Building healthier businesses

A producer's guide to UnitedHealthcare Level Funded

United Healthcare

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How does Level Funded work?

This guide covers UnitedHealthcare Level Funded plans, which are a form of self-funded plans tailored for businesses with 5–300 plan participants. With Level Funded plans, the plan sponsor sets up a self-funded medical plan, which pays for plan participants' medical benefits directly, and plan sponsors cover their fixed monthly bill. Part of the risk for medical expenses is taken on by the plan rather than by an insurance company. The rest of the financial risk for medical expenses is covered by stop loss insurance, underwritten by All Savers Insurance Company (except CA, MA, MN, NJ and NY), UnitedHealthcare Insurance Company in MA and MN, UnitedHealthcare Life Insurance Company in NJ, UnitedHealthcare Insurance Company of New York in NY, and All Savers Life Insurance Company of California in CA.

Key terms and definitions

Stop loss insurance puts a cap on the plan's medical claims payment risk. This cap is based on the amount the plan must pay for an individual's medical claims (called the "specific deductible"), as well as the combined amount of all eligible medical claims the plan must pay in a given period (called the "aggregate attachment point"). With stop loss insurance, the plan is protected from high individual medical claims and high overall claims expenses.

Specific stop loss coverage protects the plan from unexpected large medical claims incurred by covered individuals in the group.

The specific stop loss deductible is the amount of eligible medical claims the plan pays for any individual plan participant before the stop loss insurance begins to reimburse the plan (within the contract period). For example, if a Level Funded plan had a specific deductible of $15,000 per covered plan participant, and a plan participant has medical claims of $22,000, then the plan covers $15,000 of those eligible expenses and the stop loss insurance covers the rest.

Aggregate stop loss coverage provides financial protection by limiting the medical plan's risk for the sum of the group's total eligible medical claims.

The annual aggregate deductible is the total amount of eligible medical claims in the contract year that the medical plan pays before stop loss insurance begins to reimburse the plan. If the eligible medical claims exceed the plan's maximum claims liability for that contract year, stop loss insurance reimburses the plan. Although stop loss insurance is purchased for the entire year, the policy provides immediate reimbursement to plan sponsors throughout the year.

For example, if a Level Funded plan has an aggregate deductible of $4,000 per month and the number of plan participants does not change, the aggregate accumulates each month to an annual aggregate deductible of $48,000 ($4,000 x 12 months).

The aggregate stop loss coverage pays for high aggregate claims expenses throughout the year. So if claims total $40,000 by month 4, the plan will have paid up to the aggregate deductible of $16,000 ($4,000 x 4 months) and the stop loss insurance will have covered the remaining $24,000.

If, at the end of the contract period, eligible claims under the medical plan exceed the plan's aggregate stop loss deductible, the stop loss insurance will reimburse the medical plan for the amounts over the aggregate stop loss deductible.

If total eligible claims are less than the aggregate stop loss deductible, a portion of the surplus claims dollars may be refunded to the plan. Where required by law, the entire surplus will be refunded to the plan.

Incurred but not reported (IBNR) refers to health care claims that will come in after the end of the plan year. It's commonly called "runout" or "runoff."

Deficit carry-forward is something Level Funded plans do not have, but you might hear about it from other plans. If a group had a really bad claims experience year (say, $1 million in actual claims), the stop loss insurance would cover it. But the insurance company might decide to hold back all renewal refunds until that huge sum is paid back. In other words, the insurance company could carry the deficit from the one bad claims experience year forward to future years. **Again, Level Funded plans do not have a deficit carry-forward.** Level Funded plans are designed to be free from hidden costs or fees. No matter what the previous claims are, the company's tally starts each year at zero.

Eligibility requirements

Plan sponsors

Plan sponsors must be located in a state where UnitedHealthcare Level Funded or affiliated stop loss carriers ("ASIC") are licensed to do business. An affiliated group must have common ownership and common business to be eligible for coverage. Our target market for our Level Funded plans are self-insured groups with 5 enrolled to 300 eligible plan participants. Eligibility requirements may vary by state.

If a company has been in business 3 to 6 months, the following supporting documentation is required:

- Most recent wage and tax form
- Tax ID #
- Proof of organizational ownership type

Note: Retirees are not eligible for coverage under Level Funded health plans.

