



Underwriting Guidelines

Effective January 1, 2020 through December 31, 2020

Underwriting requirements may change, and AGC Health Benefit Trust reserves the right to request additional information as it deems necessary. In addition, if there are discrepancies between this document and any employer contract or *Certificate of Coverage*, the contract or *Certificate of Coverage* will prevail.

Category	Explanation/Requirements
AGC of Oregon-Columbia Chapter Membership	<ul style="list-style-type: none"> • Employer must be member in good standing of AGC Oregon-Columbia Chapter. • Benefits will terminate with a minimum of 30-day notice to the employer if AGC membership is deemed cancelled and/or delinquent. The termination will be effective with the last day of the month for which the premium was received.
Employer Eligibility	<ul style="list-style-type: none"> • AGC member firms that are active general or specialty contractors or related industry material suppliers meeting one of the following criteria are eligible to participate in the trust: <ul style="list-style-type: none"> ○ SIC Code in the range of 1500-1799 – OR – ○ Active contractor’s license from the State of Oregon or Washington – OR – ○ Certification that 50% or more of annual revenue is received from work in the commercial construction industry. • Employer must be headquartered in Oregon or Clark County, Washington and have been in business for a minimum of 60 days. • Employer must have a minimum of two enrolled permanent employees. • Permanent employees are those who work at least 30 hours in a normal work week; however, an employer may elect to reduce the eligibility requirement to 17.5 hours per week, provided it is non-discriminatory. For employers that elect a dollar bank, eligible employees also include those who have sufficient dollars in their dollar bank. • Classes of eligibility and carve-outs of certain groups of employees are not allowed. All eligible employees must be offered the same health benefit(s). • Groups consisting only of sole proprietors, husband and wife or only owners are not eligible. • 100% of eligible employees must have workers’ compensation coverage, except those legally not required to be covered by workers’ compensation coverage.
Participation	<ul style="list-style-type: none"> • 75% of the eligible employees must enroll after valid waivers (in order of a waiver to be valid, the employee must have alternate group coverage through another employer (i.e. spousal coverage), Medicare, Medicaid CHAMPUS, Indian Health Services or the Oregon Health Plan). • COBRA participants, retirees, independent contractors (whose earnings are reported on IRS Form 1099), employees in the waiting period and employees covered under a collectively bargained agreement are not considered eligible employees and are not included when determining participation. • When the employer contributes 100% of the employee premium, 100% of the eligible employees must enroll. Eligible employees are not allowed to opt out of coverage in lieu of compensation. • When both spouses/partners of the same family are employed by the same employer and are eligible for coverage, both are required to enroll as subscribers, rather than one enrolling as a subscriber and the other as a spouse/partner, if participation is affected. Dependents may enroll with either spouse but not with both.

	<ul style="list-style-type: none"> Employers dropping below two enrolled employees will have 90 days to meet minimum participation. Failure to do so will result in termination of coverage on the last day of the month in which the 90th day occurs.
Out of State Eligibility	<ul style="list-style-type: none"> At least 50% of an employer's enrolled employees must reside in areas serviced by Cambia Health Solutions (Oregon, Idaho, Utah, and Western Washington).
COBRA	<ul style="list-style-type: none"> All enrolled employers are subject to COBRA for medical, prescription, dental, vision and EAP benefits elected through the trust, regardless of individual employer size. (COBRA coverage is not applicable to life/AD&D benefits.)
Contribution	<ul style="list-style-type: none"> Employer must contribute at least 50% of the employee premium for the benefits offered by the employer. (If more than one medical plan is offered, the employer must contribute at least 50% of the employee premium to the lowest cost plan.) Group Life/AD&D coverage must be 100% employer paid. Employer must disclose to Regence policies that would offset an employee's medical deductible and/or coinsurance. Regence reserves the right to adjust rates.
Eligible Dependents	<ul style="list-style-type: none"> Employee's spouse. Domestic partners. An Affidavit of Qualifying Domestic Partnership form is required for non-certified domestic partners. Children of the eligible employees to age 26, regardless of student status. Unmarried children with physical or mental handicaps, who are incapable of self-support, may be eligible to continue coverage with required written verification. Adopted children, children placed for adoption, step children and foster children. Dependents who are court-ordered to be covered by the employee's plan.
Waiting Periods	<ul style="list-style-type: none"> Employers can set their waiting period as the first of the month following date of hire (DOH), 30 or 60 days. The maximum waiting period for newly hired employees to become eligible for coverage is first of the month following 60 days. Employers may elect to waive their selected employee waiting period at the time of initial case issue only but have the option to change their waiting period once a year at renewal. Terminated employees who are rehired within six months of termination will be eligible first of the month following the rehire date. Enrollees enroll at open enrollment only, unless they have a qualifying event. Employer groups and newly eligible employees or dependents will not be subject to pre-existing condition exclusions.
Effective Dates, Anniversary Dates and Termination Dates	<ul style="list-style-type: none"> AGC Health Benefit Trust – Oregon Columbia Chapter renews annually on January 1. Open enrollment is the month prior to renewal effective date. Employers may join the trust anytime and will receive 12-month contracts from their effective date. New employer or new employee coverage will be effective the first of the Coverage always ends on the last day of the month. Group level termination requests must be made in writing and signed by an officer of the participating employer. Any employer terminating group coverage through AGC Health Benefit Trust will have to wait twenty-four (24) months to re-join the program. Termination of association will be inclusive of all subgroups, regardless of their individual anniversary date.

