

## Assurant® Self-Funded Health Plans Agent Manual



## Assurant® Self-Funded Health Plans

Assurant Self-Funded Health Plans is an exciting new approach to self-funding a health benefit plan for small business employers. Assurant Health is a market leader in offering solutions to the health benefit needs of small business employers.

While we have made every effort to provide you with complete and current information about the administration of your self-funded plan, this guide is subject to change without notice. Active policies and procedures will take precedence over the information contained in this guide.

#### **About This Manual**

This manual is intended for agents training and reference. It contains important information you need to market, sell and service Assurant Self-Funded Health Plans. Agents are encouraged to read the manual thoroughly and to use it as a working reference in answering questions and servicing group business. If you need additional information or the manual does not address an issue, please contact your Assurant Health representative for further direction. Please note that this manual is subject to change without notice. A complete and updated copy of the current manual is available and can be downloaded from Find a Form on assuranthealthsales.com. Select self-funded as the line of business, and then select your state.

#### Important Notices

Assurant Self-Funded Health Plans is a program of services developed by Assurant Health for self-funding small business employers. This program includes tools to assist with establishing and maintaining a self-funded health benefit plan under the Employee Retirement Income Security Act (ERISA), along with stop loss insurance and plan administration. Stop loss insurance for these self-funded plans is underwritten and issued by Time Insurance Company. Plan administration is performed by a licensed third-party administrator.

No stop loss coverage is in effect until written approval is received. Existing coverage should not be cancelled until approval is confirmed.

The plan may be exempt from certain state law requirements and may not include all benefits required by state law for fully insured health insurance plans. Please refer to the Summary Plan Description (the Plan) for complete details.

This guide includes summary information and representations about this program's stop loss coverage. It is not a complete or detailed disclosure of that coverage, its benefits, exclusions or limitations. Refer to the policy of stop loss insurance for complete details.

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## Overview

#### What are Assurant Self-Funded Health Plans?

Assurant Self-Funded Health Plans is a self-funded health benefit program providing small group employers with a convenient and secure opportunity to save on health care expenses for their employees and dependents. Employer health plans established and funded by individual employers are governed by federal law. Assurant Self-Funded Health Plans brings together products and services from various sources needed by small group employers to establish and administer their self-funded health plans. This program is intended for use by employers with a minimum of five employees.

Assurant Health is committed to offering quality services to help small group employers obtain the best health care financing for their needs and circumstances.

## Providing the Opportunity to Benefit

Self funding provides employers with the ability to pay for those benefit options selected. With Assurant Self-Funded Health Plans, a small business employer may save substantially by offering a self-funded plan and protecting business assets with stop loss insurance. It's an affordable option for clients, and an advantageous option for your portfolio.

Assurant Self-Funded Health Plans include unique features to meet employers' needs for convenience and security. Please see the following discussion, "How Assurant Self-Funded Health Program Works," for product details.

## **Providing Accurate Information**

The most important service you provide to your clients is complete information about their options. The decision to self fund should be made only when the employer has a complete understanding of how self funding works.

# How Assurant Self-Funded Health Program Works

## Self Funding Combined with Stop Loss Insurance

Employers who participate in Assurant Self-Funded Health Plans program establish an employer health plan sanctioned under federal law. The employer plan establishes rules for employee and dependent participation in health coverage and defines the benefit plan offered to the group.

In a self-funded arrangement, the employer assumes responsibility for the cost of the benefits included in the Summary Plan Document (SPD). Each participating employee receives a copy of the SPD, which includes benefits information similar to a fully insured group certificate of coverage. Assurant Self-Funded Health Plans program provides the employer with stop loss insurance to reimburse the employer for expenses that exceed the specific levels, so even if a group's claims become larger than projected, the employer's financial risk does not increase. These amounts, respectively, are called the "aggregate deductible," and the "specific (for each covered individual) deductible."

## What are the Employer's Costs?

With Assurant Self-Funded Health Plans, participating employers pay a monthly bill, much like a monthly fully insured premium bill. This monthly billed amount covers all financial responsibilities for their employer plan. The monthly billing amount has three components:

- Stop loss premium This amount covers insurance to reimburse the employer for any covered expenses over the aggregate and specific deductibles.
- Administrative costs This is the charge for such administrative services as customer service, claims administration, agent commissions, case management, access to provider networks and others.
- 3. Monthly claim prefunding Employers are required to make monthly payments to fund their groups' anticipated claims for the year. These funds remain the property of the employer health plan.

## Maximum Cost

The maximum self-funding cost for the year is determined up front. Even if a group's claims become larger than projected, the employer's costs do not increase. Stop loss protects the employer's assets.

Claim funds are segregated in the employer's name in a bank account and maintained by Allied. At the end of the run-out period, any money not spent on group health claims will be refunded.

## What if Claims are More than the Balance the Employer has Prefunded?

At times, covered claims can exceed the amount the employer has deposited in the prefunded claim account. In this case, the stop loss policy advances the amount of the shortfall. Ordinarily, advances are repaid from employer prefunding deposits made in following months. If an employer terminates the stop loss policy before advances are repaid, the employer will be liable for unpaid amounts up to the aggregate deductible.

## **Products and Services**

Assurant Self-Funded Health Plans program offers employers products and services, such as HRA and HSA administration, that are provided by or through arrangements with Time Insurance Company and Allied Benefit Systems, Inc., a licensed third-party administrator (TPA).

Assurant Health and Allied both bring resources and expertise. Product and administrative systems integrate the roles they each play into seamless service for you and your customers. Administration is accessed through a single mail and phone system that enables you, your customers and medical providers to reach the appropriate person or area without complication or delay.