New companies

If a company has been in business less than 3 months and has not filed a state wage and tax form, the following supporting documentation is required:

- Payroll records from business inception to current date
- Proof of organizational ownership
- SS-4 Form/Tax ID #
- Schedule K-1 sub-corporation or partnership arrangement
- Evidence of general financial viability from a banking institution may be requested

Ineligible occupations and industries

- Non-ERISA groups
- Municipalities
- Professional employer organizations (employee leasing firms)

Plan participant eligibility

- An eligible plan participant is a regular full-time employee who is scheduled to work at least 30 hours per week
- Retirees are not eligible for coverage under Level Funded health plans

Dependents

Eligible dependents include the plan participant's spouse/domestic partner, plan participant's or plan participant's spouse's child who is under age 26 (dependent age can vary by state), including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom the plan participant or plan participant's spouse are the legal guardian; or an unmarried child age 26 or older who is or becomes disabled and dependent upon the plan participant.

Note: Dependents may not enroll in the plan unless a plan participant is also enrolled. If a plan participant and his or her spouse are both covered under the medical plan, each may be separately enrolled as a plan participant, or as a dependent of the other, but a spouse cannot be covered as both a plan participant and a dependent. In addition, if a plan participant and plan participant's spouse are both covered under the medical plan, only 1 parent may enroll a child as a dependent.

Late enrollees

Once a group is installed and issued a policy number, only an applicant with a qualifying event can be added to the coverage. If an enrollment form is received later than 31 days from the date a plan participant or dependent is first eligible to enroll, coverage will be postponed until the medical plan's next anniversary renewal date.

Waiver of medical coverage

Plan participants and their dependents may waive group medical coverage during open enrollment. Plan participants waiving coverage will be included as eligible for the purposes of determining participation requirements. Please contact a sales support office for specific information.

Participation and contribution requirements

Participation requirements

Plan sponsors must meet minimum participation and contribution requirements in order to qualify for a Level Funded plan. The minimum participation requirement is 50% of eligible employees.

Groups may be asked periodically to submit wage and tax statement(s) or other appropriate documents to verify ongoing participation and eligibility.

Contribution requirements

In addition to the participation requirements, plan sponsors must also meet minimum contribution requirements. The plan sponsor is required to contribute a minimum of 50% of the plan participant-only cost for the lowest-cost medical plan sponsored by the plan sponsor.

Prior carrier deductible

When a Level Funded plan immediately replaces prior group medical coverage, we credit each plan participant's calendar year deductible with the amount of deductible satisfied under the prior medical plan (only applies to Calendar Year Deductible plans).

Prior authorization

Prior authorization is required for certain covered expenses. In general, when services or supplies are received from a network provider, the network provider is responsible for obtaining the prior authorization. There are some benefits, however, for which the plan participant is responsible for obtaining prior authorization.

When services or supplies are received from an out-of-network provider, the plan participant is responsible for obtaining the prior authorization. Failure to obtain prior authorization will result in a reduction of benefits. Reduced benefits will be 50% of allowed amounts. Obtaining prior authorization does not guarantee payment.

Effective date

Plan sponsor applications may be submitted for a first-of-the-month effective date. Groups must be submitted (for preliminary encoding) to Medical Underwriting by the 10th of each month to get a first-of-the-month effective date. The underwriting department will contact you with the offered effective date.

Producer requirements

The writing producer must be properly licensed and appointed to represent ASIC in the state where the application was signed.

Following are some suggestions that will help the writing producer and proposed enrollees avoid misunderstandings about the type and scope of coverage that the customer wants issued.

- Brokers should advise plan sponsors and plan participants to furnish accurate and complete information on medical history including date, type of treatment, diagnosis and physician, as appropriate.
- Do not promise an effective date or promise that the group application will be approved. Certain circumstances, such as failure to meet our participation requirements, could result in our decision to not quote the case.
- The exclusions, limitations, provisions and benefits provided under the plan should be clearly and accurately described to the proposed group.
- Quotes: Initial quotes, if issued, will be based on the number of plan participants and spouses listed in the census completed on **uhceservices.com.** If required, detailed medical information will be reviewed only with the applicant's signed underwriting authorization as required under federal privacy regulations.

The writing producer is not authorized to disregard an enrollee's answer or to impose his or her own judgment as to what is or is not important to record. Plan participants should always be instructed to complete their own enrollment forms, including the medical history section. If the details don't fit in the blank section of the medical history section, attach a separate sheet and have the enrollee sign and date the sheet. Include the addendum with the enrollment form.

