



Producer guide



Your guide to the Ohio Farm Bureau Health Benefits Plan



Table of contents

What is the Ohio Farm Bureau Health Benefits Plan? 3

Underwriting guidelines and rules..... 4

Specialty (dental, vision, life, and disability)
underwriting guidelines and rules..... 8

Quote process and case submission 13

Ohio Farm Bureau Health Benefits Plan renewal 15

General administration 16

Medicare 18

Broker distribution 19

As you work with your Small Group clients to help find them the right plan for their small businesses, the Ohio Farm Bureau Health Benefits Plan can be an excellent choice. This producer guide covers many of the important details you will need when discussing this alternative with them. It will answer many of your questions regarding underwriting, quoting, plan offerings, and administrative guidelines.

The Ohio Farm Bureau Health Benefits Plan: a brief summary

As today's farmers and small businesses continue to search for health coverage options, the Ohio Farm Bureau Federation has taken action to help them save on the cost of providing their employees with comprehensive benefits. The Ohio Farm Bureau Health Benefits Plan (HBP) is a smart solution that offers predictable payments, lower rates, and potential savings for Ohio farmers and small businesses in the agricultural sector with 1 to 50 employees.

The Ohio Farm Bureau HBP is a self-funded option offered by the Ohio Farm Bureau and administered by Anthem Blue Cross and Blue Shield (Anthem). It is a multiple employer welfare arrangement (MEWA) backed by Anthem's stop loss coverage. It is filed with the Ohio Department of Insurance (ODI), and it is governed by trustees and bylaws that satisfy ODI requirements. Available to sole proprietors as well as small employers, this alternative self-funded solution can be a good fit for your Small Group clients for reasons including:

- Competitive rates
- Predictable, fixed monthly payments
- Protection of being part of a larger self-funded pool backed by Anthem's stop loss
- Anthem's broad Blue Access preferred provider organization network
- Flexibility in choice of benefit plans

In the event of a discrepancy between this guide and any contract issued as it relates to this arrangement, the terms of the contract prevail. The regulations in this guide are subject to change from time to time without prior notice.



Underwriting guidelines

The Ohio Farm Bureau Health Benefits Plan uses the underwriting regulations below to determine employer, sole proprietor, and employee eligibility for benefits. These requirements are effective with the participating employer or sole proprietor's effective date. It is very important that you read this guide and understand that **if the participation requirements listed below are not met, the participating employer or sole proprietor can be cancelled by the Ohio Farm Bureau Health Benefits Plan**, as outlined in the *Participation Agreement*.

Eligibility rules

Employers and sole proprietors must:

- Have corporate headquarters located in Ohio.
- Be current with Ohio Farm Bureau Health Benefits Plan membership dues. (See the Ohio Farm Bureau Health Benefits Plan Participating Business Acknowledgment Agreement for details.)
- Be in the agricultural economic sector, as determined by Standard Industrial Classification (SIC) code.

Eligible employers

An eligible employer is defined as a business (or other legal entity) that is actively engaged in a full-time enterprise and has the legal capacity to sponsor a group health plan on behalf of one or more common-law employees. Governmental subdivisions or educational, nonprofit organizations or religious institutions are included.

An employer must:

- Be a corporation, LLC, partnership, or proprietorship headquartered in Ohio.
- Have an employer-employee relationship.
- Be permanent in nature.
- Employ on average no more than 50 total employees.
- Maintain a minimum of one enrolled employee residing in Ohio.

Eligible sole proprietors

A sole proprietor is an unincorporated business owned and run by one individual, with no distinction between the business and the owner.

Sole proprietors must:

- Do business in Ohio.
- Meet certain underwriting requirements and demonstrate they are working more than 30 hours per week.
- Submit a cover page for Form 1040 with a Schedule C or Schedule F and a Schedule SE.
- Have final participation and premium equivalent rates approved by Underwriting and the Ohio Farm Bureau Health Benefits Plan.

Due to regulatory requirements, total sole proprietor membership cannot exceed 10% of the plan's total membership.



Eligible employees

Employees **working 30 or more hours per week** and who are past their probationary period (employer-selected waiting period options are zero, 30, 60, or 90 days or the first billing after zero, 30, or 60 days worked, not to exceed 90 days) are considered eligible employees.

Eligible employees must:

- Be full-time employees working at least 30 hours per week, paid by a W-2, or full-time owners or partners.
- Be reported on standard state and federal payroll reporting forms, or in the case of owners, a Schedule K-1 or Schedule C.
- Be actively at work on the effective date of benefits.
- Provide their Social Security numbers.
- Complete and submit all required applications within 30 days of the date they are eligible for benefits, or within 30 days after the waiting period has been met.

1099 contractors

Workers whose compensation is reported on Form 1099, rather than Form W-2, may be covered if **all** the criteria below are met:

- The contractor works at least the minimum 30 hours per week to be considered full time.
- The employer's contribution toward the contractor's premium is equal to that for other eligible employees.
- The employer makes benefits available to all current and future contractors meeting the same criteria.
- The contractor works exclusively for the company they are applying through, at least 50% of the employees are paid by W-2, and a minimum of two taxed employees are enrolled.

