as a small employer carrier in this state pursuant to section 13.3.1. A small employer shall be given at least sixty (60) days to accept an offer made pursuant to section 14.1.

14.3 A health benefit plan provided to a terminated small employer pursuant to Subsection A shall meet the following conditions:

14.3.1 The health benefit plan shall contain benefits that are identical to the benefits in the health benefit plan that was terminated or nonrenewed.

14.3.2 The health benefit plan shall not be subject to any waiting periods (including exclusion periods for preexisting conditions) or other limitations on coverage that exceed those contained in the health benefit plan that was terminated or nonrenewed. In applying such exclusions or limitations, the health benefit plan shall be treated as if it were continuously in force from the date it was originally issued to the date that it is restored pursuant to this 18 **Del.C.** Ch. 72, §3.

14.3.3 The health benefit plan shall not be subject to any provision that restricts or excludes coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan.

14.3.4 The health benefit plan shall provide coverage to all employees who are eligible employees as of the date the plan is restored. The carrier shall offer coverage to each dependent of such eligible employees.

14.3.5 The premium rate for the health benefit plan shall be no more than the premium rate charged to the small employer on the date the health benefit plan was terminated or nonrenewed; provided that, if the number or case characteristics of eligible employees (or their dependents) of the small employer has changed between the date the health benefit plan was terminated or nonrenewed

and the date that it is restored, the carrier may adjust the premium rates to reflect any changes in case characteristics of the small employer. If the carrier has increased premium rates for other similar groups with similar coverage to reflect general increases in health care costs and utilization, the premium rate may further be adjusted to reflect the lowest such increase given to a similar group. The premium rate for the health benefit plan may not be increased to reflect any changes in risk characteristics of the small employer group until one year after the date the health benefit plan is restored. Any such increase shall be subject to the provisions of 18 **Del.C.** §7205.

14.3.6 The health benefit plan shall not be eligible to be reinsured under the provisions of 18 **Del.C.** §7209, except that the carrier may reinsure new entrants to the health benefit plan who enroll after the restoration of coverage.

15.0 Separability

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

16.0 Effective date

This regulation shall become effective on January 4, 1993, to correspond with the effective date of 18 **Del.C.** Ch. 72, under which authority Regulation 1308 (Formerly Regulation 72) is promulgated. The public welfare requires the promulgation of this regulation with less than 30 days' notice, and therefore, under the emergency provisions of 29 **Del.C.** §10123, this regulation may become effective less than 30 days from signature.

APPENDIX A -- PLAN ONE		
BASIC INDEMNITY BENEFIT PLAN		
BENEFIT		**BASIC INDEMNITY**
Physician Services:		
Prescribed Periodic Screening		Covered in full
The following primary care outpatient services are covered at the co-insurance amount after $150 of services have been provided without co-insurance or deductible application:		
Prenatal & postnatal office visits		First $150 paid, then 70%/30%
Primary care visits		First $150 paid, then 70%/30%
Surgery (outpatient)		First $150 paid, then 70%/30%
Diagnostic Lab (physician's office)		First $150 paid, then 70%/30%
Inpatient visits		Covered in full after paying (Medical/surgical) deductible. Maximum 30 days per calendar year.
Outpatient surgery		Covered after deductible
Ambulatory Surgicenters		(facility charge)
Hospital Services		(No deductible)
Inpatient		70%/30%. Maximum 30 day
(Semi-private rate) per calendar year		
Emergency Room		$50 co-pay per visit (waived if admitted)

Outpatient Services		
Diagnostic X-ray, Diagnostic Lab		Covered after deductible
Chemotherapy, Radiation therapy, Physical therapy		Covered after deductible; limit 20 visits per calendar year. Condition must be subject to significant improvement.
Mental Health		Inpatient: 70%/30% Maximum $500
		Outpatient: $50 max per visit; five visit maximum. Ambulance 70%/30% (emergency only)
Home Health Care		In place of hospitalization, 30 days, 70%/30%
Outpatient Prescription drugs		Not covered
Substance abuse, allergy tests, allergy treatment, Other Conditions:		$250 deductible, two person maximum
		Coinsurance limit $3000, two person maximum
		Uut-of-pocket maximum $3250, two person maximum
		Coinsurance: carrier pays 70%, patient pays 30%, up to out-of-pocket maximum, then carrier pays 100% per calendar year
		$50,000 maximum benefit per member per calendar year. All limits are calendar year limits. All hospital inpatient benefits are paid at the prevailing semi-private rate. Physician benefits paid at the providers' usual and customary charge.
		Pre-admission testing required for non-emergency admissions.
		Pre-certification required for all non-emergency admissions.