## The Insurance Company

The following products and services are provided by Time Insurance Company:

- Stop loss insurance for employers
- Marketing and sales support
- Risk management and actuarial services
- Medical management (precertification medical review, case management)
- Access to substantial health care discounts through Assurant Health-contracted medical and pharmacy benefit managers as well as pharmacy networks

## Allied Benefit Systems, Inc. Administrative Services

Allied is a licensed third-party administrator that administers employer plans of all sizes.

Allied provides:

- ERISA plan documentation for employer plans
- Summary Plan Descriptions, Benefit Summaries and Summary of Benefit Coverage
- ID cards for covered employees
- Billing for all fees, stop loss premiums and employer prefunding for claims
- Setup for banking and accounting for customer claim prefunding accounts
- Claims payment according to ERISA requirements
- COBRA and HIPAA administration
- Customer service (for employers, employees, medical providers and producers)
- Claims for stop loss coverage purchased by the employer
- Health plan management reports that assess the Plan's performance
- HRA and HSA administration

Neither the insurance company nor the TPA acts in the capacity of an ERISA fiduciary. Employers are not prevented from seeking or establishing independent business relationships with either company, independent of Assurant Self-Funded Health Plans, or with any other company for services related to their health plans, including employee benefit consultants.

## Key Features: Employer Stop Loss Insurance

Employer stop loss is insurance for the employer's health benefit plan. Stop loss does not pay benefits to employees. It reimburses the employer plan when costs exceed pre-established limits based on expected claims. Stop loss insurance offers two protections for self-funded employer plans.

## 1. Aggregate Stop Loss Benefit

The aggregate stop loss portion of this insurance pays the health benefit plan when the sum of covered participant benefits paid for the year exceed the total pre-set contribution limit. The stop loss policy also provides monthly advances if claim levels exceed the pre-set contribution limit. (See "Financial and Billing" on page 12.)

## 2. Specific Stop Loss Benefit

When a single covered participant experiences large claim amounts, stop loss insurance protects the employer through the specific stop loss limit. The specific benefit reimburses the employer immediately.

## Rate and Deductible Guarantee

Stop loss premium rates, annual employer contribution and specific deductibles may be guaranteed for one year at a time (subject to adjustments for changing plan census, plan changes and other plan-initiated changes). Guarantee terms and periods appear in the Schedule of Insurance of the stop loss policy.

Applicable rate guarantees are shown on the stop loss policy's Schedule of Insurance. Composite rates determined at issue or renewal may be changed only upon employee census change of more than 20%. We can reserve the right to change composite rates when:

- The business moves to a new address.
- Changes are made to the plan's benefits.

## How are Aggregate, Annual Employer Contributions and Specific Stop Loss Limits Determined?

Group plan information is entered into a financial model that calculates the plan's expected claims. Expected claims may be adjusted based on medical underwriting prior to a final rate offer. The employer's monthly claim prefunding, stop loss premium and administrative costs are determined by Assurant Health. Specific and aggregate limits are set in accordance with applicable state laws.

## Key Features: Self-Funded Benefit Plans

Assurant Health has designed a variety of PPO plan options to fit almost any small employer's needs. Plan designs are based on the most popular plans sold in Assurant Self-Funded Health Plan markets and have been refined based on suggestions by producers.

## **ERISA and State Mandated Benefits**

Self-funded employer plans are not required to offer coverages mandated by state law, however, federal law mandates do apply. Despite their exemption from state mandated benefit laws, Assurant Self-Funded Health Plan designs include many of these benefits for competitive reasons.

## **Maternity Benefits**

Assurant Self-Funded Health Plans include maternity coverage.

#### Mental Health/Substance Abuse

Assurant Self-Funded Health Plans include mental health and substance abuse coverage. For groups with 50 or more employees, federally mandated health benefits are provided.

## **Provider Network Access**

The Assurant Self-Funded Health Plan Program offers access to Assurant Health-contracted medical provider networks at preferred rates. Because these plans include no gatekeeper requirements, no referral is necessary to see specialist providers.

## **Pharmacy Benefits**

The Assurant Self-Funded Health Plan Program offers network pharmacy benefits through CVS Caremark, which processes all network and out-of-network pharmacy claims. Network benefits are accessed by presenting the ID card at participating pharmacies.

Out-of-network pharmacy claims must be submitted with a special claim form, which can be downloaded from the health sales site at assuranthealthsales.com.

## Key Features: Pre-Certification and Utilization Review (UR)

Medical management staff can be reached through the Assurant Self-Funded Health Plans' toll-free phone line. Medical management policies and procedures are URAC-certified and comply with new Department of Labor ERISA claim payment rules.

## **Key Features: Claims and Customer Service**

Customer service representatives can be contacted from 7:30 a.m. to 7:00 p.m. Central time, Monday through Thursday, from 8:00 a.m. to 5:00 p.m. Fridays, and from 9:00 a.m. to 12:00 p.m. Saturdays. The toll-free telephone number is 888.292.0272. Providers should forward claims to the address indicated on the member ID card.

A secured website is available for all employees to log in and view the status of their claims or to review their benefits or personal information. The website is: assurantselffunded.com.

## Key Features: Optional Health Savings Account (HSA) Plan

An optional HSA plan is offered with high deductible plan options designed to comply with federal requirements. Essentially, an HSA plan is a tax-advantaged health plan that can make health insurance more affordable. An HSA plan includes our low-cost, high-deductible plan and a tax-favored\* HSA that can be used to offset the deductible. With an HSA plan, a group could enjoy extensive health care expense coverage plus all the cost-saving benefits of self funding.

<sup>\*</sup>Assurant Health is not engaged in rendering tax advice. Please see a qualified tax professional for tax advice.

## Key Features: Optional Health Reimbursement Arrangement (HRA) Plan

An HRA is an employer-funded (tax deductible\*) arrangement provided to employees for reimbursement of employer-specified medical expenses authorized by Section 105 of the Internal Revenue Code.