Ineligible employees

The types of employees listed below are not considered eligible employees for the purpose of health benefits:

- Employees who work fewer than 30 hours per week
- Temporary employees who have worked less than one year
- Seasonal employees who work fewer than nine months out of the year
- Employees absent from work and off payroll due to nonmedical reasons and former employees not covered under state or federal continuation programs
- 1099 contractors, except those who meet the criteria outlined above
- Retirees
- Late enrollees

Eligible dependents

- An employee's spouse, as recognized under the laws of the state where the employee lives.
- Domestic partners. Neither Anthem nor the Ohio Farm Bureau Health Benefits Plan will determine or validate domestic partner status. Domestic partner coverage is subject to group discretion. Employers must indicate on the employer application if they will offer domestic partner coverage. Domestic partner affidavits should be submitted with the member enrollment application or change form and retained by the employer.
- Children of an employee, their spouse, or their domestic partner, including natural children, stepchildren, newborn, and legally adopted children, and children who are covered under a "Qualified Medical Child Support Order," as defined by the Employee Retirement Income Security Act (ERISA) or any applicable law. This includes children of whom the employee or their spouse or domestic partner is a legal guardian or as otherwise required by law. All enrolled children are eligible until the age of 26. Those who have submitted proof of disability can be eligible beyond age 26.

Late enrollees

A late enrollee is someone who applies for benefits more than 30 days after they become eligible, or more than 30 days after the end of the waiting period. An enrollee is not late if, at the time of enrollment, they apply within 31 days of a Health Insurance Portability and Accountability Act (HIPAA) special enrollment event.

Segmenting

An employer may not segment its employees into classes for determining benefit eligibility. (Union plans are a valid segment exception to the no-segmenting rule.)

Common ownership

HIPAA states that all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code shall be considered one employer.

Underwriting rules

Minimum participation

At least 75% of the net eligible employees must be covered under the *Participation Agreement*. In determining a participating employer's minimum enrollment for net eligible employees, the Ohio Farm Bureau Health Benefits Plan will exclude any employee who waives benefits (qualified waivers) because they are:

- Covered by a spouse or domestic partner's employer-sponsored health plan.
- Covered under a parent's plan to age 26, or older than 26 with proof of disability.
- Covered by Medicare and/or Medicaid.
- Nongroup Medicare Supplement retirees.
- In a government-sponsored or low-income plan, such as TRICARE, Medicaid, the Federal Employee Program, or the Veterans Administration.
- Enrolled in an individual health plan — Affordable Care Act (on or off exchange), grandfathered, grandfathered, or short term.
- Covered through a prior employer's retiree plan.
- Covered through a second active employer.
- A member of any recognized religion that opposes health insurance.

Minimum contribution rates

An employer must contribute at least 25% of the total cost for health benefits for employees with dependent benefits, and at least 50% for employees with single benefits. Flat contribution amounts are not allowed. If the employer contributes 100% of the premium equivalent, 100% of the net eligible employees must enroll.

The Ohio Farm Bureau Health Benefits Plan recommends employers establish fixed contributions for single and family rates in order to avoid discrimination. Different contribution amounts based on class are not allowed.

Multiple product offerings

- A participating employer with 1 to 2 employees enrolled may only offer one plan design.
- A participating employer with 3 to 9 employees enrolled may offer two plan designs.
- A participating employer with 10 to 50 employees enrolled may offer up to three plan designs.
- There must be a minimum of one employee enrolled in each plan offered.

Waiting periods

Waiting period options are zero, 30, 60, or 90 days, or the first billing after zero, 30, or 60 days worked. A participating employer may change their waiting period one time per year upon written request. The earliest effective date of the change is the date of receipt of the request by Anthem or the service date following receipt of the request by Anthem.

The waiting period change will only affect new employees hired after the request becomes effective. Only one waiting period is allowed. Waiting periods based on class are not allowed.

Effective dates

The earliest possible effective date of coverage is the date all new case requirements are received by Anthem's Underwriting department. A future effective date cannot exceed 120 days from the date the applications are signed or 90 days from the date the employer's paperwork is submitted. Effective dates will be the first day of the month. It is recommended that the employer maintain current benefits until Underwriting approval is finalized.

Medical underwriting

Full medical information is required for applicants applying for health benefits, including those in their waiting period or on COBRA or state continuation. We do not require medical information for waivers.

Completion of the medical questionnaires provides answers to health questions about employees and their dependents. This information is used to calculate the premium equivalent rate for the employer based on the risk of future health expenses. Each health condition has varying degrees of associated risk. Exact information is needed regarding member diagnosis, dates, treatments, medications, and prognosis to assign an appropriate premium equivalent rate for the risk. It is important that the applicant disclose this information with full details to ensure there is no delay in the process and that the appropriate rating is assigned. Misstatements or failures to report medical information prior to the effective date may result in a material change to benefits or premium equivalent rate.

The Ohio Farm Bureau Health Benefits Plan retains the right to reconsider the pricing of this proposal if the final enrollment is different from what was assumed in development of the rates.