APPENDIX A -- PLAN TWO		
STANDARD INDEMNITY BENEFIT PLAN		
BENEFITS		**STANDARD INDEMNITY**
Physician Services		
Prescribed periodic screening		Covered in full
THE FOLLOWING PRIMARY CARE OUTPATIENT SERVICES ARE COVERED AT THE COINSURANCE AMOUNT AFTER $150 OF SERVICES HAVE BEEN PROVIDED WITHOUT CO-INSURANCE OR DEDUCTIBLE APPLICATION:		
Prenatal & postnatal office visits		First $150 paid, then 80%/20%
Primary care visits		First $150 paid, then 80%/20%
Office visit to referral provider		First $150 paid, then 80%/20%
Surgery (outpatient)		First $150 paid, then 80%/20%
Diagnostic Lab (Phys. office)		First $150 paid, then 80%/20%

Inpatient visits		Covered in full after (Medical/surgical) deductible met. Maximum 30 days per calendar year.
Outpatient surgery		Covered after deductible Ambulatory Surgicenters (facility charges)
Hospital Services		(No deductible)
Inpatient (semi-private room)		80%/20%; maximum 30 days per calendar year.
Emergency Room		$50 co-pay/visit (waived if admitted)
Outpatient Services		
THE FOLLOWING SERVICES ARE COVERED AT THE CO-INSURANCE AMOUNT AFTER THE DEDUCTIBLE:		
Diagnostic X-ray, Diagnostic lab		Covered after deductible
chemotherapy, radiation therapy Physical therapy		Covered after deductible; limit 20 visits per calendar year. Condition must be subject to significant improvement.
Mental health		Inpatient 80%/20%; max $5000. Outpatient $50 max per visit, 20 visit max per cal. year.
Ambulance (emergency only)		80%/20%
Home health care		In place of hospitalization: 30 days, 80%/20%
Outpatient Prescription drugs		Co-pay the greater of $5 or 25% of the drug cost, to a max of $500 per calendar year.
Substance Abuse		Covered as mental health benefit
Allergy tests		Covered as phys. office visit
Allergy treatment		Covered as phys. office visit
Other Conditions:		$150 deductible, two person maximum
		Coinsurance limit: $2500, two person maximum
		Out-of-pocket maximum: $2650, two person maximum
		Coinsurance: carrier pays 80%, patient pays 20%, up to out-of-pocket, then carrier pays 100% per calendar year
		All limits are calendar year limits; except mental health
		Lifetime maximum - $1,000,000
		Mental health lifetime maximum - $20,000
		All hospital inpatient benefits paid at the prevailing semi-private rate
		Physician benefits paid at the providers' usual and customary charge
		Pre-admission testing required for non-emergency admissions
		Pre-certification required for all non-emergency admissions

PLAN EXCLUSIONS

(Applicable to both Basic and Standard Indemnity Benefit Plans):

There are no benefits available for the following services, supplies or charges:

1. Which are not medically necessary.
2. Which are determined to be experimental or investigational in nature; including any service, supply, procedure or treatment directly related to an experimental or investigational treatment.
3. For any condition, disease, illness or bodily injury which occurs in the course of employment if benefits or compensation is available, in whole or in part, under the provisions of any legislation of any government unit. This exclusion applies whether or not the member claims the benefits or compensation.
4. To the extent benefits are provided by any governmental unit except as required by federal law for treatment of veterans in Veterans Administration or armed forces facilities for non-service-related medical conditions.
5. For any illness or injury suffered as a result of any act of war or while in the military service.
6. For which the member would have no legal obligation to pay in the absence of this or similar coverage.
7. Received from any dental or medial department maintained by or on behalf of an employer, labor union, trust or similar person or group
8. Surgery and any related services intended solely to improve appearance, but not to restore bodily function or to correct deformity resulting from disease, trauma, congenital or developmental anomalies.
9. Incurred prior to the member's effective date.
10. Incurred after the member's termination date.
11. For telephone consultations, charges for failing to keep an appointment, charges for completion of forms or charges for medical information.
12. For inpatient visits primarily for diagnostic studies.
13. For whole blood, blood components and blood derivatives which are not classified as drugs.
14. For custodial, domiciliary care or rest cures.
15. For reverse sterilization.
16. For dental work or treatment which includes hospital or professional care when performed in conjunction with: - an operation or treatment for the fitting or wearing of dentures - orthodontic care of treatment for malocclusion - operations on or treatment of or to the teeth or supporting tissues of the teeth except for removal of malignant tumors and cysts.
17. For treatment of weak, strained or flat feet, including orthopedic shoes or other supportive devices, or for the cutting, removal or treatment of corns, calluses or nails, other than with corrective surgery, or for the metabolic or peripheral vascular disease.
18. For eye glasses or contact lenses and the vision examination for prescribing or fitting of eye glasses or contact lenses, except for aphakic patients; and soft lenses or scleral shells intended for use and when used for the treatment of disease or injury.
19. For hearing aids and supplies, tinnitus maskers, or examinations for the prescription or fitting of hearing aids.
20. For radial keratotomy, myopic keratomileusis and any surgery which involves corneal tissue for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error.
21. For inpatient admissions which are primarily for physical therapy.
22. For any treatment leading to or in conjunction with transsexualism, sex changes or modification, including but not limited to surgery.
23. For treatment of sexual dysfunction not related to organic disease.
24. For conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation, or for inpatient confinement for environmental change.
25. For services or supplies for or related to fertility testing, treatment of infertility and conception by artificial means, including but not limited to: artificial insemination, in vitro fertilization, ovum or embryo