These specified expenses can include copays, deductibles, wellness and more. Advantages for employers include:

- Tax-deductible contributions
- No need to pre-fund the account
- Employer is allowed to retain ownership of the funds if the employee terminates
- Great flexibility in HRA plan designs
- HRAs are available to any size group
- Able to self fund and split the funding on a portion of the deductible
- The employer creates a more attractive package for employees who may be reluctant to accept a high-deductible plan

## Quoting and Selling Assurant Self-Funded Health Plans

This section contains information and answers to frequently asked questions about quoting and submitting new business. It is intended to provide step-by-step advice to make your job easier. However, our sales support staff is available to answer questions and help assess business situations.

## Simple to Quote

Assurant Self-Funded Health Plans have a webbased proposal system for self-funded proposals. Proposals will be run by the Assurant Health sales representative supporting your territory and e-mailed to your office. Please contact your sales representative for more information about the proposal process.

### What's in the Quote?

Group quotes show the following:

- Plan selection and effective date
- The components of the maximum monthly cost to the employer
- Stop loss premium
- Administration cost
- Monthly prefunding
- Aggregate and specific deductibles
- Group rate
  - Rates per employee and coverage requested
  - Composite rate single, employee and spouse, employee and children, family

## **Quoting Very Small Groups**

If the quote shows aggregate and specific deductibles of the same amount, it is because the group's expected costs are so low that the annualized prefunding amount is not as much as the minimum specific deductible allowed by law. In such a case, the aggregate deductible cannot be set lower than the specific deductible. Therefore, the group would be required to prefund the amount shown, even though it is likely the group would save substantially, based on its actual claims. This situation is less likely as the number of employees, spouses and other dependents grows and where more expensive coverage is chosen.

## **Presenting the Case**

You know your clients' needs and motivations best. However, many agents who have become successful with Assurant Self-Funded Health Plans follow the same general themes presenting the program to clients and prospects:

- Assurant Self-Funded Health Plans can offer a great savings opportunity
- Self-funding has saved money for other small groups — in 2012, over 60% of Assurant Health groups received a refund at the end of their plan year

## Evaluating Groups: Underwriting and Sales Support

If you are unsure whether a group will qualify when underwritten, our underwriters will prescreen particular conditions or answer questions for you or your clients. We are committed to helping you become familiar with our underwriting criteria and process (see the following section "Underwriting Guidelines," for details).

Our underwriters are experienced with small group business and are specially trained for these plans. We have developed specific standards for underwriting. Therefore, it may be prudent to ask questions of our underwriters, even where experience suggests an unfavorable answer.

- 1. Target your prospects by focusing on eligible groups in the five and over market
- 2. Discuss Assurant Self-Funded Health Plans using the point-of-sale materials provided
- 3. Gather employer information needed to generate a proposal
- 4. Complete the proposal
- Present the proposal along with application materials

<sup>\*</sup>Assurant Health is not engaged in rendering tax advice. Please see a qualified tax professional for tax advice.

## Submitting a Case

Once a group commits to try Assurant Self-Funded Health Plans, the following items must be submitted for underwriting.

- 1. Employer application signed by the employer and you
- Employee enrollment forms on all employees.
   Employees not requesting coverage must complete the Waiver of Coverage section on the employee enrollment form
- 3. New business proposal (quote) signed and dated by employer
- 4. Signed Risk Management Services Agreement
- 5. Signed Administrative Services Agreement
- The employer's last State Quarterly Unemployment Withholding Form
- 7. Census form (24311) listing full-time and part-time employees if a State Quarterly Unemployment Withholding Form is not filed
- 8. Signed Network Services Agreement (if applicable)
- 9. The full first month's maximum cost payable to Allied Benefit Systems, Inc.
- 10. A copy of the employer's last bill from the current carrier
- 11. Employer must fill out a completed NY Goods TPA transfer form

Request additional forms by contacting the Supply Department at 800.800.1212, ext. 8325

## **Underwriting Guidelines**

#### Plan Effective Date

Effective dates shall begin on the first or the fifteenth of the month for all groups. Completed employee enrollment forms should be received at Assurant Health at least 15 days prior to the requested effective date. This allows the underwriting department sufficient time to decide on the acceptance and rating of the proposed group and to finalize estimated claim prefunding requirements.

We cannot guarantee timely action if applications are incomplete or received late. However, we will accommodate your clients to the best of our ability if applications are received late. Enrollment forms must be postmarked prior to the requested effective date in order for the employee to receive consideration for enrollment on the group's effective date.

Enrollment forms cannot be dated more than 60 days prior to the effective date.

## Responsibility for Monthly Costs

The employer must contribute at least 50% of the monthly cost for each employee. The employer may pay all or part of the monthly cost for each dependent's portion of the employees' health benefit costs at the option of the employer. The employer is responsible for all payments associated with Assurant Self-Funded Health Plans. Two billing options are available to choose from: automatic debit of the employer's designated account or direct billing. The employer is responsible for remitting all billed amounts when due. Subsequent monthly charges will be billed by Allied and must be submitted directly to Allied. Assurant Health representatives are not authorized to collect subsequent monthly charge amounts.

## Whole Group Coverage

All eligible employees (those who meet requirements under Employee Eligibility on Page 10) not waiving coverage must be covered by the employer under this plan or another plan offered by the employer.

## **Participation Requirements**

- Employers must have a minimum of five participating employees
- Employers must enroll at least 75% of all eligible employees after considering valid waivers or 50% of all eligible employees regardless of waivers

For an eligible employee or dependent to have a valid waiver, he or she must submit satisfactory proof of the other coverage. To provide this proof, the Waiver of Coverage section of the employee enrollment form must be fully completed, and the following information must be provided:

- Reason for waiving our coverage
- The name and telephone number of the carrier providing the other coverage
- Although not required, a copy of the medical ID card of the other carrier expedites processing

## Participation and Eligibility Review

Participation requirements must be maintained throughout the life of the contract. Employers may be requested to verify participation and eligibility information. Groups who fail to maintain participation requirements or supply the requested information to verify participation may be terminated.