Case submission process

Groups should wait until coverage is confirmed in writing before cancelling their present group medical coverage to assure no lapse in coverage occurs.

All case submission is conducted through the broker portal on **uhceservices.com.** The producer submits new business information (see "Case submission requirements" below) to their sales support office via the website. The sales support office will forward the new group case submission to underwriting for processing. The sales support office will communicate all underwriting offers to the producer. If the new group case submission is complete and no additional information is required, expect an underwriting decision within 15 working days. If the new group case submission is incomplete, the sales office will request the missing information from the producer and hold the case submission for a maximum of 3 working days. If information is not received, the case will be returned to the producer. If additional medical data is required, the sales office will hold the case open for a maximum of 60 days from the enrollment form signature date. If outstanding information is not received in this time frame, the case will be closed out.

Complete and accurate forms will speed the review of the submitted case during underwriting. Forms will be returned to the producer if required signatures and/or dates are missing or medical questions are left unanswered. Any additional information needed to underwrite the case will be requested by the underwriting department. A member of the underwriting staff or sales office staff may contact either the enrollee, plan sponsor or producer depending on the nature of the information that is outstanding. Outdated or incorrect enrollment forms will be returned to the producer along with the correct version for enrollee completion.

Case submission requirements

To facilitate processing, the writing producer should include the following forms:

- Plan sponsor Group Application Packet that includes the Payment Authorization for Level Funded (including producer and plan sponsor signatures), Stop Loss Application, New York Surcharge forms, and the Billing and Collection Agreement
- Plan participant Enrollment forms, including signed waivers for plan participants not selecting medical coverage
  - All plan participant enrollment forms must include heights and weights, dates of birth, coverage type selected, and signatures and dates signed by plan participants
- Underwriting authorization (Authorization to use Medical Information for Enrollment)
- The plan sponsor's most recent quarterly wage and tax report with status of plan participants when applicable
- First month's payment; if selecting Electronic Funds Transfer (EFT) billing mode, include the plan sponsor Payment Authorization Form
- Copy of quoted rates for plan design(s) selected

The final effective date for the case is confirmed after underwriting review. If underwriting can't make an accurate assessment of the risk, additional information may be requested. Effective dates will be determined by underwriting after discussing the offer with the sales office. Effective dates will be the first of the month.

Prices may change based on any change in census (change in group size due to additions or termination of plan participants during the work-up process), change in plan, change in effective date or new medical information received after initial offer.

Customer service authorization

Plan participants who wish their family members, producer or a company contact to have access to their personal health information must complete and submit an Authorization to Disclose Medical Information for Customer Service.

Underwriting and risk assessment

The underwriting process is designed to help assess the relative risk of future loss on the part of any given enrollee for purposes of stop loss insurance as part of this plan.

The plan participant enrollment form is a critical piece of information in the underwriting process. It provides a place for enrollees to provide medical information that is required to underwrite the plan. Therefore, the enrollment form should be completed as meticulously as possible, including details such as the type and duration of treatment given for a condition, medications taken, when and if completely recovered, residual symptoms, and the names and addresses of the relevant physician(s). If an enrollee has seen more than one physician, it's important to indicate which physician would have the relevant records.

Contract period

Level Funded plans offer a base claim reimbursement on a 12/60 basis. This means that eligible medical claims incurred within the contract period (12 months) and paid within the contract period or paid within 48 months immediately following the end of the contract period will be covered by the plan or stop loss insurance.

Payment

The plan sponsor is responsible for both the total fixed costs, which includes administrative costs and stop loss insurance premiums, and claims funding on a monthly basis. Plans are offered with maximum funding.

Monthly payments

The first month's payment can be accepted via EFT or by check. When sending by check, the payment must be submitted to:

United HealthCare Services, Inc.
UHS Billing
P.O. Box 19032
Green Bay, WI 54307-9032

Subsequent payments are due on the first of each month and can be withdrawn via EFT on the first business day of each month. If direct monthly billing is selected, payments must be sent to one of the addresses indicated below and received by the end of the 31-day grace period.

Regular mail

United HealthCare Services, Inc.
UHS Billing
P.O. Box 19032
Green Bay, WI 54307-9032

Overnight

United HealthCare Services, Inc.
UHS Billing
2020 Innovation Court
De Pere, WI 54115

Plan participant and dependent changes

Requests for benefit changes must be submitted on a completed, signed and dated plan participant enrollment form or via the broker or plan sponsor websites.