placement or transfer, gamete intra-fallopian tube transfer, or cryogenic or other preservation techniques in such or similar procedures.

26. For travel whether or not recommended by a physician.
27. For complications or side effects arising from services, procedures or treatments excluded by this policy.
28. For private duty nursing.
29. For skilled nursing facility, unless specifically provided for in this contract.
30. For home health care, unless specifically provided for in this contract.
31. For durable medical equipment, unless specifically provided for in this contract.
32. For prescription drugs, unless specifically provided for in this contract.
33. For the care and treatment of an injury due to the commission of, or an intent to commit, an assault or a felony or an injury or illness incurred while engaging in an illegal act or occupation.
34. For wigs.
35. For weekend admission charges, except for emergencies or maternity.
36. For speech therapy except to restore speech abilities which were lost due to an injury or illness.
37. For treatment of Temporomandibular Joint Dysfunction (TMJ) and Craniomandibular Pain Syndrome (CPS).

APPENDIX B -- PLAN ONE		
BASIC HMO BENEFIT PLAN		
BENEFITS		**BASIC HMO BENEFITS**
All care must be provided by or authorized by the primary care physician		
Physician services		
Prescribed Periodic Screening		Covered in full
Prenatal & postnatal office visits		$10 copay per visit
Primary care visits		$10 copay per visit
Office visit to referral provider		$20 copay per visit
Surgical care in physicians office		$50 copay per procedure
Inpatient visits Medical/surgical		Same as referral office visits
Outpatient surgery		$100 copay per procedure
Hospital Services		
Inpatient (Semi private rate)		$250 per day days 1-5 balance paid at 100%
Emergency Room		$100 copay/visit (waived if admitted)
Outpatient services		
Outpatient non-surgical care		Covered in full (including lab and xray)
Mental Health		$250 per day
- Inpatient		3 days per calendar year
- Outpatient		$20 copay per visit 5 visit per calendar year
Ambulance		$25 copay (emergency only)
Home Health Care, Outpatient		Not covered

Prescription drugs, Substance Abuse, Maternity Care		Same as all other illness
Other conditions;		No deductible
		Maximum out of pocket limit 200% of annual premium
		all limits are calendar year limits
		All hospital inpatient benefits paid at the prevailing semi-private rate
		Physician benefits paid at the providers usual and customary charge
		Pre-admission testing required for non-emergency admissions
		Pre-certification required for all non-emergency admissions
		All Managed care utilization controls apply

APPENDIX B -- PLAN TWO		
STANDARD HMO BENEFIT PLAN		
BENEFITS		**STANDARD HMO BENEFITS**
All care must be provided by or authorized by the primary care physician		
Physician services		
Prescribed Periodic Screening		Covered in full
Prenatal & postnatal office visits		$10 copay per visit
Primary care visits		$10 copay per visit
Office visit to referral provider		$10 copay per visit
Surgical care in physicians office		$25 copay per procedure
Inpatient visits Medical/surgical		Same as referral office visits
Outpatient surgery		$50 copay per procedure
Hospital Services		
Inpatient (Semi private rate)		$100 per day days 1-5 balance paid at 100%
Emergency Room		$50 copay/visit (waived if admitted)
Outpatient services		
Outpatient non-surgical care		Covered in full (including lab and xray)
Mental Health		$100 per day
-Inpatient		10 days per calendar year
-Outpatient		$10 copay per visit 20 visit per calendar year
Ambulance		$25 copay (emergency only)
Home Health Care		$10 copay per visit

