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Medical Coverage Offered To Individuals and Families

California – Preferred 2000 (Form 225) Underwriting & Administrative Guidelines

These guidelines are in place to comply with health insurance legislation in California and include Fortis Insurance Company's underwriting practices and procedures.

Medical Products: The Preferred 2000 plan is available in California. To enroll for coverage, enrollment form 27658 is required, along with the Health Advocates Alliance Membership Application, which is part of the enrollment form.

State Farm, use Tele-App packet Form 27926.

A high-level and low-level health benefit plan is also available to all applicants. The high-level and low-level plans will be guaranteed issue to Federally Eligible Individuals. Guidelines for Federally Eligible Individuals are found on the last page of this document.

Eligibility Requirements: In order to be eligible for coverage, an applicant must be a resident of California and must not have coverage sponsored by a small employer. Below are key definitions to assist in determining whether or not the coverage is employer-sponsored. If a small employer is sponsoring coverage for 2 or more eligible employees as defined below, then they are ineligible for the Preferred 2000 plan and should apply for a small group health plan.

California defines **employer-sponsorship** as meeting any one of the following criteria:

- 1) Any portion of the premium for a health benefit plan or benefits is paid by a small employer, or any covered individual is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the premium.
- 2) The health benefit plan is treated by the small employer or any of the covered individuals as a part of a plan or program for the purpose of sections 106 or 162 of the Internal Revenue Code.

A **small employer** is defined as any person, proprietary or nonprofit firm, corporation, partnership, public agency, or association that is actively engaged in business or service that, on at least 50% of its working days during the preceding calendar quarter or preceding calendar year, employed at least 2, but not more than 50 eligible employees, the majority of whom were employed within the state of California.

An **eligible employee** is defined as any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal work week of at least 30 hours. The term includes: sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis in the small employer's business, and they are included as employees under a health benefit plan of a small employer. Permanent employees who work at least 20 hours per week are also considered eligible employees if the employer

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offers all similarly situated employees health coverage under a health benefit plan and the employee has worked at least 20 hours per week for at least 50 percent of the weeks in the previous calendar quarter. Part-time employees who do not meet the requirements above, temporary or substitute employees are not considered an eligible employee.

The Employer Sponsored Business Questionnaire: In order to determine whether or not the coverage is employer sponsored, the Employer Sponsored Business Questionnaire, Form 26661, is required in the following situations:

- If 2 or more enrollment forms are being paid with an employer or business check;
- If 2 or more enrollment forms are being linked to the same Check-O-Matic (COM) account, or if an individual is being added to an existing COM account;
- If 2 or more enrollment forms are being billed to the same employer or business address

Underwriting Actions : Underwriting actions may include the following:

- Healthy individuals may qualify for preferred or preferred smoker rates. Please refer to the Agent's Guide Supplement Form 26580-CA for more information on preferred rating.
- An applicant may be issued coverage standard with tobacco or non-tobacco user rates.
- Special exception riders will not be applied.
- Special class premiums (ratings) may be applied. If a special class premium is required, the minimum drug card deductible available is \$500.
- An applicant may be declined due to medical history.

Testing : Paramed exams and lab tests will be requested at the underwriter's discretion upon review of the applicant's file. If lab tests need to be ordered, they will include venipuncture blood testing, urine screening and physical measurements (height, weight and 3 blood pressure readings).

If we order exams and lab work, we will use either Examination Management Services, Inc. (EMSI) or American Para Professional Systems, Inc. (APPS). Agents will be notified when these tests are ordered.

Changes To An Existing Plan: To make a change to a plan with an effective date prior to 3/1/2001, Supplemental Application 19690 should be completed. To make a change to an association plan with an effective date of 3/1/2001 or after, enrollment form 27658 should be completed.

Pre-existing Conditions : Pre-existing conditions will not be covered for 12 months following the effective date of coverage, except as provided under the continuity of coverage provision. A pre-existing condition is defined as an illness or injury and related complications, not fully disclosed on the enrollment form, if during the 12 month period immediately prior to the effective date, the individual received medical treatment, diagnosis, consultation, or took prescription drugs for the condition; or the condition produced symptoms or was capable of being diagnosed.

Continuity of Coverage : The pre-existing condition limitation will be credited with the time an individual was previously covered under creditable coverage, provided there is no more than a 62 day gap in coverage between the termination date of their prior coverage and the effective date of the Fortis Health plan.

In order to provide continuity, we require that proof of prior creditable coverage be submitted with the enrollment form. This proof includes at least one of the following:

- A copy of the declarations, summary of benefits or schedule pages

- A copy of the most current premium payment or billing statement
- A copy of the prior carrier's certification of coverage.

If proof of creditable coverage is provided at a later date, we will provide continuity of coverage.

Creditable Coverage: An individual or group policy, contract or program that is written or administered by a disability insurance company, health care service plan, fraternal benefit society, self-insured employer plan, or any other entity that provides medical, hospital and surgical coverage not designed to supplement other private or governmental plans, Medicare, Medicaid, a public health plan, TRICARE (formerly CHAMPUS), a medical care program of the Indian Health Service or tribal organization, a state risk pool, a health plan offered to federal employees, a health plan offered under the Peace Corps Act.

Underwriting Guidelines For Eligible Individuals as defined by the Health Insurance Portability and Accountability Act

Eligible Individual: An Eligible Individual is defined as an individual:

1. For whom, as of the date the individual seeks coverage, has an aggregate period of creditable coverage of 18 months or more;
2. Whose most recent creditable coverage was under a group health plan that provides medical care directly or through insurance, a governmental plan or church plan;
3. Who is not eligible for coverage under a group health plan, Part A or Part B of Medicare or Medicaid and does not have other health insurance coverage;
4. Who submitted their application to us within 63 days after their most recent creditable coverage terminated;
5. Whose most recent coverage was not terminated due to nonpayment of premiums or fraud;
6. Who if offered the option of state continuation or COBRA, elected and exhausted such coverage.

Underwriting Requirements: If an individual meets all the requirements to be considered an Eligible Individual, please submit the following:

1. Enrollment form 27658. (State Farm, use Tele-App packet Form 27926).
2. A HIPAA Eligibility Form 25238.
3. A certification of coverage from their previous group carrier. If a certification is not available, please submit all of the following: Continuity of Coverage, Form 25178, a copy of their prior carrier's specification page or summary plan document, a copy of their ID card, a copy of their latest bill or premium payment.

Underwriting Actions for Eligible Individuals: HIPAA Eligible Individuals will be guaranteed issue coverage under a high-level or low-level health benefit plan. Eligible Individuals will not be subject to any exclusion riders or pre-existing condition provisions. Special class premiums may be applied based on medical history.

