Assurant. On **your** terms.®

Assurant® Self-Funded Health Plans Employer Guide

Time Insurance Company
John Alden Life Insurance Company

Assurant Health is the brand name for productsunderwritten and issued by Time Insurance Company and John Alden Life Insurance Company.

Table of Contents

Welcome to Assurant® Self-Funded Health Plans

Thank you for selecting Assurant® Self-Funded Health Plans. Assurant Health is proud to bring together the services and products you need to establish and maintain your self-funded employee health plan.

About This Guide

This Employer Guide is designed to be a resource for you to effectively manage your self-funded plan.

This guide will answer most of the common questions asked by employers. However, we understand that certain situations will require personalized service. We encourage you and your employees to contact Allied Benefit Systems, Inc., (Allied) directly at 888.292.0272, and a trained service professional will gladly assist you.

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.

We look forward to a long and mutually rewarding relationship between Assurant Health and your small business.

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.

General Overview

Now that you have a self-funded plan, you are in a position to save substantially by paying your own expenses for employee health care claims. And with stop loss coverage to protect against large losses, you don't have to worry that you may have taken on excessive risk by self funding.

Our aim is to ensure that you continue to have the opportunity to financially benefit from participation in this program.

How Assurant Self-Funded Health Plans Work

Assurant Self-Funded Health Plans is an innovative program that conveniently combines the products and services needed to enable small business employers like you to self fund your employees' health benefits. These products and services are provided by:

The Insurance Company

The following services are provided by Time Insurance Company:

- Stop loss insurance to employers participating in this program
- Underwriting and enrollment
- Managing risk for this program
- Product design for the pre-packaged PPO plan you have selected as your self-funded plan
- Medical management (precertification, medical review, case management)
- Access to Assurant Health-contracted medical networks and pharmacy benefit managers at deeply discounted rates

The Third-Party Administrator (TPA)

Allied Benefit Systems, Inc. is a third-party administrator (TPA) that administers employer self-funded plans. Through its relationship with Assurant Health, Allied offers administrative services at a substantial discount to employers participating in this program. Allied's services include:

- Set up, banking and accounting for customer claim prefunding accounts and HSA/HRA accounts
- Paying claims under ERISA requirements
- COBRA and HIPAA administration
- Customer service (for you and your employees)
- Administering employer stop loss coverage
- Providing participating employers with financial information to judge whether self-funding continues to be their best option

Neither the insurance company nor the TPA acts in the capacity of ERISA fiduciary. You are not prevented from seeking or establishing independent business relationships with any of these companies, or any other, for services related to your health plan.

Participation and Eligibility Review

Participation requirements must be maintained in order to continue to qualify for this program. These include:

- Having a minimum of five participating employees
- Enrolling either 50% of all eligible employees regardless of waivers or 75% of all eligible employees after considering valid waivers

We may administer reissue questionnaires or make a telephone call to verify participation and eligibility information. We may also request payroll records and/or other documentation at any time during the life of the stop loss coverage. Groups that fail to maintain participation requirements or supply the requested information to verify participation may be terminated from participation in this program.

If the group size or enrolling employees reduces down to one individual, you will not be given a subsequent plan year offer for the stop loss policy.

Enrolling Employees

Eligibility Requirements

The following eligibility requirements have been developed by Assurant Health on behalf of your self-funded plan.

Eligible Employees

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 requested by the employer) 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 29-40 hours per week.
- 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

Eligible Dependents

- A lawful spouse
- Dependent children under age 26 whose legal address is the same as the employee's

Please review the Summary Plan Description for dependent eligibility.

