General Underwriting FAQ

What types of group's are eligible for coverage?
Eligible groups are corporations, partnerships, and sole proprietorships where there is a clear employee - employer relationship.

What kinds of groups are considered ineligible?
Ineligible groups include but are not limited to entities that band together for the purpose of obtaining insurance such as multiple employer trusts (MET's), multiple employer welfare associations (MEWA's), associations, religious organizations, Taft-Hartley Trusts, and employee leasing firms. In addition, the following is our **ineligible industry list**:

SIC Group	Description
851	Forestry Services
910	Commercial Fishing
1000	Metal Mining
1200	Coal Mining
1300	Oil and Gas Exploration / Extraction
1400	Mining and Quarrying of Nonmetallic Minerals
201x	Meat Packing Plants
2100	Tobacco Products
2892	Explosives
3292	Asbestos Products
33xx	Primary Metal Industries
4121	Taxi Cabs
4213	Long Haul Trucking
4950	Sanitary Services
55xx	Automotive Dealers and Gasoline Service Stations
58xx	Eating and Drinking Places
592x	Liquor Stores
5993	Tobacco Stores and Stands
7011	Casino Hotels
7381	Detective, Guard, and Armored Car Services
7363	Employee leasing firms
752x	Automobile Parking
7542	Car Washes
794x	Commercial Sports
7993	Gambling establishments
8100	Legal Services
8600	Membership Organizations (Includes Church Organizations)

Note: The use of the letter "x" is to indicate the inclusion of all numbers. For example, Meat Packing includes multiple four-digit SIC codes which all begin with the numerals 201. Instead of listing all of the meatpacking SIC codes, the abbreviation 201x was used to indicate that all SIC codes which begin with the numerals 201 are included within that category.

Are any industries subject to special requirements?
Hospitals are subject to a minimum $50,000 specific deductible. In addition, the lesser of the current domestic reimbursement percentage or 70% of claims incurred at the plan sponsor's / employer's facilities or with the employee providers thereof are eligible to accumulate toward or for reimbursement under the aggregate and / or specific excess loss contracts.

Will Bardon offer a proposal to a group that has a history of frequent carrier changes?
Groups should have a stable history of carrier and TPA relationships. Cases with more than 2 stop loss vendors in the most recent 3 plan years may be declined unless there are clear reasons for the changes (i.e. carrier no longer in the market).

Are there any limitations on COBRA participants or retirees?
COBRA participants and Non-Medicare primary retirees may comprise no more than 10% of the group.

Is a stop loss proposal available for groups that have a fully insured HMO and a self funded PPO dual option plan (HMO penetration)?
Bardon will offer proposals to groups that have had a dual option plan for 2 years or more years. A proposal will be offered on the non-HMO employees only assuming that consistent enrollment in can be demonstrated. HMO employees may be allowed to join the plan if satisfactory health information can be obtained.

Can the aggregate margin be specified in the request for proposal?
Aggregate margin (corridor) is the underwriter's determination and is subject to minimums defined by agreement with our carrier. It is not open for modification or request.

When does Bardon require claims experience?
Bardon requires claims experience when any of the following conditions exist:
- The group has 100 or more employee lives
- The group is currently self funded
- Experience is available

What types of claims and enrollment data is required
The information that is needed is:
- Monthly paid claims, corresponding enrollment figures and time periods (preferably by line of coverage)
- Detailed shock loss data (claims greater than 50% of current or lowest proposed specific deductible) including individual paid claims (from first dollar) and diagnosis information by plan period
- If claims are not provided by line of coverage, a explanation of benefits included in the experience is necessary
- Details of changes to benefits, provider networks, specific deductible / contract type, aggregate contract type or any other change that would have impacted the payment of claims.

How much experience is needed?
In order to quote, it is recommended that there be at least 21 months of experience (12 months of the prior year and 9 months of the current). Should this not be available at the time of proposal, it will be at the underwriter's discretion as to whether a proposal will be offered with a contingency for the missing data. If there is a special situation, call an underwriter prior to submission.

No coverage can be bound on a case that requires experience without at least 23 months of data (12 months of the prior year and 11 months of the current).

Will Bardon use HMO claims experience?
We are unable to offer a proposal based on HMO data or other experience that includes significant amounts of capitation.

What about groups that have less than 100 lives and do not have claims experience?
Manually rated quotes are available for groups with less than 100 employee lives contingent upon the completion of Bardon's individual health statement by the enrolling participants. The health statements do not have to be completed in order to receive a quote. Contact one of our staff for more information.