## **Waiting Periods**

Waiting periods for future employees of 0, 30, 60, 90, 180 or 365 days are available. Waiting periods may be chosen for different classes of employees. (An ideal temporary solution that provides coverage during the waiting period is Assurant Health's Short Term Medical insurance. Ask your Assurant Health representative for details.)

In addition, all employees must:

- 1. Satisfy the waiting period in effect on their hire date.
- 2. Abide by the waiting period chosen. Waiting periods may not be waived for any employee.

For underwriting purposes, the enrollment form is required for all employees employed at the time of application, regardless of the waiting period chosen for future employees.

## **Enrollment Form Required for all Employees**

For employees within the waiting period, the employer may choose to 1) enroll all eligible employees at the time of group submission or 2) have all eligible employees wait until the waiting period is satisfied before their coverage becomes effective. All employees must abide by the waiting period chosen. The waiting period may be changed once per 12-month period. Employees and dependents choosing to waive coverage must complete the Waiver of Coverage section of the employee enrollment form.

## **Medical Underwriting Standards**

All eligible employees and their dependents, regardless of whether they are in waiting periods or waiving coverage, must complete applications for consideration. The underwriting team reserves the right to investigate medical conditions as it considers necessary, including, but not limited to, requiring a blood or urine profile and/or an attending physician's statement. If the group cannot be issued as applied for, you are contacted before any coverage is issued. If questions arise during underwriting, a telephone call is made to you or the employee.

It is important that all medical history and pertinent information regarding the employee, spouse and dependents be fully disclosed on the employee enrollment form. Failure to do so may result in rescission of stop loss coverage or premium surcharge retroactively to the effective date of the group. Health questionnaires have been developed to help expedite the number of medical details post submission and minimize the need to request medical records.

The health questionnaires are listed below:

- Alcohol
- Arthritis/Fibromyalgia
- Cancer/Tumor
- Congenital Heart Conditions
- Disability
- Heart Attack, Bypass or Angioplasty
- Heart Murmur/MVP/Arrhythmias
- Heart Palpitations or Heart Valve Disease
- Neurology/Seizures
- Thalassemia
- Ulcerative Colitis

If an enrollee indicates any of these medical conditions on the employee enrollment form, have the enrollee complete the appropriate health questionnaire and submit it along with the enrollment form. You can obtain these questionnaires from our website at assuranthealthsales.com.

## Eligibility

## **Group Eligibility**

Assurant Self-Funded Health Plans are designed for employers that have no fewer than five full-time employees.

Employer groups formed primarily for the purpose of purchasing insurance are not eligible. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer. Groups that no longer meet these requirements because of census changes or other factors will be terminated.

- The business must have been in existence for a minimum of six months and be a viable business at the time of application.
- Seasonal businesses are not eligible.
   "Seasonal" is defined as operating fewer than six months every calendar year.
- "Scattered groups" (where some employees live in a state different from where the business is located) are eligible, provided the principal business location is a state in which Assurant Self-Funded Health Plans are marketed.

A telephone verification call may be conducted at the underwriter's discretion. These calls entail a short interview with the employer or employee conducted by an underwriter. The focus of this interview is to clarify information reported in the employer application or employee enrollment forms.

## **Employee Eligibility**

The employer has the right at the time of issuance to establish eligibility requirements for the group by selecting the number of hours (must be between 20 and 40) for an employee to be considered eligible for coverage. If the employer does not specify a different requirement, eligibility will be defined as at least 30 hours per week.

A partner, proprietor or corporate officer of the employer is eligible if he/she performs services for the employer on a full-time basis (defined above) at any of the employer's business establishments.

The employer has the right at the time of issuance to establish eligibility requirements for the group, allowing part-time employees to be eligible.

Part-time employees working 20+ hours per week are eligible to enroll if all of the following apply:

- The employee otherwise meets the definition of a full-time employee except for the number of hours worked
- The employee must have worked at least 20 hours per week for at least 50% of the weeks in the previous calendar quarter. In order to verify this, we may request any documentation including but not limited to payroll records and employee wage and tax filings.
- The employer elects to offer coverage to all employees working 20-29 hours per week
- To be eligible for coverage, employees must be 18 years old, a U.S. citizen or a legal alien who possesses a green card and a Social Security number

Straight-commissioned employees under an exclusive contract may be eligible but need to be pre-approved. If approved, the group must select at least a 90-day waiting period.

Employees are eligible for coverage on the original effective date if they are employed at the time of application.

The following are not considered eligible employees under this plan (this list is not inclusive):

Leased employees

Temporary employees\*

Seasonal employees

Subcontractors

Personal employees (e.g., nannies, gardeners)

Employees who are not paid a salary

Retirees

Part-time employees, unless otherwise allowed as above

\* Ask your Assurant Health representative about Short Term Medical insurance for temporary employees.

To be an eligible employee, there must be a formal employer-employee relationship that can be confirmed by demonstrating that the employer pays FICA wages and that wages are reported on federal form W-2 or a form 1099.

## **Dependent Eligibility**

Eligible dependents include the lawful spouse and unmarried children of the employee who are legally listed as dependents for income tax purposes, or for whom a court order requires the employer to provide health insurance. Children must be age 26 or less. If divorced, the former spouse is not eligible for coverage. Common law marriage is basis for dependent eligibility and the burden of proof is on the covered participant.

## **Adopted Dependents**

An adopted child is eligible as a dependent when the self-funded plan participant has agreed to assume total or partial responsibility of support for a child in anticipation of adoption or legal physical placement of the child in the home. Please provide legal documentation.