Outpatient prescription drugs		The greater of $5 copay or 25% of the cost of the drug
Substance Abuse		Not covered
Maternity Care		Same as all other illness
Other conditions;		No deductible
		Maximum out of pocket limit 200% of annual premium
		all limits are calendar year limits
		All hospital inpatient benefits paid at the prevailing semi-private rate
		Physician benefits paid at the providers usual and customary charge
		Pre-admission testing required for non-emergency admissions
		Pre-certification required for all non-emergency admissions
		All Managed care utilization controls apply

PLAN EXCLUSIONS

(Applicable to both Basic and Standard HMO Benefit Plans):

There are no benefits available for the following services, supplies or charges;

**All services must be provided by or authorized by the patients primary care physician.

1. Which are not medically necessary
2. Which are determined to be experimental or investigational in nature; including any service, supply, procedure or treatment directly related to an experimental or investigational treatment
3. For any condition, disease, illness or bodily injury which occurs in the course of employment if benefits or compensation is available, in whole or in part, under the provisions of any legislation or any governmental unit. This exclusion applies whether or not the member claims the benefits or compensation
4. To the extant benefits are provided by any governmental unit except as required by federal law for treatment of veterans in Veterans Administration or armed forces facilities for non- service related medical conditions.
5. For any illness or injury suffered as a result of any act of war or while in military service
6. For which the member would have no legal obligation to pay in the absence of this or similar coverage.
7. Received from any dental or medical department maintained by or on behalf of an employer, labor union, trust or similar person or group.
8. Surgery and any related services intended solely to improve appearance, but not to restore bodily function or to correct deformity resulting from disease, trauma, congenital or developmental anomalies
9. Incurred prior to the members effective date
10. Incurred after the members termination date
11. For telephone consultations, charges for failing to keep an appointment, charges for completion of forms or charges for medical information
12. For inpatient visits primarily for diagnostic studies
13. For whole blood, blood components and blood derivatives which are not classified as drugs
14. For custodial, domiciliary care or rest cures
15. For reverse sterilization

16. For dental work or treatment which includes hospital or professional care when performed in conjunction with; - an operation or treatment for the fitting or wearing of dentures - Orthodontic care of treatment for malocclusion - operations on or treatment of or to the teeth or supporting tissues of the teeth except for; . removal of malignant tumors and cysts
17. For treatment of weak, strained or flat feet, including orthopedic shoes or other supportive devices, or for the cutting, removal or treatment of corns, calluses or nails, other than with corrective surgery, or for metabolic or peripheral vascular disease
18. For eye glasses or contact lenses and the vision examination for prescribing or fitting of eye glasses or contact lenses; except for aphakic patients and soft lenses or scleral shells intended for use and when used for the treatment of disease or injury
19. For hearing aids and supplies, tinnitus maskers, or examinations for the prescription or fitting of hearing aids
20. For radial keratotomy, myopic keratomileusis and any surgery which involves corneal tissue for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error
21. For inpatient admissions which are primarily for physical therapy
22. For any treatment leading to or in conjunction with transsexualism, sex changes or modification, including but not limited to surgery
23. For treatment of sexual dysfunction not related to organic disease
24. For conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation, or for inpatient confinement for environmental change
25. For services or supplies for or related to fertility testing, treatment of infertility and conception by artificial means, including but not limited to; artificial insemination, in vitro fertilization, ovum or embryo placement or transfer, gamete intra-fallopian tube transfer, or cryogenic or other preservation techniques in such or similar procedures
26. For travel whether or not recommended by a physician
27. For complications or side effects arising from services, procedures or treatments excluded by this policy
28. For private duty nursing
29. For skilled nursing facility, unless specifically provided for in this contract
30. For home health care, unless specifically provided for in this contract
31. For Durable Medical equipment, unless specifically provided for in this contract
32. For Prescription drugs, unless specifically provided for in this contract
33. For the care or treatment of an injury due to the commission of, or an intent to commit, an assault or a felony or an injury or illness incurred while engaging in an illegal act or occupation
34. For wigs
35. For weekend admission charges, except for emergencies or maternity
36. For speech therapy except to restore speech abilities which were lost due to injury or illness
37. For the treatment of Temporomandibular Joint Dysfunction (TMJ) and Craniomandibular Pain Syndrome (CPS).