<p>Qualifying Events/Status Changes</p>	<ul style="list-style-type: none"> • Qualifying events include birth of a child, marriage, divorce, legal separation, adoption, death, loss of other coverage, placement for adoption, loss of eligibility for Medicaid or other governmental health care program and/or termination of domestic partnership. • Effective date of status change shall be controlled by applicable law. • Enrollment changes due to qualifying event/status change must be communicated to the trust within 30 days of the date of the event.
<p>Plan Offering</p>	<ul style="list-style-type: none"> • AGC Health Benefit Trust – Oregon-Columbia Chapter contracts with Regence Blue Cross Blue Shield of Oregon for fully insured medical and prescription benefits, The Standard Insurance Company for fully insured dental and vision benefits, and LifeMap Assurance for life/AD&D benefits. • Employers must select at least one medical and prescription (Rx) option. <ul style="list-style-type: none"> ○ Groups of all sizes can elect up to three of any medical plans (PPO, HSA). ○ Groups of all sizes can elect one PPO prescription (Rx) plan. All PPO options must have the same Rx plan. HSA medical plans have specific Rx plans associated with them. ○ Complementary Care (Alternative Care) is included with all medical plans. • A minimum \$10,000 Life/AD&D benefit offering is required for all participating employers. • Ancillary lines of coverage are optional to the employer but are not available on a stand-alone basis. If elected, uncommon employee and dependent enrollment is allowed. • AGC Health Benefit Trust medical and prescription must be administered by Regence BlueCross BlueShield of Oregon.
<p>Deductibles and Coinsurance Maximums</p>	<ul style="list-style-type: none"> • Deductibles and coinsurance maximums run January 1 – December 31. • Within 60 days of initial enrollment, an employer or employees may request credit for any medical or dental deductible met within the same calendar year while covered by a previous group plan. Coinsurance maximums cannot be credited from prior coverage.
<p>ID Cards</p>	<ul style="list-style-type: none"> • ID cards are mailed to employee’s home addresses within 10-14 business days of initial enrollment. • Medical ID cards are available to members online at www.regence.com. • Dental ID cards are available to members online at https://wf.employeebenefit-service.com/dental/?app=content&pres=standard. • Vision ID cards are not issued. Providers can confirm eligibility and benefits with VSP using the member’s SSN.

Requirements for Case Submission and Administrative Guidelines

Final Rates	<ul style="list-style-type: none"> All rates are based on final enrollment and subject to underwriting approval.
Required Documents	<ul style="list-style-type: none"> Employer Application for Coverage, completed and signed by employer and broker. Verification of Employment Status (see below for additional information). Census of all eligible employees. The census should include coverage election, gender, dates of birth, employee home zip codes, and dependent status/number of dependents. SBC Acknowledgement and Distribution Form, signed by employer and broker Late Submission Letter (if applicable). EFT Authorization Form, completed and voided check attached (if applicable). COBRA Administrative Agreement (if applicable). Enrollment/waiver form for all eligible employees completed and signed by each employee.
Verification of Employment Status	<ul style="list-style-type: none"> Employers with 2-4 enrolled employees must supply a copy of their most recent quarterly wage and tax report. The report should be reconciled to indicate full-time, part-time, COBRA/state continuation and terminated employees (include last day worked). If the employer has not yet filed a quarterly wage and tax report, or is not required to do so, a current two-week/quarterly payroll is required to validate that employees are working at the business and that an employer/employee relationship exists. If the owner(s) are not listed on the quarterly wage and tax report, proof of ownership is required.
Submission Deadline	<ul style="list-style-type: none"> All new employers requesting coverage should be submitted to the General Agent's office by the 15th of the month prior to the month coverage is to be effective. Any case submitted after the 15th of the month must be accompanied by a signed late submission letter. The General Agent reserves the right to request a late submission letter from any employer (regardless of submission date) if enrollment delays or difficulties are anticipated.
Premium Remittance	<ul style="list-style-type: none"> All quoted rates assume premium remittance via EFT. Premium payments are due by the 10th of the month. Payment by EFT is automatically withdrawn from the employer's designated bank account on the 10th of the month, or the following business day if the 10th is a weekend or holiday. Check payments incur a monthly 2% administrative fee. Payment made after the due date will result in a \$30 late payment fee. Repeated delinquencies may result in an increase in the late payment fee. Payments returned for non-sufficient funds will incur a \$30 processing fee. Receipt of payment must be made by the end of each month to avoid termination of benefits. The termination will be effective with the last day of the month for which a premium was received.
Groups Previously Terminated for Nonpayment	<ul style="list-style-type: none"> Reinstatement must be requested in writing within 30 days of the date coverage is terminated for nonpayment. If approved, a reinstatement charge of \$250 will be assessed to any reinstated employer. Reinstatement will not be offered once an employer has been terminated for nonpayment twice in the most recent twelve months.