Final rates will be based on the actual effective date and location, enrolled census, and final benefits selected. Final approval of proposed rates is subject to review of employee applications and medical conditions for all enrolling in the plan. Proposed rates can be modified due to changes in the census and/or medical risk profile contained in final applications.

Medical open enrollment

After initial enrollment, employees can make changes to benefit elections at open enrollment. Coverage will be effective on the renewal date if the application is received by Anthem within 31 days prior to the group's renewal date or up to 31 days after the group's renewal date. Applications received for existing employees outside of this period will be late enrollees, and they must wait until the next open enrollment period unless they qualify for a HIPAA special enrollment. Open enrollment periods apply on the original effective date and at renewal of every year, regardless of when originally effective. Open enrollment changes will be effective on the renewal effective date.

Specialty underwriting guidelines

As a participating employer of the Ohio Farm Bureau Health Benefits Plan, employers are eligible for discounted rates on dental, vision, life, and disability plans. These are stand-alone, fully insured plans for which the employer contracts directly with Anthem. Because of this, billing will be separate from the medical plan.

All dental, vision, life, and disability plans will renew on the same renewal date as medical plans. Contract lengths will vary, depending on medical and specialty plan renewal dates. Dual options are not available. The dental, vision, life, and disability plans and rates offered to Ohio Farm Bureau Health Benefits Plan members are only available to employer groups currently enrolled in or enrolling in medical coverage. These plans and rates are not available without Ohio Farm Bureau Health Benefits Plan medical coverage.

Sole proprietors are not eligible for group life and disability products.

Dental

- Annual open enrollment is the same as medical.
- Dental offices are not eligible for coverage.
- Orthodontic coverage is available for groups of five or more enrolled employees.
- Plans with an unlimited annual benefit maximum are available for groups of 10 or more eligible employees.

Employer-sponsored plans

- Minimum participation is two enrolled employees and at least 50% of net eligible employees.
- There are no contribution requirements.
- There are no waiting periods.
- This plan assumes no underlying funding of any type, including (but not limited to) copays, deductibles, and other cost shares.

Nonvoluntary plans

- Group must have a minimum of five eligible employees. A minimum of two employees must enroll.
- A 12-month waiting period applies to major and orthodontic services. The waiting period can be waived only for initial enrollees with prior comparable group coverage. Prior comparable coverage is defined as at least 12 months of consecutive coverage with the same coverage categories (such as preventive, basic, or major orthodontic) as the dental plan the group selects. Dental health maintenance organization (DHMO) plans may be considered comparable coverage.

Sole proprietors

Sole proprietors are eligible for nonvoluntary plans without orthodontia only.



Vision

Annual open enrollment is the same as for medical.

Employer-sponsored plans

Minimum participation is two enrolled employees and at least 50% of net eligible employees.

Voluntary plans

Group must have a minimum of five eligible employees.

A minimum of two employees must enroll.

Life and disability^{1,2}

Life and disability underwriting guidelines apply to all life and disability products and differ from medical underwriting guidelines. This is not a complete list of all life and disability underwriting requirements. Each group is evaluated during the underwriting process. These basic underwriting guidelines are subject to change at an underwriter's discretion.

Additional guidelines

- Group must have at least two eligible employees for basic life, short-term disability, and long-term disability. Group must have at least 10 eligible employees for supplemental life, voluntary life, voluntary short-term disability, and voluntary long-term disability.
- Valid and appropriate SIC code must be used for quoting. Rates are subject to change if appropriate SIC code is not used.
- Group must be in good financial status. Groups in bankruptcy are not eligible.
- Employees must be actively at work. Employees must be U.S. citizens working in the U.S. or approved foreign nationals with U.S. work visas working in the U.S.
- Retiree coverage is not available.
- 1099 workers/contractors are not eligible for coverage.
- Employees must work at least 30 hours per week to be eligible.
- Groups must maintain the minimum participation levels to remain eligible. Groups may not be renewed if participation falls below the required minimum.
- No more than 50% of any group may be related by marriage or blood. **Exception:** Underwriting may agree to an exception to quote a basic life and accidental death and dismemberment (AD&D) flat benefit if the group exceeds the 50% marriage or blood relationship rule. To qualify for this exception, family members must be employed for one year.

Basic life^{1,2}

- Timely enrollment is required for new employees. Employees hired after the effective date of the plan will become eligible for insurance after completing the waiting period specified in the policy. Eligible employees must be enrolled within 31 days after they satisfy the employer's eligibility period or they will be required to submit an Evidence of Insurability form for Underwriting approval.
- There is no annual open enrollment. An Evidence of Insurability form is required for late enrollees and increases in coverage regardless of the amount.
- Employees whose coverage amount exceeds the guaranteed issue limit must submit satisfactory evidence of insurability to Underwriting for approval.
- Benefit may vary by class based on employer offering by class up to a maximum number of classes: 2 to 9 employees, one class; 10 or more employees, five classes. No more than 2.5 times the difference in life benefit amount between classes. It is acceptable to create a class with a \$50,000 maximum benefit for those employees wanting no imputed income for tax purposes.
- Minimum employer contribution (not including dependent coverage) is 25% for contributory plans and 100% for noncontributory plans.
- All eligible employees must participate when coverage is entirely employer paid.
- 75% of eligible employees must participate when employee contribution is required.
- All benefits terminate at retirement.

