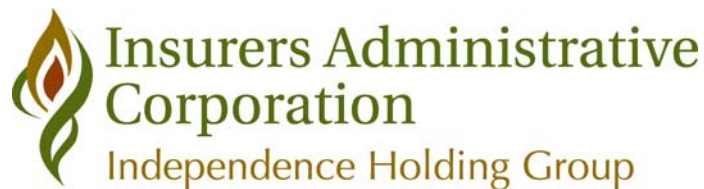


Group Health Plans

Employer's Administrative Guide

**Information to help you administer your
group health insurance program**



Group Health Plans

Administrative Instructions for Employers

Welcome! Your administrative kit provides you with complete information, forms and instructions for managing your insurance program. Each covered employee receives a health plan identification card (if applicable) and a Certificate of Insurance booklet for health plan coverage, and, if applicable, dental and life coverage. If vision benefits are offered, a certificate of coverage is included for you, the employer (in some states, your employees may also receive a copy) and each employee receives a vision plan ID card in a separate mailing.

Please review all materials immediately to ensure that they agree with the plan of benefits you requested.

Administration Services for your health plan are provided by Insurers Administrative Corporation (IAC). Please direct all communications to:

Insurers Administrative Corporation
PO Box 37457
Phoenix, AZ 85069-7457

(800) 518-4510
(602) 906-6310
(602) 906-4745 fax
e-mail: admin@iacusa.com

Please include your group or case number on all communication about your health insurance plan.

Employer Class

You are considered the Plan Administrator, as defined by ERISA, for this plan, which you have selected for your employees.

Group Eligibility Requirements

To maintain coverage under the Health Plan, your business must be located in a state where the plan is approved for sale. If you relocate or expand your business to another state, notify IAC of that change to verify that coverage can continue. The group health plans are intended for employers with 2 to 50 covered employees. We reserve the right to discontinue coverage if employee participation falls below 2 eligible employees (based on state mandates).

Multiple Location Groups

We will consider providing coverage for multiple location employers. All multiple location groups require approval by IAC before offering employee coverage in other employer locations.

When Both Spouses are Covered Under the Same Group Plan

If both the husband and wife are eligible employees of the employer and not constituting the only two employees of the employer group, then:

- 1) Each person can apply as an employee. Insured dependent children may be covered under either employee, but not both.
or
- 2) The husband and wife employees can enroll as an employee and spouse. Whichever employee is oldest must be considered the employee for plan coverage/rating purposes. If the husband and wife employees are enrolling under employee and spouse coverage, Life Coverage will only be offered to the person considered the employee.

Premium and Rate Information

Due Date

Your first premium payment is due on the date of issue of the plan. Subsequent premiums are due on the 1st of each succeeding month. If full premium due is not received on or before the expiration of the 31-day Grace Period (see below), coverage will cease automatically as of the due date for nonpayment of premium. As the participating employer, you are responsible for notifying your employees in the event that coverage lapses.

Billing Date

Although your coverage may be issued with either a 1st or 15th of the month effective date, the billing cycle for all plans is the 1st of the month. If your group's coverage was issued with a 15th of the month effective date, you will receive a billing statement at the time of approval for one and one-half months of premium, to move your plan into the regular 1st of the month billing cycle.

Grace Period

A period of 31 days will be allowed for payment of any premium due after the initial premium. If not paid within that period, coverage will automatically terminate retroactive to the premium due date of the unpaid premium. IAC reserves the right, on behalf of the insurance companies, to recover expenses associated with benefit payments paid during the grace period from the employer when premium has not been paid timely. It is important to notify IAC of a plan termination at least 30 days in advance to avoid exposure to additional expense liability due to plan termination.

Reinstatement

If your group's coverage terminates due to non-payment of premium, it may be reinstated providing that within 20 calendar days immediately following the 31-day grace period, you remit all unpaid premium and the current month's due premium. This provision may be used only once during any consecutive 24-month period.

When Rates May Change

Each employer has an initial 6-month rate table guarantee or an initial 12-month rate table guarantee. However, your premiums may change during a rate guarantee period if: (1) you add or delete employees or your employee adds or deletes dependents; (2) your insured employee moves into a higher rate bracket due to an age change; (3) you relocate your business to a different geographic area; (4) you modify your selected plan of benefits; or (5) your network access or other administrative fees change.

Monthly Administration Fee

A monthly administration fee is charged to all employer groups. This fee will be included on your monthly premium billing. The administration fee is based on group size and may vary depending upon state mandates.