## **Avoid Delays**

Below is a list of the most commonly missed items when submitting group applications. Omitting any of these items causes a delay in approval and issuance:

- 1. The first month's cost payable to Allied Benefit Systems, Inc. Note: Checks are not cashed until group coverage is issued
- 2. A copy of the employer's most recent billing statement from the current carrier for the period up to the requested effective date
- 3. State Quarterly Unemployment Withholding form
- 4. Missing information on each full-time employee's (those requesting coverage, in waiting periods and waiving coverage) Employee Enrollment form, such as:
  - Signature
  - Date
  - Medical questions left blank
  - Details to medical questions answered "yes"
  - Waiver of Coverage section not completed
  - Dependent's name, birth date or social security number

- 5. Missing information on employer application, such as:
  - Signatures
  - Dates
  - City and state
- 6. A copy of the group proposal (form must be signed and dated)
- 7. Signed risk management and administrative services agreements
- 8. Signed NY payor election form

Send a check for the first month's bill to:

Allied Benefit Systems, Inc. 200 West Adams Suite 500 Chicago, IL 60606

Attention: Accounting Department

Send the completed application and other required documents to your sales office or directly to:

Assurant Health P.O. Box 2069 Milwaukee, WI 53201-2069

Fax: 763.577.4921

Email: group.self.funded.new.business@assurant.com

## **Accepting and Declining Groups**

Acceptance of groups applying for Assurant Self-Funded Health Plans is determined by the insurance company that underwrites the stop loss insurance. When a group is accepted for stop loss insurance, the insurance company and Allied will provide services to the group. Groups that elect not to abide by the policies, terms and conditions of Assurant Self-Funded Health Plans – whether accepted or declined – are not prevented from approaching any of the above service vendors to seek an alternative arrangement.

If a group is declined for Assurant Self-Funded Health Plans, the agent will be informed by the underwriting department.

Note: No stop loss coverage is in effect until accepted in writing. Caution your group against canceling other health coverage until accepted for stop loss insurance.

## Issuing a New Group

When your client group is accepted to participate in Assurant Self-Funded Health Plans:

- You, as the agent, will be informed by your marketing representative.
- Allied will establish the employer's plan and an email will be sent to the Employer within two business days welcoming them to the new plan, which will include instructions on how to log into the assurantselffunded.com website. There they'll be able to access to the following documents:
  - Employee Summary Plan Descriptions
  - Employer's Guide
  - Stop loss contract
  - Administration forms
  - ID Cards (hard copies will be mailed to each employee)

Employees will be mailed their ID cards along with information as to how to access their plan information.

Note: Whenever the employer's email is not provided, materials will be mailed through the U.S. Postal Service.

#### Cost

The monthly cost charged to an employer group depends primarily on the specific benefit plans the group has selected, and other factors. These include the following, but may vary by state:

- Age of employees
- Preferred provider network chosen
- Geographic location of the business
- Eligibility of employees for Medicare coverage
- Medical history of employees and dependents
- Expected future medical claims

New business rates for stop loss insurance are "trended" monthly to account for medical inflation. It is important to remember this when deciding upon an effective date of coverage for the business. Changing the effective date to a later date may result in a change in rates. The monthly trend factor is built into the proposal software program.

## Workers' Compensation

Owners and employees are generally not covered for work-related injuries. However, in states where business owners may opt not to accept workers' compensation, the owner would be covered for workrelated injuries.

## **Continuation Coverage**

At the time of application, no more than 20% of the total employees in the business may be on COBRA or other continuation.

The federal agency administering the Medicare program requires administrators of group health insurance plans to provide to their insurance company the Social Security numbers for all employees, spouses, domestic partners and dependents covered by their plan. Assurant Health must request this information to comply with the governmental requirements set forth in the Medicare, Medicaid and SCHIP Extension Act of 2007. The information will be reported to the Centers for Medicare and Medicaid Services (CMS). We realize this is sensitive information and have appropriate safeguards in place to protect it. For additional information on the mandatory reporting requirements, you can visit the CMS website at cms.hhs.gov.

## Medicare Eligibility/TEFRA

For employers of 19 or fewer full-time and part-time employees, the employer's self-funded plan pays eligible benefits secondary to Medicare.

Groups that have had 20 or more full-time and parttime employees working each day during 20 or more weeks of the current or preceding calendar year fall under the federal legislation referred to as Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). TEFRA determines premium and reimbursement guidelines. Under TEFRA rules, the employer's plan is the primary insurer and Medicare is secondary.

## Financial and Billing

## Monthly Payment by the Employer

Each month, the employer will receive a notice that their monthly invoice is available for viewing at **assurantselffunded.com**. The email will come from: notifications@alliedbenefit.com. The employer is billed for the stop loss insurance premium, administrative fees and required claim prefunding. The bill is due on the first day of each month. For employers electing the ACH payment option, their accounts will automatically be debited on the 1st of the month. For employers electing to mail in their payment, the bill is due on the first day of each month. Although there is a 31-day grace period for late payment of the insurance premium portion of the bill, payment of premiums and all other amounts must be received by the 30th day or stop loss coverage and participation in all Assurant Self-Funded Health Plan programs will be terminated.

## **Claim Prefunding**

Employers participating in Assurant Self-Funded Health Plans must agree to pay a monthly amount to prefund anticipated claim costs for the employer's health plan. This amount is based on expected claims. We estimate each group's expected claims at initial underwriting and reissue. In addition, expected claims may be re-estimated during the plan year, based upon changes in the individuals covered under the employer plan and upon occurrence of events that indicate significant change in claim expectations.

## **Employer Fund Accounting**

Claim funds claims are segregated in the employer's name in a bank account and maintained by Allied. These funds are the employer's property until used for authorized purposes such as claim payment. By signing the Administrative Services Agreement with Allied at the time of enrollment, the employer authorizes Allied to pay claims from the employer's account.