Basic and supplemental/voluntary dependent life

- Dependent life is only available when the employee elects the corresponding life coverage (in other words, employee must elect supplemental life for a dependent to be covered under supplemental life).
- Dependent coverage cannot exceed 50% of the employee amount.
- Child coverage begins on 15th day following birth and ends at age 26.
- Family unit rate structure applies.

Increase in coverage for basic life

Noncontributory basic life

- Increase at renewal, groups of more than 10: If a group wants to increase coverage at renewal of more than two times their current benefit, all employees must submit evidence of insurability and be approved by Medical Evidence Underwriting. If any employee is not approved, the increase in the group's benefit amount will not be effective for the entire group.
- Increase at renewal, groups of 2 to 9: If a group wants to increase coverage at renewal of more than two times their current benefit, all employees must submit evidence of insurability and be approved by Medical Evidence Underwriting. If any employee is not approved, the increase in the group's benefit will be capped at two times their current benefit.
- Increase midyear/not at renewal, all size groups: If a group wants to increase coverage, all employees must submit evidence of insurability and be approved by Medical Evidence Underwriting. If any employee is not approved, the increase in the group's benefit amount will not be effective for the entire group.

Contributory basic life, all size groups

Increase at renewal or midyear/not at renewal: If a group wants to increase coverage, all employees must submit evidence of insurability and be approved by Medical Evidence Underwriting. If any employee is not approved, the increase in the group's benefit amount will not be effective for the entire group.

Supplemental life/voluntary life

- Supplemental life must be sold with group basic life. Voluntary life is sold as stand-alone.
- Participation requirement: 20% of eligible employees or five employees must enroll, whichever is greater. Example: A group with 10 employees will need to have five employees enroll to satisfy the "greater of" requirement.
- Contribution requirement: The employee pays 100%.
- Supplemental life only: Employees must be enrolled in basic life coverage.
- Takeover coverage: Initial one-time enrollment is included for 30 days prior to group effective date for takeover coverage on groups with 10 or more eligible lives.

- For groups with supplemental/voluntary life employee guaranteed issue limit of more than \$100,000, the initial one-time enrollment employee guaranteed issue limit is \$100,000. For example, if the group's employee guaranteed issue limit is \$200,000, the initial one-time enrollment employee guaranteed issue limit is \$100,000.
- For groups with supplemental/voluntary life employee guaranteed issue limit of less than \$100,000, the initial one-time enrollment employee guaranteed issue limit is the group's employee guaranteed issue limit. For example, if the group's employee guaranteed issue limit is \$50,000, the initial one-time enrollment employee guaranteed issue limit is \$50,000.
- For groups with supplemental/voluntary life spouse guaranteed issue limit of more than \$10,000, the initial one-time enrollment spouse guaranteed issue limit is \$10,000. For example, if the group's spouse guaranteed issue limit is \$20,000, the initial one-time enrollment spouse guaranteed issue limit is \$10,000.
- For groups with supplemental/voluntary life spouse guaranteed issue limit of less than \$10,000, the initial one-time enrollment spouse guaranteed issue limit is the group's spouse guaranteed issue limit. For example, if the group's spouse guaranteed issue limit is \$5,000, the initial one-time enrollment spouse guaranteed issue limit is \$5,000.
- This is not an annual open enrollment.
- Future enrollments require evidence of insurability for late enrollees and increases in coverage regardless of amount.
- Requests for takeover/grandfathering of supplemental/voluntary life amounts need to be reviewed and approved by Life and Disability Underwriting.
- New coverage: Initial one-time enrollment is included for 30 days prior to group effective date for groups that have never offered supplemental/voluntary life. Employees and dependents may enroll up to the guaranteed issue limits without evidence of insurability.
- No annual open enrollment. Evidence of insurability is required for late enrollees and increases in coverage regardless of amount.
- Evidence of insurability is required for all coverage amounts above guaranteed issue limits.

- Increase in coverage for supplemental life and voluntary life, all size groups, at renewal or midyear/not at renewal:
 - If a group wants to increase coverage, all employees must submit evidence of insurability and be approved by Medical Evidence Underwriting. If any employee is not approved, the increase in the group's benefit amount will not be effective for the entire group.

Disability^{1,2}

- All coverage is guaranteed issue for groups with 2 to 50 eligible employees.
- All eligible employees must participate when coverage is entirely employer paid.
- The minimum employer contribution for short-term disability and long-term disability insurance coverage is 25% for contributory plans and 100% for noncontributory plans.
- Short-term and long-term disability are available independent of each other.
- Groups must be in business for at least one year.
- No open enrollment allowed. Timely enrollment is required for new employees. Employees hired after the effective date of the plan will become eligible for insurance after completing the waiting period specified in the policy.
- Increase in coverage for short-term disability and long-term disability, at renewal or midyear/not at renewal:
 - If a group wants to increase coverage, all employees must submit evidence of insurability and be approved by Medical Evidence Underwriting. If any employee is not approved, the increase in the group's benefit amount will not be effective for the entire group.