Minimum Employer Contribution

As a participating employer, you are required to contribute a portion of the premiums under your group's plan. The minimum contribution is 50% of the employee cost or 25% of the employee and dependent cost.

What Are the Employee & Dependent Unit Participation & Maintenance Requirements?

All eligible employees are expected to apply for coverage during the employer's initial enrollment period, including those who may not be eligible for coverage yet because they are still in their benefit-waiting period. The employer may waive the benefit-waiting period at the initial enrollment period to maximize plan participation. The following table shows the minimum required participation for groups by number of eligible employees, both for the employee and dependent units, with and without the optional maternity benefit:

Note: For purposes of defining dependent participation, a dependent unit refers to any application in which the employee is applying for coverage for a dependent spouse or dependent spouse and children.

Group Size	Employee Participation	Dependents Units (No Maternity)	Dependents Units (With Maternity)
2-4 Employees	100%	50%	N/A
5-9 Employees	75%	50%	75%
10+ Employees	75%	None	None

In calculating the employee and dependent percentage of participation, it is not necessary to include those who have group health coverage through another source. The employer application helps you calculate the percentage of participation by first subtracting the number of individuals who have other group health coverage. This determines how many "eligible" employees are in the employer group for participation purposes. Then, the percentage of participation is calculated by dividing the number of individuals who actually apply versus the total number "eligible".

Those not applying for coverage must complete an employee application and the "Request to Decline Coverage" section. During the underwriting process, the information provided about other group coverage availability is periodically verified for accuracy.

An employer must maintain at least the minimum employee and dependent participation requirements of the plan that were in effect at the time the employer application was submitted. Periodically, the employer will be requested to assist in the verification of employee participation by providing documentation, such as a copy of a state quarterly unemployment tax report or other documentation. Failure to cooperate with the participation verification or failure to meet minimum participation requirements may result in coverage termination or loss of protection under the Health Insurance Portability and Accountability Act.

If an employer-selected benefit is non-contributory for employees and/or dependents, submissions of Request to Decline Coverage forms should be infrequent. Please explain any circumstances that would warrant consideration of an exception to this rule when submitting the employer application.

Adding Employees to Your Health Plan

Eligible Employees

An employee whom you have hired on a permanent, full-time basis and who works a minimum of 30 hours per week (or as otherwise specified by state law) for at least nine months of the year, who appears on your State Quarterly Unemployment Tax Report, and whom you compensate for his/her services as an employee may apply for group insurance following completion of your selected waiting period.

Application

An application must be **fully** completed for each employee whom you are adding to the plan. Send the completed applications to Insurers Administrative Corporation (PO Box 37457, Phoenix, Arizona 85069-7457; fax 602-906-4745; e-mail admin@iacusa.com) at least 30 days before the employee's eligibility date. Failure to provide a complete application or failure to provide requested documents in a timely manner could result in a delay or denial of coverage.

Employers offering **Employee Choice** (up to 3 different benefit plans) must verify that employees select a plan choice on page 3 of the application. A minimum 20% participation level is required in each plan design being offered.

Employer Name

Please use the employer name and group number as listed on your premium billing statement as the "Employer" on all applications for insurance.

Waivers of Coverage

If your employees are waiving coverage for themselves or their eligible spouses or dependents, they must complete a Waiver of Coverage. The Waiver of Coverage must include the reason for which coverage is being waived. Participation requirements must be maintained.

Changes in Premium

Do **not** send premium with the application or adjust your premium billing statement to reflect new coverage for employees and/or their dependents. After we have approved the addition of an employee, we will bill you for the additional premium on your next premium billing statement.

Late Applicants

A person who declines coverage during an initial enrollment period or who requests coverage outside of an initial enrollment period is a late applicant. However, applicants who are eligible under the Health Insurance Portability and Accountability Act (HIPAA) and who qualify for a special enrollment period because of a "qualifying event" will not be considered late applicants, unless coverage is not selected during the special enrollment period.

Qualifying events include loss of coverage due to legal separation, divorce, death, termination of employment or a reduction in the number of hours of employment. The following qualifying events apply to eligibility of new dependents: 1) marriage; 2) birth; and 3) adoption and placement for adoption. Employees and their new dependents may be added following one of these qualifying events within 30 days of the event.

Loss of eligibility due to failure to pay premiums on a timely basis or by our termination of coverage for cause does not fall under the definition of a qualifying event under HIPAA. (Examples of loss of coverage for cause include making of a fraudulent claim or an initial misrepresentation of fact in connection with a group health plan.)

A late applicant's **effective date** will be the first of the month following the date we receive and approve the application for coverage. However, covered charges will be subject to the pre-existing limitation period described below.