Funds not used for claim payment accumulate in the employer's account. At the end of the stop loss policy's run-out period, any remaining unused funds will be returned to the employer via check.

In addition, Allied is authorized to pay stop loss insurance premiums and administrative fees from the employer's funds.

## **Commission Payments**

Commissions are paid weekly. Note: When a premium is paid early, the commission is not paid until the week of the due date.

## Enrolling Employees: New Groups

## **Pre-existing Limitations**

Covered medical charges do not include any charges incurred in connection with a pre-existing condition, except those charges incurred 12 months after employees' or their dependents' effective date under the plan, or in the case of a late enrollee, 18 months after such enrollment date. A pre-existing condition is any illness or injury for which the employee received diagnosis, medical advice or treatment or had taken any prescribed drug, or where distinct symptoms were evident during the 12 months immediately preceding the employee's enrollment date in the plan.

A late enrollee who enrolls for coverage under the plan may be subject to an 18-month pre-existing condition in lieu of the 12-month pre-existing condition limitation described above. The pre-existing condition limitation will also apply to:

- 1. Any dependent(s) over the age of 18 that are added after the effective date of coverage in the plan (unless such limitation is otherwise waived)
- 2. Any optional coverage added after the effective date of any dependents coverage under the plan

## **Exceptions**

The pre-existing condition limitation does not apply to:

- 1. Pregnancy, including complications of pregnancy
- An adopted dependent child as described in the adopted children provision in the Eligibility section, provided the dependent is enrolled within 31 days of adoption or placement
- 3. Eligible dependents under the age of 19

## **Pre-existing Condition Credit**

The pre-existing conditions limitation is credited for any time the participant was covered under creditable coverage, if coverage was continuous and if there is no more than a 63-day gap between coverages, exclusive of any waiting period. Creditable coverage includes:

- A group health plan
- Health insurance coverage
- Medicare
- Medicaid
- TRICARE
- A medical care program of the Indian Health Service or of a tribal organization
- A state health benefits risk pool
- A health plan offered under the Federal Employees Health Benefits Program
- A public health plan
- A health benefit plan under the Peace Corps Act

For pre-existing condition credit to be considered, the following information must be submitted with the original employee enrollment form:

- Certification of Prior Creditable Coverage form
- Copy of the front and back of the insurance card from the previous carrier or member ID card from the previous self-funded plan

## Claim Submission and Service

## **Advance Funding Provision**

Monthly advance funding is automatically provided with stop loss policies. Advance funding provides reimbursement to the plan's claim account for claims payable from the policy's specific or aggregate benefit any time during the policy year that the employer's prefunded claim account balance is insufficient. The plan doesn't need to have paid claims in excess of stop loss insurance limits and aggregate limits to qualify for advances. Advances are repaid from subsequent months' plan payments into the claim prefunding account. Advances are only available if the plan's stop loss insurance premiums and monthly claim prefunding contributions are paid-to-date.

#### **Deductible Credit**

Credit is given for any portion of a calendar-year deductible satisfied under the prior plan during the same calendar year. The deductible credit does not apply to the family out-of-pocket maximum.

## Health Benefit Plan Claim Submission

Participants are not required to submit claim forms in order to make a claim for benefits. Bills from health care providers are accepted as an indication of loss. If the participant assigns benefits to the provider, Allied will pay benefits under the employer's self-funded plan directly to that provider. The itemized bills should always include the group number. If family members have the same first name, the date of birth and Social Security number should be indicated for the claimant.

All medical bills should be sent within 90 days after an expense was incurred.

If an inpatient hospital stay or surgery is planned, the participant needs to follow the instructions for precertification or preauthorization, which are included in his or her Summary Plan Description. Penalties may be incurred if a precertification is not obtained.

## Health Benefit Plan Claim Payment

As the primary risk bearer, the plan is responsible for all claim decisions. Neither Allied nor the insurance company, as the stop loss insurance carrier, will interfere in the plan's decision. However, since the plan's decision may be binding on later decisions to pay similar claims, it may be prudent for the plan to ask the insurance company to determine whether the claim or one like it would be reimbursable under the stop loss insurance. By doing this, the plan may avoid the risk that stop loss coverage may

not reimburse amounts that have become the plan's obligation after stop loss limits are reached.

In addition, should a plan elect to override the denial of a claim payment, the dollar amount paid will be considered income to the participant. In such case, the employer must add this amount as "bonus" wages on the employee's W-2.

## **Prescription Claims**

At a participating pharmacy, participants will pay the appropriate copayment according to the Summary Plan Description.

Prescription copays, deductible (if chosen) and ancillary charges do not apply toward medical benefits, deductibles or out-of-pocket maximums.

Pharmacy out-of-network charges are based on the amount the plan would have paid a network pharmacy for the covered drug, less the network copayment, coinsurance and any applicable ancillary charges.

Log on to assuranthealthsales.com to obtain a pharmacy out-of-network claim form.

## Stop Loss Claims

In addition to administering the plan's claims, Allied is also responsible for paying claims against the stop loss insurance. Allied tracks each plan's claims payments on its system to determine when aggregate or specific limits are reached and a stop loss insurance claim needs to be filed. Under its Administrative Service Agreement with the employer, Allied is responsible for filing stop loss claims on the plan's behalf. When stop loss claims are paid, they are credited directly to the plan's account so claims against the plan can be paid immediately.

## **Health Plan Management Reports**

Employers have access through a secured website to reports showing claims paid in the current period, the current balance in the claim prefunding account, and funding advances and repayments. The employer can use this information to track the performance of the self-funded program against what fully insured health insurance would have cost.