New plan participant

A new plan participant must submit an enrollment request within 31 days of his or her eligibility date. The plan participant's spouse and dependents can also enroll during this time. Eligibility dates are based on the plan participant's date of hire and the waiting period selected on the Plan Sponsor Group Application.

If an enrollment request is not received within 31 days after the eligibility date, the plan participant is a late enrollee and coverage will be postponed until the group renewal date.

Adding a dependent

A completed enrollment request must be received for a spouse and/or child(ren), including newborns. The enrollment request must be submitted within 31 days of the event that qualifies a spouse or child(ren) as a dependent (i.e., marriage, birth, adoption).

Termination of plan participant coverage

A plan participant's coverage will terminate at the end of the month when any of the following occur:

- Employment is terminated
- The plan participant retires
- The plan participant requests termination of coverage following a life event such as divorce, marriage, or the birth or adoption of a child. The plan participant must sign the request for termination of coverage
- The plan participant's hours are reduced to part-time

Termination of dependent coverage

A plan participant can terminate a dependent's coverage at any time. To terminate dependent coverage, the plan participant should send the requested date of change and the plan participant's signature. Coverage will be terminated at the end of the requested month.

Stop loss and administrative services termination procedures

Certain ERISA regulations, decisions and obligations must be considered when terminating a self-funding agreement. Producers should refer plan sponsors to their own legal counsel for additional information.

The plan sponsor is solely responsible for providing any required notifications to the plan participants in the event that the Administrative Services Agreement and/or the Stop Loss Insurance Policy is terminated.

Early termination

If termination occurs before the end of the contract period (due to nonpayment of total fixed costs or claims liability, or if the plan sponsor decides to terminate before the contract period is fulfilled), any maximum liability that is owed prior to the termination date must be paid.

Claims incurred prior to termination will be paid by runout. Claims incurred after termination remain the plan's responsibility.

Contract period end termination

If the Administrative Services Agreement and Stop Loss Insurance Policy for a self-funded plan terminate at the end of the contract period, claims incurred prior to termination will be paid by runout.

Administrative provisions

Plan changes

Plan changes can only be done at the group's renewal. Plan changes must comply with the following guidelines:

- Plan changes are available only on the plan anniversary renewal date
- Plan changes can be requested as early as 60 days prior to the plan anniversary renewal date

Probationary waiting periods

A request to change a plan sponsor's probationary period for new hires is considered a plan change and can be made only on the plan's anniversary renewal date. The new probationary period will apply to new hires after the plan's anniversary renewal date.

Direct-billing fee

There may be a direct-billing fee included on each billing statement. The direct-billing fee is waived for EFT.

Service fee

If payment by check or EFT is declined or returned, a service fee may be applied.

Cost changes

Service fees for the administration of the self-funded medical plan, and premiums for the Stop Loss Insurance Policy, are determined by a combination of factors including experience of all groups of a similar nature, demographic composition of the group (e.g., age, dependent coverage and geographic location), and annual increases in the cost of medical services. The third-party administrator has the right to change the service fees on any payment due date after the plan has been in effect for 12 consecutive months. Changes to the premium rates under the Stop Loss Insurance Policy may be made in accordance with the terms of that policy.

Important contact information

Policy Administration Correspondence

United HealthCare Services, Inc.
P.O. Box 31394
Salt Lake City, UT 84131

Phone: 1-877-797-8816
Email: **adminlevelfunded@uhc.com**

Claims Correspondence

United HealthCare Services, Inc.
P.O. Box 31394
Salt Lake City, UT 84131

Phone: 1-877-797-8816

Regular Payments

United HealthCare Services, Inc.
UHS Billing
P.O. Box 19032
Green Bay, WI 54307-9032

Overnight Payments

United HealthCare Services, Inc.
UHS Billing
2020 Innovation Court
De Pere, WI 54115

Website
uhceservices.com

Questions?

Contact your UnitedHealthcare representative for more information

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Administrative services provided by United HealthCare Services, Inc. or their affiliates, and UnitedHealthcare Service LLC in NY. Stop-loss insurance is underwritten by All Savers Insurance Company (except CA, MA, MN, NJ and NY), UnitedHealthcare Insurance Company in MA and MN, UnitedHealthcare Life Insurance Company in NJ, UnitedHealthcare Insurance Company of New York in NY, and All Savers Life Insurance Company of California in CA.

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