Short-term disability

- All coverage is guaranteed issue for groups with 6 to 50 eligible employees. Groups with 2 to 5 eligible employees must submit an Evidence of Insurability form for a maximum weekly benefit over \$500.
- Short-term disability does not replace the state-mandated benefits of CA, NY, NJ, HI, PR, or RI. This plan will integrate or offset with the state-mandated coverage where employees covered by such plans exist at time of claim. If the census data provided for a quote includes state location at the employee level, the state-mandated plan benefits will be considered in setting our pricing.

Long-term disability

- Long-term disability with 2 to 9 lives: Private households and groups where more than 60% of the employees over the age of 50 are not eligible.
- Preexisting condition limitation applies.

Voluntary short-term and long-term disability

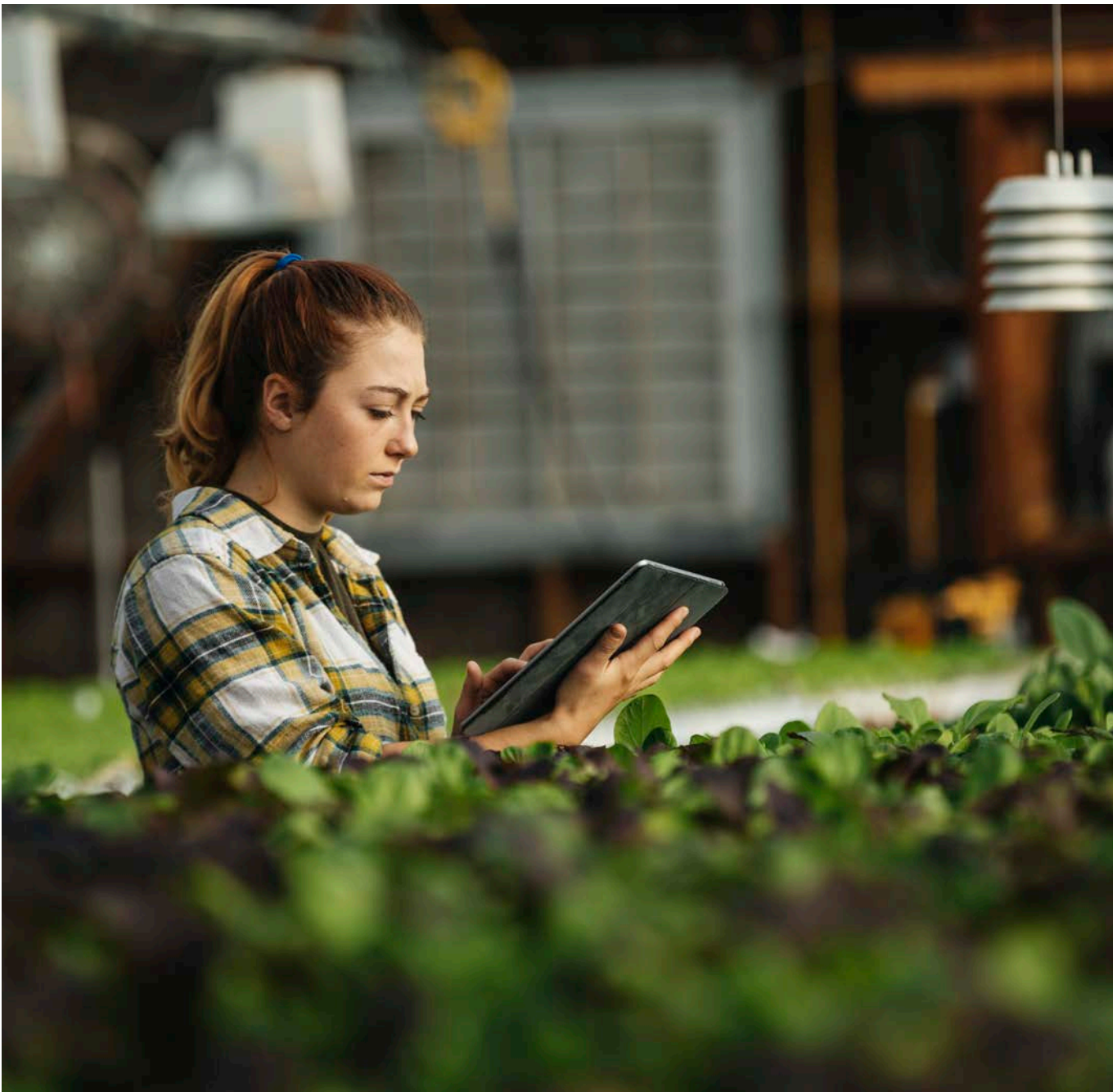
- Available to groups of 10 or more eligible employees.
- Participation requirement: 20% of eligible employees or 10 employees, whichever is greater, must enroll.
- Voluntary short-term disability (VSTD) and voluntary long-term disability (VLTD) are available independent of each other.
- Contribution requirements: The employee pays 100%.
- For VLTD, evidence of insurability is required for all amounts.
- No initial one-time enrollment for new coverage, initial one-time enrollment takeover coverage. Evidence of insurability is required for late enrollees and increases in coverage regardless of amount. Does not apply to VSTD.
- For new coverage, initial one-time enrollment is included for 30 days prior to group effective date for groups that have never offered VSTD and VLTD. Employees may enroll up to the guaranteed issue limits without evidence of insurability.
- For VLTD, there is no annual open enrollment. Evidence of insurability is required for late enrollees and increases in coverage regardless of amount. Does not apply to VSTD.