## Servicing Existing Groups

## **Annual Open Enrollment**

An employee or dependent who waived medical coverage originally and is now requesting coverage may enroll in the plan at the time of the group's annual effective date without being considered a late enrollee. Submit the request 60 days prior to the annual effective date to ensure benefits are paid correctly.

## **Adding New Employees**

New employees should enroll one month prior to the expiration of the waiting period to allow for sufficient time for underwriting evaluation and issuance of Summary Plan Description(s).

A new employee (add-on) must fully complete an employee enrollment form. The enrollment form must be signed, dated and submitted no later than 15 days of the date of hire. The employee will be considered a late enrollee if we receive his or her form later than 30 days after the expiration of the employee's waiting period. New employees are added on the first day of the group's billing cycle following the expiration of the waiting period if they enroll on a timely basis. A late enrollee's effective date will be on the first day of the group's billing cycle following approval.

Under no circumstances is the effective date of coverage prior to the employee's date of employment. If the employee had previous health coverage, the other carrier's effective date, termination date and type of coverage must be provided. Submit a copy of the previous carrier's identification card.

Note: Enrollment forms dated more than 60 days prior to the eligible effective date are not accepted.

All add-on employees and dependents over the age of 18 are subject to the pre-existing condition provision, unless evidence of pre-existing credit is received. All add-on employees must complete the medical questions on the employee enrollment form. For self-funded plans, timely eligible enrollees requesting medical coverage must be accepted to the employer's plan as required by HIPAA regulations.

All other lines of coverage are medically underwritten. Payroll records must be submitted with the Employee Enrollment form to verify pre-existing condition credit (see page 13).

## **Adding Dependents**

 The employer's self-funded plan insures new spouses and dependent children, without evidence of insurability, provided that an enrollment form with the dependent's name and date of birth (or date of marriage) is submitted to Allied within 31 days of birth (or marriage). An enrollment form must be completed in full, including the health and medical history sections.

- If coverage for an eligible spouse or dependent children was previously waived with no creditable coverage in force, the dependent(s) may be considered a late enrollee. See late enrollee guidelines in the following section.
- Submit changes in coverage to Allied in writing.
  For dependent children being added, include
  the date of birth or date of legal documentation
  stating intent of adoption or physical placement
  of a child in a home.

## Late Enrollees

A late enrollee is defined as an employee or a dependent who is otherwise eligible under the plan and:

- Did not apply for coverage under the plan within 31 days after becoming eligible
- Did not apply for coverage under the plan when the group coverage initially went into effect
- Did not apply for coverage under the plan during the annual open enrollment period (if the employer has chosen to apply an open enrollment period)

All late enrollees will be subject to a pre-existing period of up to 18 months.

## **Effective Dates of Coverage**

- The effective date of a new employee who applies for coverage on time is the first day of the billing month following the expiration of the selected waiting period and upon acceptance.
- The effective date of a new spouse, when coverage was applied for within 31 days of the date of marriage, is the date of marriage unless otherwise requested.
- The effective date of coverage is the date of birth or date of legal dependence. Coverage must be applied for within 31 days of the birth or legal dependence. Legal dependence, as used here, means the legal responsibility to provide support.
- The effective date of a late enrollee (employees or dependents) is the first billing month following the date the application for insurance is approved.

## Plan Coverage Changes

- 1. Employers may request changes to their selffunded plan to offer another plan design available through Assurant Self-Funded Health Plans
- Employers may request a change to their self-funded employee plan once during any 12-month period
- All change requests should be submitted in writing, signed and dated by the employer

- 4. Request should be submitted 70 days prior to the effective date to ensure benefits are paid correctly; employees to be notified 30 days prior to the effective date of the change(s)
- 5. The premium adjustment may not appear on the next billing notice
- 6. A change to a health benefit plan is effective the first of the month following the date the request is received by Allied
- 7. A change to a health benefit plan with a higher level of benefits (e.g., upgrading from the 50/50 plan to the 90/70 plan) must be approved by the underwriting department

## **Continuation Coverage**

Self-funded plans must comply with the COBRA Continuation mandate. COBRA applies to groups with 20 or more employees.

In addition, employers with fewer than 20 employees are offered the same benefits as COBRA under the Assurant Self-Funded Health Plan. Notification of continuation must be received in writing by Allied. Employees on continuation are only eligible for medical coverage. Additional information is contained in the employee's Summary Plan Description.

## **Billing for Continuation Premium**

Both the employer and member on Continuation will be billed for the premium. When the employee pays their premium, a reimbursement check will be cut to the employer at the end of the month.

Note: In situations where the employer has paid the premium but the member hasn't, no claims will be paid for that member if they haven't remitted their premium yet. The member's paid to date must be current for claims to be processed.

## **New Policy Periods**

#### **Stop Loss Premium**

Employers may receive an offer for a subsequent stop loss policy period following each year of coverage. Rates for this policy period reflect claims experience and changes in health status among members of the employer's group, changes in coverage and changes to the makeup of the group, including age increases, census changes and other objective differences. In addition, changes in the experience and characteristics of the overall stop loss block are considered. Subsequent policy periods do not represent a renewal, but an issuance of a new stop loss policy.

## Claim Prefunding

Required claim prefunding is adjusted at the start of the new plan year based on changes in anticipated claim costs for the coming year.

Employers who have unused funds in their prefunding account will receive those funds back in the form of a check when the run-out period expires.

## **Administration Costs**

The fee charged by Allied for claim administration, customer service and other services may be adjusted annually.

Assurant Health may adjust charges for underwriting services, medical management (precertification, utilization review and other claim-related services) and other services. These changes will be reflected in the monthly billed administration fees.