Enrolling a New Employee

- Have your employee fully complete, sign and date the employee enrollment form.
- Submit the employee enrollment form to Allied 30 days prior to the expiration of your group's waiting period (see Waiting Period in this section) to allow for sufficient time for the insurance company to review the enrollment form and Allied to issue the Summary Plan Description.
- If you submit the Employee Enrollment Form more than 30 days after the expiration of the waiting period, the employee will be considered a late enrollee and must follow the late enrollee guidelines on page 6.
- Employee enrollment forms are only valid for 60 days after they are signed and dated.
- Do not send any payment. If the employee is approved, you are billed from the effective date of coverage on your next billing notice.
- When the employee is approved by Assurant Health, his or her effective date will also be determined. It will be on the next first or fifteenth day of the month, depending on the date your self-funded plan was originally effective. Refer to the Summary Plan Description for your plan effective date. For example, if your group originally became effective on the fifteenth of the month, the effective date for all enrolling employees will be the fifteenth of the month.

Waiting Period

- You cannot waive the waiting period for any employee. All employees must abide by the waiting period chosen.
- You may change your group's waiting period only once during any 12-month period. The change will apply to all employees.
- The effective date for the waiting period change is the first of the month following the date the request is received by Allied.
- Your employees must satisfy the waiting period that is in effect as of their hire date.

Assurant Health's Short Term Medical insurance is available to fill the temporary gap in coverage during your employees' waiting periods and can also be an alternative to COBRA. Contact your agent to determine which coverage is right for your employees' temporary needs.

Adding a Spouse

- Your employee may add a spouse by providing written notification to Allied within 31 days of the date of marriage.
- The effective date of coverage can be either the date of marriage or the first of the month following the date of marriage.
- If notification is not received within 31 days of the date of marriage, the spouse is considered a late enrollee and must follow the late enrollee guidelines in this section.

Adding Newborns or Adoptees

- Your employee may add a newborn or adoptee by providing written notification to Allied within 31 days of the date of birth or the date of legal dependence. Allied may ask for proof of legal dependence.
- The effective date is the child's date of birth or the date of legal dependence.
- If notification is not received within 31 days of the date of birth or legal dependence, the child is considered a late enrollee and must follow the late enrollee guidelines in this section.

Note: For employer monthly cost payment responsibilities, please see the Monthly Costs and Billing section on page 8.

Avoid Delays

Make sure you and your employees run through this checklist to ensure that their employee enrollment forms are properly completed and submitted at the appropriate time:

1. **Are you sending in the employee enrollment forms too early?** A new form should not be submitted more than 60 days prior to the eligible effective date.
2. **Was the form completed in its entirely (including signed and dated) if not, the form is returned to the employee for completion.**
3. **Have any of the signatures or dates been altered?** If the signature is altered, we will ask for a new form. If the date is altered, we return the form to the employee to initial and confirm the altered date.
4. **Has the employee provided medical history details for each medical question that is answered "yes"?** If not, we will contact the employee for details or return the form to the employee for completion.
5. **Are any medical questions left blank?** If yes, we will return the form to the employee to have the questions completed, initialed and dated.
6. **Has each employee completed the Waiver of Coverage section?** If not, the form is returned to the employee for completion.

OBRA

The Omnibus Budget Reconciliation Act of 1993 (OBRA93) contains several provisions affecting group plans that are governed by the Employee Retirement Income Security Act (ERISA). This Act is essentially an "employer" law in that it places requirements on employers who maintain group health plans for their employees.

Qualified Medical Child Support Orders (QMCSO)

OBRA requires compliance with QMCSO, which includes any court-issued judgment, decree or settlement agreement that requires a non-custodial parent to provide medical coverage for his or her child. An order may not require the plan to provide any particular type or form of benefit, or any option not otherwise provided under the plan.

Note: This information is not intended as legal advice. Please consult with your benefits attorney for determination of your plan's compliance with OBRA93 and QMCSO provisions.

Late Enrollees

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

1. Did not apply for coverage under the plan within 31 days after becoming eligible
2. Did not apply for coverage under the plan when the group coverage initially went into effect
3. 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.

Coverage for late enrollees (employees or dependents) is effective on the first of the month following the date Allied receives the employee's enrollment form.