¹ Sole proprietors are not eligible for group life and disability benefits.

² This information is intended to be a brief outline of life and disability underwriting guidelines and not intended to be a complete description of the underwriting policies. Each group is underwritten individually, and other underwriting factors apply. Anthem may decline to quote on a group. Groups in certain SIC classifications are not eligible for coverage. In the event of a conflict between a proposal and this document, the terms of the proposal will prevail.

Voluntary short-term and long-term disability (cont'd)

- Increase in coverage for VSTD and VLTD, all size groups, at renewal or midyear/not at renewal:
 - If a group wants to increase coverage, all employees must submit evidence of insurability and be approved by Medical Evidence Underwriting. If any employee is not approved, the increase in the group's benefit amount will not be effective for the entire group.
- Preexisting condition limitation applies to VSTD and VLTD.
- Quote for voluntary long-term disability assumes participation in Social Security. Groups that do not participate in Social Security or have other state or local disability plans must be quoted by Life and Disability Underwriting.



Quote process and case submission

Quote process

Ohio Farm Bureau Health Benefits Plan quotes are generated via Anthem's Producer Toolbox. You can find information on how to use the quoting and enrollment tool at anthembrokerhub.com.

To receive a prescreened quote for a new client, you will need:

- A completed employer questionnaire.
- Completed medical questionnaires. Medical information on waivers is not required unless fewer than 50% of total eligible employees are enrolling.
- Census of enrolling members, including those in their waiting period, on COBRA, or state continuation.

Administrative services only (ASO) groups require claims experience, large claimant listing, breakdown of fee or claim components, and fully insured equivalent rates.

A limited number of specialty options will be available to quote in the Producer Toolbox quoting and enrollment tool. Additional plans can be quoted through the Anthem Connect team.

Anthem Connect email: connect@anthem.com

Anthem Connect phone: **866-956-8602**

Sold-case submission process for medical and specialty products

The sold-case submission process will also be handled via the Producer Toolbox quoting and enrollment tool. Please allow a minimum of 15 days for processing a new case submission.

To submit a sold Ohio Farm Bureau Health Benefits Plan case for enrollment, you will need to complete the following:

1. Ohio Farm Bureau Health Benefits Plan *Participation Agreement*
2. Ohio Farm Bureau Health Benefits Plan Document
3. Ohio Farm Bureau Health Benefits Plan employer application
4. Final quote (it will be included automatically by the quoting and enrollment tool)
5. Ohio Farm Bureau Health Benefits Plan employee applications with completed medical questionnaires
6. Electronic funds transfer (EFT/ACH) banking form (Initial premium will be withdrawn via EFT.)
7. *Annual Rate and Census Reconciliation (ARC)*
8. **Optional:** *Anthem Spending Account Questionnaire* is required if an employer requests to set up integrated Anthem spending account health savings accounts on behalf of enrollees. Please contact your Sales representative for details.
9. If life/AD&D is purchased, a *Hold Harmless Agreement* is required.
10. A *Wage and Tax Statement* may be requested by the plan auditors but is not required as part of the submission.

In addition to the above, one of the following is also required for sole proprietors:

- Cover page for Form 1040 with Schedule C
- Cover page for Form 1040 with Schedule F and a Schedule SE

Prior carrier deductible credit

Deductible credit is available to new cases. This is available only to participating employers with previous calendar-year benefits. Please work with your Sales representative to submit the proper documents.

Dental, vision, life, and disability upsell process

If specialty lines are added after initial installation, please send the requirements below to newamembermaintenance@anthem.com.

- Administrative and Benefit Plan Change Authorization Form
- Anthem Ancillary Specialty Benefit Modification Form

The preferred method of enrollment is EmployerAccess. We can also accept a membership listing. The preferred Anthem format can be obtained from your Anthem Connect or Anthem Sales representative. Please include these items with the enrollment submission:

- Signed rates and benefits for each line of coverage sold
- For life only, include the Hold Harmless Agreement



Ohio Farm Bureau Health Benefits Plan renewal

Renewal process

Renewals will be produced via the Small Group renewal process approximately 90 days prior to the renewal date and posted to Producer Toolbox.

- All renewals are mailed directly to the employer group and will include alternate renewal options.
- If the group decides to renew with the plan that is offered, nothing is required. Groups will automatically be renewed to the plans illustrated in the renewal packet.
- If the group decides to make a plan change, the requested change should be submitted two weeks prior to the renewal date in order to be processed in time. Anthem only needs paperwork (signed rates and signed benefits, along with the Administrative and Benefit Plan Change Authorization Form) for groups opting to change current plans or add new lines of coverage. Changes can be submitted to mewamembermaintenance@anthem.com.

All open enrollment member-level changes need to be made in EmployerAccess.