A late applicant's **pre-existing limitation period** will be the 18 consecutive months following the effective date (or as otherwise specified by state law). During the pre-existing limitation period, any eligible charges incurred in connection with a condition that was pre-existing within the 6-month period preceding the applicant's effective date will not be covered.

Pre-existing Condition Limitation Credit

An insured person who has creditable coverage as defined by HIPAA to a date no more than 63 days (or more, if required by state law) before the date of application under a group health plan will be given credit for the full or partial satisfaction of a pre-existing condition limitation waiting period by such creditable coverage. Pre-existing condition limitation waiting periods will be reduced to the extent of the insured person's prior creditable coverage.

Termination of Coverage

To terminate your group health plan coverage, you must submit a written request to cancel the policy. The request must be signed by an owner/ officer of the company. Your coverage will cancel the first day of the month following receipt of the request, or the last day of the month which the premium was paid in full.

Termination of Employees' Employment

Reporting Terminations from Coverage

To report terminations from coverage, complete the form enclosed with your premium billing statement, and **note the last day worked on a full-time basis**. The maximum amount of premium credit available for a terminated employee is 60 days provided that the terminated employee has not submitted any claims.

When Coverage Ends

Insurance coverage will cease on the last day of the month following the date of termination of employment or reduction in hours to less than full-time as described under "Eligible Employees".

Premiums for Terminated Employees

Premium is due for the month in which an employee is terminated, as coverage will be continued until the end of that month.

Changes in Existing Coverage

Voluntary Termination of Coverage

If an employee wishes to cancel his/her coverage but remains employed, he/she **must** complete a Waiver of Coverage. A Waiver of Coverage is also required when an employee wishes to cancel coverage for an eligible spouse or dependent. **Any changes will be made effective the 1st of the month following approval of the change by IAC**, unless a later date is requested. (Refer to participation requirements.)

Changing Plan Type or Adding Benefits

To change plan type or add optional benefits to the group plan, contact In-Force Administration Customer Service at (800) 518-4510 for requirements and availability.

Decreasing Benefits

You can remove optional benefits only at the anniversary date of your benefits plan. To remove optional benefits, a letter requesting the change and signed by an officer of the corporation must be submitted during the 31-day period occurring three months before your health plan anniversary date. If approved, the change will be made effective as of the health plan anniversary date.

Continuation of Coverage

In some situations, state laws allow for Continuation of Coverage is available for employees with fewer than 20 employees. You may contact IAC for specific details regarding your plan.

Medical Leave of Absence

Employees on medical leave of absence are not eligible to remain on the health or life insurance plan. Employers are responsible to notify IAC when they become aware of an employee not working the minimum of 30 hours per week (or as otherwise specified by state law).

If an employer fails to notify IAC they are potentially liable for all claims incurred.

Continuation of Coverage (COBRA)

Federal law requires employers with 20 or more employees (either part-time or full-time) on at least 50% of the workdays during the preceding calendar year to provide written notice to their employees and/or eligible dependents who lose eligibility of their rights under the Consolidated Omnibus Budget Reconciliation Act (COBRA). Under COBRA, such employees and their eligible dependents that lose their eligibility under their group health plan due to certain circumstances must be given written notice from their employer of their option to continue their group health plan coverage for up to 18 months for the employee and up to 36 months for the dependent. Please note that federal penalties apply to employers for non-compliance with COBRA legislation or for failure to provide proper and timely notification of the right to continue group health coverage. You are considered the plan administrator. Please consult with your benefits advisor to understand your obligations as the plan administrator under COBRA.

Conversion of Coverage

In some states, coverage may be converted to an individual policy without evidence of insurability if: 1) the insured individual's employment is terminated or he/she loses eligibility; and 2) the insured individual is under age 65; and 3) the insured individual has been insured for at least three consecutive months. Applications for conversion of coverage must be made within 31 days from the date the group coverage terminates. Contact In-Force Administration Customer Service at (800) 518-4510 to obtain an application for conversion.

Network Information

How Regional Provider Networks Are Handled

Many health plans are Preferred Provider Network plans, which require a selection of a Primary Preferred Provider Organization (PPO) at the time of application for health coverage. A PPO is a formal network of Health Care Providers including Physicians, Hospitals, Nurse Practitioners, Chiropractors, Physical Therapists, Skilled Facilities and others offering specialized Health Care Services on a contracted basis with established fees for their services. When services are provided by providers participating in the Primary PPO Network, usually lower out of pocket expenses will be experienced due to a combination of pre-arranged discounts for services and higher levels of benefits paid for accessing these providers. Other advantages of accessing a provider in the Primary PPO networks are:

- Providers will collect only patient co-payments or deductible at time of treatment, not the full amount of the charges.
- Providers file your medical claims directly with the insurance company
- Providers often need to maintain standards of educational and professional credentials and continue with quality improvement programs
- Provider are not to balance bill patients beyond the agreed upon contracted rates.