Special Enrollment Period

A special enrollment period is a period of time during which eligible employees may apply for coverage under your group self-funded plan for themselves and their eligible dependents without being considered a late enrollee. A special enrollment period commences with:

1. The day following termination of coverage under another group health plan or other health insurance coverage if all the following criteria are met:
   A) The employee and/or dependent were covered by creditable coverage when they were first eligible to apply
   B) The employee previously waived coverage under your group self-funded plan because of being covered under some other health insurance coverage and

C) The coverage described in "A":

- Was under the federal COBRA continuation provision and the period for which coverage could be continued has been exhausted or
- Has terminated as a result of loss of eligibility for coverage due to legal separation, divorce, death, termination of employment, reduction in the number of qualifying hours of employment, or termination of employer contributions toward this coverage

2. The date of the employee's marriage
3. The date the employee acquires a dependent child through birth or adoption or
4. In the case of a dependent spouse or child, the date a court orders coverage to be provided under your group self-funded plan

For items listed above, the request for enrollment must be received within 31 days of the qualifying event.

For items 1 and 2 listed below, the request for enrollment must be received within 60 days of the qualifying event.

1. The date an employee or dependent is no longer eligible for coverage under a Medicaid plan or under a State Children's Health Insurance Plan (SCHIP)

2. The date an employee or dependent becomes eligible for assistance under a Medicaid plan or under a State Children's Health Insurance Plan (SCHIP)

Deductible Credit

When coverage under this program first begins, credit is given for any portion of a calendar-year deductible satisfied under a prior plan during the same calendar year. However, no credit is given for past deductibles. The deductible credit does not apply to the family out-of-pocket maximum.

If the prior plan had a prescription drug card, credit is provided for any portion of the deductible satisfied under the prior prescription drug card. These drug charges are applied to the medical calendar-year deductible. The deductible credit does not apply to the family out-of-pocket maximum.

Group Plan Information

Notification of Group Plan Changes

Submit all changes in writing, making sure they are signed and dated by the employer or group administrator. (If you obtain a quote to change your self-funded employee plan, you may submit the quote instead of a written request.) Also, submit the request 70 days prior to the effective date to ensure benefits are paid correctly on your behalf. Note: Any adjustments appear on future billing notices.

> A plan change is a group level change to your self-funded employee health plan. This change affects all active employees.

Changing your Self-Funded Health Benefit Plan

- You may request to change your self-funded health benefit plan to any of the numerous pre-packaged plan designs available through this program.
- You may request a change to your self-funded health benefit plan once during any 12-month period.
- Requests 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).
- 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 team at Assurant Health.

Administrator Changes

Your company's group administrator is the designated liaison between your company and Allied. We recommend that the person named as your administrator be responsible for notifying Allied of any coverage changes. Because the primary means of communication will be through email, it is essential that Allied have the most current name and email address for your administrator. Note: your current administrator's name appears on all bills and correspondence from Allied. Thus the importance we are given advance notice of any changes in order to avoid errors, delays and interruptions in your group's coverage.

Ownership Changes

If your business undergoes a change in ownership, please contact your agent for a new employer application form. You need to complete this form and return it to Allied.

Group Address Change

If your business moves to a new address within the original state of issue:

- Notify Allied in writing of any address change.
- Your group's monthly cost may be adjusted due to the ZIP code change.

If your business moves to a new address outside the original state of issue:

- Notify Allied in writing of any address change.
- Allied will notify you of the stop loss policy termination date due to the move outside of the original state of issue.
- You may have the option to reapply for the Assurant Health Self-Funded Program or a fully insured small group plan from Assurant Health, provided your business moves to a state in which we market our products and you continue to meet our business eligibility and participation requirements.

No coverage is in effect until approved by the insurance company.

Monthly Costs and Billing

Monthly Cost Payments

Payments are due in full on the first of the month and must be submitted by the administrator, not by the individual employees (even if employees pay a portion of the premium). Write your group number on the memo section of your check.