When a proposal requests additional medical information on an individual, what is needed in order to satisfy the contingency?
You are more than welcome to submit case management or pre-certification notes, medical records, individual paid claims reports with diagnosis and procedure codes or other records that might be pertinent. We will let you know in writing if they are insufficient with which to make a determination. However, it is preferred that you get a Bardon "Authorization to Release Medical Information" form completed and signed by the individual and send it to

us. You may use another form provided that it is HIPAA compliant and specifically references Bardon and Case Management Specialists as parties that are authorized to receive the information.

We have contracted with Case Management Specialists to secure medical information and provide evaluations based what is received. It is often the situation that the entire process can be handled in a matter of hours and sometimes over the phone. In any case, the information received is what we need in order to make an appropriate determination. You avoid the hassle including the possibility that the information provided is insufficient and more is needed. Contact one of our staff for more information.

Are higher individual specific deductibles (lasers) mandated on new or incumbent business?
Specific excess loss premium is for risk that is truly unknown. That being said, we never mandate that a group take a higher specific deductible on a particular individual for new business or incumbent groups, but we do offer it first because we believe it to the most prudent option for the employer in most cases.

When a situation comes to light that presents a high probability of a relatively significant claims event, underwriting action is necessary. The premium must be altered or other action taken to account for the heightened risk. Accounting for such a situation under the premium requires that the expected claims for the condition be included in fixed costs. When this course of action is selected, the ultimate premium increase is for the amount of the predicted treatment plus the additional premium tax and expense loads that are part of every dollar of premium.

Often, the best course of action for the plan sponsor is to place a higher specific deductible on the particular individual to account for the expected treatment. In this manner, the employer only assumes the risk of the actual predicted dollars, not the additional expense loads and premium taxes. Whether or not the anticipated event occurs, the employer is in a much better position than they would have been if the additional premium route was chosen.

Are aggregating specific deductibles (corridors) available?
Bardon does offer aggregating specific deductibles (ASD's). There are two types of ASD's:

- **Pricing (PASD)** - premium is traded for the plan sponsor's assumption of additional risk in excess of the group's specific deductible. These are an excellent opportunity for the plan sponsor to save on fixed costs.
- **Medical (MASD)** - typically used when there is more than one individual with a potentially significant claims event. This is often more advantageous for the employer than higher specific deductibles for each condition because the amount of the aggregating specific is typically less than the sum of the higher specific deductibles and is reduced by the amount of the group's specific deductible. The typical aggregating specific deductible applies to all claims that exceed the specific deductible. Sometimes, a limited or "bubble" aggregating specific deductible is used. Instead of having all claims that exceed the group's specific deductible apply toward the ASD, only the excess claims of named individuals will apply. When an MASD is used there is no reduction of premium as it is being used to deal with known medical issues.

Does Bardon have a minimum participation requirement?
We will offer quotes for groups that can demonstrate 75% net participation or greater. Net participation is defined by the following formula:

$$\frac{\textit{Enrolling Employees}}{\textit{(Total Eligible Employees – Eligible Employees waiving due to other coverage)}}$$

How does Bardon require that eligible employees be defined within the plan document?
Eligible employees should be defined as those individuals who minimally work 30 hours per week (on average) within the scope of the employer's business. Consultants, contractors, employees for whom income is reported on a 1099 form and other non-traditional employees should be excluded from the plan.

Can groups with a rich plan of benefits be quoted?
Plans with extremely rich benefits can be quoted as long as there is sufficient credible claims experience due to potentially volatile utilization patterns. Groups without satisfactory experience may be quoted as long as there is a minimum $500 individual out of pocket maximum (deductible and coinsurance).

What does Bardon require to be in the plan document?

Plan documents must clearly state the coverage granted to the participants. Eligibility, termination provisions, exclusions, limitations and restrictive covenants such as pre-certification and non- network utilization penalties should also be specified. In addition, the plan document is expected to exclude coverage for the treatment of infertility (with the exception of surgical correction of anatomic structures, i.e. blocked fallopian tube), coverage for medical treatment, surgical treatment and drugs that are experimental, investigational or not approved by the FDA for the particular condition, coverage for injuries and conditions that are a result of wars and acts of war (declared or undeclared), coverage for occupational injuries, coverage for injury or condition arising from the commission of a felony, coverage for claims for which an individual has no obligation to pay, coverage for cosmetic surgery or eye surgery for a condition that can be corrected with contacts or eye glasses and coverage for claims incurred more than 12 months prior to the date that it is presented for payment. The preceding list is not all inclusive. Bardon must review and approve the plan document prior to stop loss coverage being bound.

IMPORTANT: The above are meant to be a brief overview of Bardon's underwriting guidelines and is by no means all inclusive. Contact one of our underwriting staff with any questions.