If a medical emergency occurs, as defined by the Policy, that requires hospitalization, that admittance is treated as a "In- Network" benefit level regardless of whether a Primary PPO facility was accessed. Once the patient can be safely moved they would need to be transferred to a PPO facility in order to continue receiving the "In-Network" benefit level. Otherwise, the benefits are reduced to the "Out-of-Network" benefit level.

As an exception, if an admitting physician is participating in the Primary PPO, and a Primary PPO facility is being used, but the anesthesiologists, pathologists, or radiologists do not participate as PPO providers, we will nevertheless cover their services as In-Network to reduce confusion for your clients

The PPO will have a logo on the front of the health plan identification (ID) card. Network websites address and 800 telephone numbers located on the back of the ID card provides a direct link to

information about the networks available providers. IT IS IMPORTANT TO REMEMBER THAT EACH PERSON HAS THE RESPONSIBILITY TO VERIFY THE PROVIDER THEY ARE GOING TO USE IS PARTICIPATING IN THEIR PRIMARY PPO. Providers change constantly and directories or word of mouth should never be relied upon. A PPO network will not accept responsibility for an error or a misunderstanding unless they were called or their website was accessed to validate a provider participates in their network.

Multiple Location Networks

Alternative PPO's may be added to a group health plan where a true business location is situated in a geographically distinct location away from the main business location and access to the Primary PPO creates a provider access problem. Premium rates may need to be adjusted to accommodate this request. Please attach a letter of explanation with the group submission outlining your PPO requests.

Changing Networks

You may change your choice of Primary PPO network at any time. Requests to change your network should be submitted in writing and sent to via website, fax or mailing address shown on page 1 of this guide. The new Primary PPO network selection will apply to all employees within a group except as previously discussed under multiple location networks). New Primary PPO network choices will not become effective until the first of the month following a 30 day period starting from the change date request in order for the PPO's to properly adjust their records and new ID cards be issued. PPO changes may require a rate adjustment.

National PPO Network Access

Several PPO networks we offer have provider's in most or all of the United States and provide national coverage in most metropolitan cities and towns. These PPOs may be the best solution for employers who have employees in many remote locations or individuals who have children away at college. Accessing these networks allow the health plan to offer In-Network benefit levels across the US.

PPO access while travelling outside your Primary PPO service area

The health plan provides for a Travel PPO network that should be used only when travelling outside your Primary PPO service area. Your Primary PPO service area is defined by your PPO and often is illustrated on their website. The health plans Travel PPO identification is located on the back of your ID card as well as contact numbers on how to locate a provider. .

It is important to know that accessing the Travel PPO will allow members to obtain services at the discounted rate that the Travel PPO provides. If services are obtained by a provider who is contracted with the Travel PPO and the services were performed while traveling outside of the Primary PPO area or in a state other than where the health plan is covering the employer group or individual the services will be allowed at the In-Network benefit level. Use of a provider who is contracted with the Travel PPO while the member is within the primary PPO coverage area will result in services being covered at the Out-of-Network benefit level.

Notice of Claim

You must send written notice of a claim to the Administrator within thirty (30) days after the occurrence or commencement of any loss covered by your health plan policy, or as soon as possible thereafter. Notice given by or on behalf of the claimant to the Administrator, or to any authorized agent of the Administrator, with information sufficient to identify the insured individual, will be deemed to meet these notification requirements.

Questions and Answers

Who is the Third-Party Administrator for the group health plans?

The third-party administrator for the group health plans is Insurers Administrative Corporation (IAC). IAC is a bonded third-party administrator licensed and incorporated in the State of Arizona as of March 1, 1978. IAC provides total services of underwriting, billing and claims payment for the health plans. IAC has over 400 employees serving the insurance needs of individuals and employers in the area of medical, dental, life and AD&D, voluntary worksite, self-funding, 401K and Section 125 plans.

This Employer's Administrative Guide contains a brief description of the plan requirements. It is neither a contract nor a part of the policy. The exact provisions governing the insurance contract are contained in the Master Policy. For full details, consult the Certificate of Insurance. This plan may not be available in all states. Please check with your health plan benefits advisor regarding availability. Some provisions, benefits, exclusions or limitations listed herein may vary depending on state of residence.