Employer Responsibility for Monthly Cost Payments

- As the employer, you must pay at least 50% of your employees' portion of the monthly cost.
- Your employees may pay all or part of their dependents' portion of the medical cost at the employer's option. In either case, the employer is responsible for remitting all costs to Allied when due.
- The employer is responsible for all payments associated with the program.
- The employer is responsible for remitting all COBRA premiums to Allied when due.

General Billing Information

- Premium past due will result in the generation of a late notice. A monthly late fee of $25 will be assessed for payments received 10 days after the due date.
- Timely payment can be critical in ensuring that your stop loss coverage continues uninterrupted.
- If you cannot locate or have not received your billing statement or a late notice, please log on to the **assurantselffunded.com** website to obtain a copy or call Allied at 888.292.0272 for assistance.
- In an effort to provide a safeguard against overlooking a due premium, we send your agent notification of overdue bills. You may receive a courtesy follow-up call from your agent when this situation occurs.

Reminder: If your monthly cost is received later than the 31st day after the due date, coverage lapses and your participation in all plans will terminate. You are responsible for advising your employees of the lapse for their plan. Please refer to the Lapsed Coverage section on page 11.

Checks Returned Unpaid

If your bank notifies you that your monthly cost check has been returned to your bank unpaid, please follow the procedure below:

- Wait until Allied has notified you by letter before resubmitting your check. We make two attempts to cash your check. If the payment does not clear our bank on the second attempt, we contact you by mail.
- Our letter provides the check number and the amount of the returned item. You have 20 days from the date of our letter to resubmit the monthly cost.
- You may receive the next month's billing before we have resolved the outstanding non-payment issue. Pay this monthly cost as due. Withholding payment of the next month's cost may result in a lapse of your coverage.

You may be charged fees for returned checks or for late payments.

Adjustments

Adjustments on your billing statement will reflect changes in the make up of your self-funded employee health plan. Monthly billing amounts can change if:

- A new employee is added to the group.
- An employee is terminated.
- The business moves to a new address.
- An employee makes a change in the type of coverage selected, e.g., family to single.
- Changes are made to the plan's benefits.

In an effort to limit billing adjustments, please pay the monthly cost as billed. If you add an employee, dependent or spouse, do not adjust your monthly cost until the change appears on your bill. You will be back-billed and/or will receive credit for changes on the next statement generated after the changes are processed. An explanation of possible reasons for the adjustment is indicated on the reverse side of your bill. Please call Allied at 888.292.0272 if you need clarification on your billing.

First Year Monthly Cost

At time of application for stop loss coverage, you provide a census of your group. The initial monthly cost assigned is based on the age of your employees at the time they are approved for coverage under your self-funded plan, the types of coverages selected, the location of your business and expected future medical claims.

In some cases, there will be adjustments within the first 12-month period to your actual monthly billing. These adjustments reflect coverage changes or changes in the location of your business.

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

- Age and gender of employees
- Geographic location of the business
- Eligibility of employees for Medicare coverage
- Medical history of employees and dependents
- Type of industry in which the group is involved
- Expected future medical claims

Employer Fund Refund

Funds not used for claim payment accumulate in the employer's account. At the end of the stop loss policy run-out period, any remaining employer funds not applied toward group health claims will be refunded via a check to the employer.

Medicare Eligibility/TEFRA

The federal agency administering the Medicare program requires administrators of group health insurance plans to provide their insurance company with 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 Web site at **cms.hhs.gov.**

For groups with 19 or fewer full-time and part-time employees, the medical rates for an employee who reaches the age of Medicare eligibility will generally decrease, and your self-funded plan will pay benefits secondary to Medicare. This means that Medicare processes the expenses first and your self-funded plan benefits are supplemental. This change is effective the first of the month in which the employee and/or dependent reaches age 65. If a 65-year-old employee has a covered dependent under age 65, your self-funded plan continues to pay primary benefits for the dependent, subject to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) guidelines.