#### **Termination**

An employer group's stop loss coverage and participation in Assurant Self-Funded Health Plans can be terminated upon notice for any of the following reasons:

- Any portion of the billed monthly cost is not received by Allied on the date it is due
- The number of employees insured in a group is fewer than two persons
- There is evidence of fraud or misrepresentation
- There is non-compliance with plan or stop loss policy provisions
- The business is no longer engaged in the same business that it was on the date it was effective
- The group fails to meet participation requirements
- All stop loss coverage in the state in which the group is located is terminated
- The business moves to a state where Assurant Self-Funded Health Plans are not offered
- The group submits a voluntary written request for termination

The Patient Protection and Affordable Care Act (PPACA) added restrictions on the rescission of coverage, which is defined as a cancellation or termination of coverage that has a retroactive effect. PPACA prohibits plan sponsors and issuers from rescinding coverage unless there is fraud or intentional misrepresentation of a material fact. This requirement is not limited to rescission based on misrepresentation of medical history. It also includes retroactive terminations of coverage in the "normal course of business."

For example, if an employee is enrolled in a plan and makes the required contribution, his or her coverage cannot be retroactively terminated even if the employee was mistakenly enrolled and is not eligible for coverage. The employee's coverage can only be terminated on a date in the future.

## Early/Mid-year Termination

In the event the employer's stop loss coverage terminates mid-plan year for any reason, the date of termination becomes the end of the policy period. The run-out period will commence on the termination date.

The full specific and aggregate deductibles remain remains in effect for the shortened policy period.

In cases where the aggregate deductible has been adjusted due to changes in the number of covered participants under the plan, the aggregate deductible in effect as of the termination date will be determined as the average of the aggregate deductible in effect for each month of the policy period.

Stop loss benefits for eligible expenses in excess of the specific and aggregate attachment points and incurred before the termination date of coverage will be eligible for payment if claim has been received within the run-out period.

The employer continues to bear all responsibility for plan eligible expenses under the applicable specific and aggregate attachment points.

If we have provided advance funding, any outstanding advance funding amounts due to your stop loss carrier will be withheld from claims payment and any premium refund as recoupment of the advance funding to your stop loss carrier. If such funds are insufficient to satisfy the amounts owed to your stop loss carrier, all remaining outstanding advance funding must be repaid to your stop loss carrier by the end of the run-out period.

After recoupment by your stop loss carrier of any outstanding advance funding, remaining unearned policy premium that has been paid for periods beyond the termination date, if any, will be refunded to the employer.

Any expenses incurred by the plan after the policy termination date are not eligible expenses and are not eligible for claims under this stop loss policy.

## Website Portal

A member portal is available for agents, employers and members. Agents can access this through assuranthealthsales.com, by selecting the self funded product tab. Employers and members can access through assurantselffunded.com.

Below is an outline of information available on the website for:

## Agents

- View Benefit Summary, Summary Plan
   Descriptions and Summary of Benefit Coverage
- Group reports such as claims summary, census and large claim
- Access to preferred provider networks and pharmacy provider links
- View claim fund levels

## **Employers**

- Check claims status
- View ID cards, invoices and other plan documents
- Claims fund reporting
- Find in-network doctors and hospitals
- Estimate costs of provider services and prescription drugs
- Compare providers

## Members

- Check claims status
- View ID cards and other plan documents
- Find in-network doctors and hospitals
- Estimate costs of provider services and prescription drugs
- Compare providers

## **Customer Service**

For assistance with underwriting, service or information, please contact us using the information below:

## **Phone**

Agents [Employers/Employees]: 888.292.0272

Hours (Central time):

Monday through Thursday: 7:30 a.m. to 7:00 p.m.

Friday: 8:00 a.m. to 5:00 p.m. Saturday: 9:00 a.m. to 12:00 p.m.

## Fax

For Underwriting (new submitted groups): 763.577.4921

For signed reissue group quotes, EFT requests, etc.: 312.906.8443

For paper claim submissions: 312.906.8359

## E-mail

AH.claims@alliedbenefit.com

AH.eligibility@alliedbenefit.com

AH.newgroup@alliedbenefit.com

AH.commissions@alliedbenefit.com

## Mail

200 West Adams, Suite 500 Chicago, IL 60606

#### Website

assuranthealthsales.com assurantselffunded.com

## Marketing Materials

To order marketing materials, call the supply department at 800.800.1212, Ext. 8325.



Assurant Health 501 West Michigan Milwaukee, WI 53203

#### About Assurant Health

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company (est. 1892), John Alden Life Insurance Company (est. 1961) and Union Security Insurance Company (est. 1910) ("Assurant Health"). Together, these three underwriting companies provide health insurance coverage for people nationwide. Each underwriting company is financially responsible for its own insurance products. Primary products include individual, small employer group and short-term limited-duration health insurance products, as well as non-insurance products and consumer-choice products such as Health Savings Accounts and Health Reimbursement Arrangements. Assurant Health is headquartered in Milwaukee, Wisconsin, with operations offices in Minnesota, Idaho and Florida, as well as sales offices across the country. The Assurant Health website is assuranthealth.com.

Assurant is a premier provider of specialized insurance products and related services in North America and select worldwide markets. The four key businesses — Assurant Solutions, Assurant Specialty Property, Assurant Health and Assurant Employee Benefits — partner with clients who are leaders in their industries and build leadership positions in a number of specialty insurance market segments. Assurant provides debt protection administration; credit-related insurance; warranties and service contracts; pre-funded funeral insurance; solar project insurance; lender-placed homeowners insurance; manufactured housing homeowners insurance; individual health and small employer group health insurance; group dental insurance; group disability insurance; and group life insurance.

Assurant, a Fortune 500 company and a member of the S&P 500, is traded on the New York Stock Exchange under the symbol AIZ. Assurant has approximately \$27 billion in assets and \$8 billion in annual revenue. Assurant has approximately 14,000 employees worldwide and is headquartered in New York's financial district. www.assurant.com.