Off-cycle benefit changes

Participating employers are allowed to make one off-cycle benefit change per year outside of the 150-day period prior to the renewal date. To make a change to or to add a plan or benefit, email the signed rates and benefits along with the Administrative and Benefit Plan Change Authorization Form and Material Modification Form (the ACA requires plan sponsors or issuers provide 60 days' advance notice to enrollees when making material modifications to the plan) to mewamembermaintenance@anthem.com.

Census reconciliation process

All active employers enrolled in the Ohio Farm Bureau Health Benefits Plan are required to complete the Annual Rate and Census Reconciliation (ARC) form during the initial sale and at the end of each plan year.

Annual submission of the ARC form

Participating employers will be given a 60-day time frame to complete the ARC form. The collection period will be mid-July to mid-August. This is to ensure that the employer still qualifies under the Ohio Farm Bureau Health Benefits Plan underwriting requirements. Additionally, the information captured on the ARC form is used by the plan administrator to complete the IRS Form 5500 for the Ohio Farm Bureau Health Benefits Plan.

Employers will be emailed a link to their personalized portal in mewa.io, the digital MEWA management platform that collects and stores Ohio Farm Bureau Health Benefits Plan ARC data. Some information will be prefilled into the ARC form. Employers need to review the form for accuracy, make any necessary changes or updates, and submit. If employers need assistance completing the form, mewa.io will provide a link to request broker assistance. The collection period will end in mid-August. Mewa.io will then submit completed forms to the plan manager.

A Wage and Tax Statement is not required. You may be required to provide a Wage and Tax Statement later if your group is selected by the plan auditors for additional testing. If you do provide a copy of your Wage and Tax Statement with the ARC form, the document will be saved in the plan's files and you will not be required to provide the document again if your group is selected for audit testing. Contact the Consoliplex Service Team at service@consoliplex.com with questions.

General administration

Medical premium equivalent billing

Anthem will bill the participating employer a premium equivalent rate on behalf of the Ohio Farm Bureau Health Benefits Plan. EFT/ACH will be the required method of payment. Anthem will initiate the demand debit transaction on the invoice due date; however, if the invoice due date falls on a banking holiday, a Saturday, or a Sunday, the withdrawal will be made on the next banking day. It is the employer's responsibility to review their invoice for accuracy every month. Errors not reported will be processed for the current effective date.

Ohio Farm Bureau membership dues

Membership dues are billed to the participating employer every month by Anthem at a per-subscriber, per-month rate of \$7.50 per employee listed on the product due invoice. No retroactive adjustments will apply. The product dues will be invoiced separately from the premium equivalents and will be debited from the same bank account authorized via the *EFT/ACH Authorization Form* for medical premium equivalents and dental, vision, life, and disability premiums. Please see the *Ohio Farm Bureau Health Benefits Plan Participating Business Acknowledgment Agreement* for additional details.

Dental, vision, life, and disability premium billing

Dental, vision, life, and disability premium (if applicable) will be invoiced together, but separate from the medical premium equivalents. EFT/ACH will be the required method of payment. Anthem will initiate the demand debit transaction on the invoice due date; however, if the invoice due date falls on a banking holiday, a Saturday, or a Sunday, the withdrawal will be made on the next banking day.

Delinquency process

If a participating employer fails to pay their premium equivalent rate by the due date, they will receive a termination or reinstatement letter. The participating employer will have 15 days to apply for reinstatement via the process outlined in the letter.

Group terminations

Group termination letters must be on letterhead from the participating employer and submitted to the Sales representative for processing 30 days prior to the requested date for terminations at renewal time and 60 days prior to the requested date off cycle.

Member maintenance

Member maintenance changes should be submitted through EmployerAccess.

New hires and member/dependent status changes

Eligible employees (and their dependents) working 30 hours or more may apply for benefits as a new hire.

- Applications must be submitted to Anthem within 31 days of the employee's eligibility date.
- Special enrollment event applications should be submitted within 31 days of the qualifying event date. Special event qualifications are marriage, birth or adoption of a child, or loss of coverage.
- Late enrollees will be denied. They can elect benefits at the participating employer's next open enrollment period.
- An employee can request to terminate a dependent from benefits at any time.
- An employee's benefits will terminate when any of the following occurs: termination of employment, retirement, employee requests plan termination, or a reduction of hours below the 30-hour minimum. Terminations must be provided to Anthem within 31 days of the termination date.
- Benefits will terminate at the end of the month in which the status change occurs.

Enrolling rehired employees

If an employee loses coverage due to a layoff, is rehired within 62 days, and put back on the group plan, that employee's earliest effective date of coverage will be the date of rehire. The waiting period will be waived. If 63 days or more have passed, the group's waiting period applies.

COBRA and state continuation

COBRA and state continuation under the Ohio Farm Bureau Health Benefits Plan follow federal and Ohio laws. Under Ohio law, for groups up to 50 eligible employees, an employee may have a right to continue health benefits upon termination of employment if the employee has been continuously enrolled under a group policy during the entire three months preceding termination of employment and meets certain other Ohio law requirements. See O.R.C. Section 3923.38 for more information.