Groups that have had 20 or more full-time and part-time employees working each day during 20 or more weeks of the current or preceding calendar year fall under TEFRA legislation.

TEFRA determines premium and reimbursement guidelines. Under TEFRA rules, your self-funded plan is the primary insurer and Medicare is secondary. Please notify Allied immediately of any changes in group size that would impact the rules used when administering benefits, as governed by TEFRA.

To determine your employee count and to coordinate benefits for persons who are eligible for Medicare coverage, Allied will send you a TEFRA form to complete and return every year, six months after your effective date.

TEFRA guidelines state that specific requirements must be met six months out of the year in order to indicate secondary or primary coverage for your self-funded plan.

Filing Claims

Your employees can find details on filing for claim reimbursements and receiving benefits in their Summary Plan Description. Encourage your employees to read their Summary Plan Descriptions before using their coverage. When employees understand the financial impact prior to incurring expenses, their satisfaction increases dramatically. Employees may also contact Allied directly for assistance. While Allied will not guarantee your self-funded plan benefits over the phone, their customer representatives can help your employees understand their benefits and the claim process.

The Summary Plan Description advises employees of the following:

- If a planned treatment or service is a covered expense.
- Specific instructions on how to pre-certify. The telephone number for precertification is listed on the employee's identification card.

How to Submit Medical Claims

- No claim forms are required.
- Encourage your employees to use a provider in the Assurant Health network. This ensures that your self-funded plan is charged the best negotiated price available.
- For all submissions, make sure key identification information is provided, including the group number and the employee's identification number. This information is located on the employee's identification card.
- Make sure itemized statements are submitted. Balance due statements are not acceptable. Statements should include:
  - Date of service
  - Type of service
  - Diagnosis
  - Amount charged
- On behalf of your self-funded plan, Allied may request information concerning the coverage of a previous carrier so we can coordinate benefits and provide deductible credit.

How to Submit Pharmacy Claims

- No claim forms are required.
- Encourage your employees to use a pharmacy associated with the network indicated on their identification card. This ensures that your self-funded plan is charged the best negotiated price available.
- Instruct your employees to send receipts for any prescription drug purchases outside the network, along with a Direct Reimbursement Claim Form, to the address provided on the claim form. Please note that injectable drugs other than insulin and Imitrex are not covered under the prescription drug card, but may be considered for possible coverage under the medical portion of the self-funded plan. Concerned employees should contact Allied at 888.292.0272 for assistance.

Termination

Your stop loss coverage and participation in this program can be terminated for the following reasons:

- Monthly payment 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 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.
- The business moves to a state where we do not write business.
- The group submits a voluntary written request for termination.

Notification of Termination

Submit all termination requests in writing within five business days to Allied.

> Note: The earliest date for the group's termination is the paid-to date of the group.

Group Health Plan Termination

To terminate your company's health benefit plan, submit a written request indicating that coverage for all employees is to be terminated. You do not need to list all employees individually in your written notification.

Stop Loss Termination

To terminate your company's stop loss coverage, submit a written request indicating that stop loss coverage is to be terminated.

Lapsed Coverage

- If Allied does not receive your monthly cost payments within 31 days of the due date, stop loss coverage and administrative services for all employees terminates as of the due date. (The due date is always the first of the month.)
  - All monthly cost payments must be remitted to Allied. After the initial monthly cost payment, any monthly payment given to your agent is not considered received by Allied.
  - Please be advised that all checks are automatically deposited and cashed, regardless of the status of your plan. Cashing of a monthly check on a lapsed plan does not guarantee approval for reinstatement.
- Assurant Health does not notify employees that their coverage is terminated. It is your responsibility to advise your employees of your group's termination.

