Underwriting Guidelines for AGC Oregon – Columbia Chapter

Effective October 1, 2022 through September 30, 2023

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	• 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	• AGC member firms that are active general, or specialty contractors or related industry material suppliers are eligible to participate in the Trust. • 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. • Groups consisting only of sole proprietors, husband and wife or 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.
Out of State Eligibility	• Employers must have a minimum of 51% of its enrollees located in Oregon or Clark County, WA.
Participation	• 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 not sponsored by the employer, government-sponsored plans and state/federal exchange plans). • An active employee cannot waive coverage due to Medicaid eligibility (Share of Cost). • COBRA participants, 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 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. • 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.
COBRA	• All enrolled employers are subject to COBRA for medical, prescription, dental and vision benefits elected through the trust, regardless of individual employer size. (COBRA coverage is not available for life/AD&D benefits.)
Contribution	• Employer must contribute at least 50% of the lowest cost plan.

Eligible Dependents	• Employee's spouse. • Employee's domestic partner. • Children of the eligible employees through the age of 25, 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, stepchildren and foster children. • Dependents who are court-ordered to be covered by the employee's plan.
Classes of Eligibility	• The Patient Protection and Affordable Care Act ACA contains provisions that prohibit favoritism toward highly compensated individuals in benefit plan design or eligibility rules. Employers are subject to financial penalties for noncompliance. Because the definition of "highly compensated individuals" does not have a monetary threshold, and the analysis is complex, we encourage employer to see appropriate advice to determine if these provisions apply to their group. • Groups may set different waiting periods for different classes of employees. However, this should be carefully evaluated in light of federal health care reform provisions regarding treatment of classes of employees. • If employers provide more than one plan option for different classes of employee this also should be carefully evaluated in light of federal health care reform provisions regarding treatment of classes of employees.
Effective Dates, Anniversary Dates and Termination Dates	• AGC Health Benefit Trust – Oregon Columbia Chapter renews annually on October 1st. • Employers may join the trust anytime during the year for a 12-month contract. • New employer or new employee coverage will be effective the first of the month for which they are eligible. • Open enrollment is the month prior to renewal effective date. • Coverage always ends on the last day of the month. • Termination requests must be made in writing and signed by an officer of the participating employer.
Qualifying Events/Status Changes	• Qualifying events include birth of a child, marriage, divorce, 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.
Plan Offering	• AGC Health Benefit Trust – Oregon Columbia Chapter contracts with United Healthcare for fully insured medical and life/AD&D benefits and Standard Insurance Company for fully-insured dental and vision benefits. • Employers must select a minimum of one medical plan to contribute to but may choose to contribute to more than one plan. • $10,000 Life/AD&D benefits are included with all medical plans. • Ancillary lines of coverage are optional to the employer but are not available on a stand-alone basis. • Uncommon employee and dependent enrollment among the benefits is allowed.
Deductibles and Coinsurance Maximums	• 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.

Requirements for Case Submission and Administrative Guidelines

Required Documents	• 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 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 the employee.
Verification of Employment Status	• A copy of the most recent quarterly wage and tax report is required and should be reconciled to indicate full-time, part-time, COBRA/state continuation and terminated employees (include last day worked) for all employers. • 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	• 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	• 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 retroactively to the beginning of the month.
Groups Previously Terminated for Nonpayment	• 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.
ID Cards	• ID cards are mailed to employee's home addresses within 10-14 business days of initial enrollment. • Medical ID cards list subscribers and enrolled dependents. Dental cards list subscribers and "Yes" or "No" for dependent enrollments. Dependent names do not appear on dental ID cards. • Medical ID cards are available to members online at www.myuhc.com. • Dental ID cards are available to members online at https://wf.employeebenefitservice.com/dental/?app=content&pres=standard. • Vision ID cards are not available. Benefits and coverage can be confirmed with VSP using the member's SSN.