For groups with 20 or more employees for at least half of the previous calendar year, federal COBRA law allows for continuation coverage under certain situations. The employer is responsible for administration. The law requires a timely application and payment of premium for COBRA benefits to continue.

COBRA administration will be done by MyCOBRA Plan. They will administer federal and state continuation services, including general notice distribution, qualifying event administration, premium equivalent billing and collection, and COBRA termination processing.

The Ohio Farm Bureau Health Benefits Plan uses mewa.io to ensure plan members are offered the appropriate continuation of coverage options, as required by the Employee Retirement Income Security Act (ERISA). Group administrators will be asked to confirm member term reasons via a mewa.io notification before election paperwork is mailed to COBRA-eligible members.



Regulatory compliance

Participating employers who offer ERISA-governed employee benefit plans must comply with regulatory requirements for plan sponsors. The Ohio Farm Bureau Health Benefits Plan provides assistance in meeting these compliance obligations by offering an ERISA compliance service. Participating employers should exercise care in meeting these compliance obligations. Please refer to the *Participation Agreement* for further details, in addition to seeking legal guidance from your attorney.

Group summary plan description and compliance documents

Group summary plan descriptions (SPDs) for medical and specialty coverage, as well as compliance documents, are available on Anthem's EmployerAccess site. You may find these documents by selecting the **Reports and Tools** tab under Tools and Resources.

Medicare

In order for Medicare Primary Payor rules to apply under the Ohio Farm Bureau Health Benefits Plan for participating employers with fewer than 20 employees (on each working day in 20 or more calendar weeks in the current or preceding calendar year), participating employers must request and be approved for Small Employer Exception to the Medicare Secondary Payor rules.

Frequently asked questions about small employer exception and Medicare

Who qualifies for small employer exception?

To qualify, employers and their Medicare-aged employees must meet two criteria. (Some additional criteria apply to specific circumstances.)

1. Employees and/or dependents must be entitled to Medicare on the basis of age and still be enrolled in their participating employer's Ohio Farm Bureau Health Benefits Plan group health plan.
2. Participating employers must employ fewer than 20 total employees (full and part time) for the preceding 20 calendar weeks, and must continue to employ fewer than 20 total employees for the entire time the exception is allowed.

How does the process start?

The Ohio Farm Bureau Health Benefits Plan identifies possible candidates for this exception request based on age and group size, and will notify the group by email from mewa.io 30 days prior to the Medicare-aged participant's 65th birthday. Once the request is submitted by the plan manager, it will take approximately 12 weeks to receive a response from the Centers for Medicare & Medicaid Services (CMS). Responses will be sent to the carrier and the group contact by the plan manager. The notification contains further instructions on how a participating employer can request the exemption. Read all instructions fully. If the identified Medicare-aged participant is not going to be enrolled on the group health plan or the participating employer does not meet the criteria above, no registration needs to be completed.

How do I check the status of a pending request?

Unfortunately, CMS does not provide a status on pending requests. It typically takes 12 weeks to receive a response from CMS.

Can a group request an exemption in anticipation of a member turning 65 or if the Ohio Farm Bureau Health Benefits Plan has not sent an invitation to request an exemption?

No, CMS will not accept requests before a member turns 65. Only candidates identified by the Ohio Farm Bureau Health Benefits Plan may request an exemption. Exemption requests require initiation by the Ohio Farm Bureau Health Benefits Plan.

What should be done to ensure that the group has the opportunity to register for the exemption?

Make sure all information on EmployerAccess is up to date. Group administrator email address, group size, and enrollment information must be current for the notification process to correctly identify candidates.

Who can be contacted for questions about Medicare?

Contact CMS directly or go to [cms.gov](https://www.cms.gov).

Broker distribution

Commission information

Business written prior to July 1, 2022

	Direct brokers new and renewal	Nondirect brokers new and renewal
Medical	\$42 PEPM	\$38 PEPM
Dental	10%	10%
Vision	10%	10%
Life and AD&D	15%	15%
Disability	15%	15%

PEPM = per employee per month
AD&D = accidental death and dismemberment

New business written on or after July 1, 2022

	Direct brokers new and renewal	Nondirect brokers new and renewal
Medical	\$32 PEPM	\$28 PEPM
Dental	10%	10%
Vision	10%	10%
Life and AD&D	15%	15%
Disability	15%	15%

PEPM = per employee per month
AD&D = accidental death and dismemberment



Thank you for your trusted partnership. If you would like more information about the Ohio Farm Bureau Health Benefits Plan, contact your Anthem Sales representative.

Ohio Farm Bureau Federation is a member of American Farm Bureau Federation®, a national organization of farmers and ranchers including Farm Bureau® organizations in 49 other states and Puerto Rico, and is responsible for Farm Bureau membership and programs within the state of Ohio. Ohio Farm Bureau Federation programs and services are available only to Farm Bureau members within Ohio.

This Ohio Farm Bureau Health Benefits Plan producer guide will answer many of your questions regarding underwriting, quoting, plan offerings, and administrative guidelines. If you find a discrepancy between this guide and any contract issued as it relates to this arrangement, the terms of the contract prevail. The regulations in this guide are subject to change without prior notice.

Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company, Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.