Termination Due to Company Closing

The group health plan and stop loss coverage terminates on the first day of the month following the closing of your business. Please send notification in writing. (See Termination Notifications in this section.)

Early/Mid Year Termination

In the event stop loss coverage terminates 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 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 by us prior to the end of the run-out period.

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

After recoupment by us 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 stop loss policy termination date are not eligible claims under this stop loss policy.

Employee Termination

The following termination guidelines have been developed by Assurant Health on behalf of your self-funded plan.

Notification of Termination

Submit all termination requests in writing within 30 days to Allied.

Employee Terminations

Employee coverage will terminate:

- If the monthly cost is not paid.
- On the day of the month one day before the employee's effective date. For example, if the employee terminates January 10 and your plan has an effective date of the 15th, the coverage will be terminated on January 14.
- The first day of the month following termination or retirement from employment (e.g., if the employee terminates January 15, coverage will be terminated February 1). If an employee works even one day of the month, coverage continues through the end of the month.
- The first day of the month following a change in the employee's regularly scheduled hours to less than the hours specified in your contract (which defines a full-time employee).

To terminate an employee from your plan:

- Notify Allied in writing within 30 days of the termination of the employee.
- Use the back of your billing statement to request termination or send a separate notice.
- Termination requests should be emailed to the employer group's eligibility coordinator or to: AH.eligibility@alliedbenefit.com

Caution: Verify that you are terminating the correct employee. An employee who was inadvertently terminated as a result of a written request will need to reapply for coverage and may be considered a late enrollee.

- Include the employee's name, Social Security number and employment termination date.
- Once the termination is processed, any credit due for past months will appear as a credit adjustment on your next billing statement.
- Review your next billing statement to ensure the employee was deleted from your plan.
- If the employee was not terminated, please contact Allied at 888.292.0272 for assistance.

Important: Be sure to collect and destroy the ID cards of all terminated employees.

Dependent Terminations

A dependent's coverage terminates on the earliest of the following:

- The date the employee's coverage ends or the date the employee's family coverage ends.
- The first of the month following the date the individual ceases to be an eligible dependent.
- The first of the month following Allied's receipt of your written request.

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.

Continuation of Coverage

Continuation of coverage options are determined by federal laws, product options and employee preference. This section provides brief descriptions of options. Information specific to your state's requirements is contained in the Summary Plan Description. Please contact Allied for assistance at 888.292.0272.

Notification of Continuation

Submit all continuation requests in writing within 30 days to Allied.

Once a continuation option is selected, the start date of the continuation will coincide with the termination date. State continuation is not available under this product.

COBRA

A federal law, referred to as Consolidated Omnibus Budget Reconciliation Act (COBRA), was passed in 1986. This law requires employers, who employ 20 or more full- or part-time employees for at least 50% of its typical business days during the previous calendar year, to offer continuation of the group's plan to employees who may lose coverage for one of several reasons. In some states, employers with fewer than 20 employees may be eligible for the same benefits as COBRA under this program.

COBRA is designed to protect individuals who would otherwise lose their health insurance coverage. A person who elects COBRA continues on the employer's plan at the group rate. The terminated individual must pay the monthly cost to the employer. The employer may charge the individual a small administrative fee (2% of the monthly cost) to defray the administrative expense. If you are unsure whether your company is required to comply with COBRA, please contact your legal advisor.

COBRA Guidelines

- COBRA law requires an employer to notify employees who qualify for coverage under COBRA within 14 days of the event that terminates coverage.
- It is the employee's responsibility to notify the employer, within 60 days, of a change in status of a dependent, which may entitle the dependent to a COBRA continuation.

- The covered employee, spouse or dependent child must make his or her election to continue coverage no later than 60 days from the date of the notice from the plan administrator.

How to Request COBRA Coverage

- Follow the process for terminating an employee's or dependent's coverage outlined in the Employee Termination section on page 12.
- The terminated individual must submit a signed and dated request. Allied must receive the request within 30 days of the terminated employee's election to accept the COBRA option.
- A terminated employee may elect to continue coverage for up to 18 months (29 months if disabled) from the date of any of the following qualifying events:
  - A) Termination of employment for any reason other than gross misconduct
  - B) Reduction in work hours to less than full-time status
- If the covered employee's spouse and/or dependent child also loses coverage for the above events, they too may continue coverage for up to 18 months.
- If during the 18 months, a second qualifying event listed below (C, D, E or F) occurs, continuation of coverage may be extended for up to a maximum of 36 months from the date of the first qualifying event described in items A and B above.
- If the covered employee's dependent spouse or child loses coverage due to one of the reasons listed below, coverage may be continued for a maximum period of 36 months.
  - C) Covered employee divorces or legally separates from spouse
  - D) Covered employee is entitled to or is receiving Medicare benefits
  - E) Covered employee dies
  - F) Dependent child loses dependent status

For billing information, please refer to the Monthly Cost and Billing section starting on page 8.

Pre-existing Condition Coverage

If an employee with COBRA coverage becomes covered under another group health plan, COBRA coverage under the employer's group health plan may continue if the other plan excludes from coverage or limits coverage due to a pre-existing condition. Payment of benefits is subject to coordination of benefits.

Early End to COBRA Coverage

COBRA coverage may end earlier than the required period. Such coverage will end on:

- The first day for which timely monthly cost payment is not made.
- The date upon which the employer ceases to provide any health plan to any employee.
- The date upon which the qualified beneficiary becomes covered under another group health plan not maintained by the employer (see the Pre-existing Condition Coverage on this page).
- The date that the qualified beneficiary is first entitled to Medicare.
- The date on which coverage is terminated for a cause. Termination for cause will end the coverage of a qualified beneficiary in the same manner that the coverage ends for employees who have not undergone a qualifying event.

Layoff

Standard rules for termination and continuation apply.

- The termination date of an employee is the first of the month following the date the employee is laid off.
- Allied must receive written notification within 30 days of the layoff.
- If an employee returns to work, an employee enrollment form must be completed. Enrollment is subject to the guidelines described in the Enrolling Employees section on page 4.

Leave of Absence

If an employee ceases active work due to illness, injury or pregnancy, the employee may be eligible for 12 weeks of leave under the Federal Family Leave Act of 1993. For an employer with 50 or more employees, an employee has to have worked for the employer for at least 12 months and 1,250 hours during the 12-month period immediately preceding the leave to be eligible. You must notify Allied within 30 days if the employee is going on leave of absence.

For non-disability-related leaves of absence, layoffs or retirement, the employee may not be eligible for the 12 weeks of leave, and the continuation options outlined in the Continuation of Coverage section on page 12 may apply. Please refer employees to the Summary Plan Description for availability of this benefit.

If an employee is not eligible for COBRA or state continuation, coverage terminates on the first of the calendar month after the date the employee ceases active work for the participating employer.

Leave of Absence Coverage Continuation

Coverage may continue until the earliest of:

- Twelve weeks
- The date the employer ceases making monthly cost payments
- The date the employer no longer considers the employee a full-time employee and terminates the employee's coverage
- The date the employer ceases to provide any health plan to the employees

Reinstatement after the Leave of Absence

- If the employee returns prior to the end of the 12-week leave of absence period, notification must be sent to Allied so employee coverage is not terminated.
- If notification is not received resulting in the employee's termination, an employee enrollment form must be completed. Enrollment is subject to the guidelines described in the Enrolling Employees section on page 4.

Military Leave

There are several coverage alternatives for employees who serve in the military during their employment. In most situations, your employee will have government-sponsored health coverage while actively serving. Due to military coverage, his or her benefits under your self-funded plan may be terminated for the duration of duty unless otherwise requested. Be sure to notify Allied in writing within 31 days of a covered participant being placed on active duty.

Return from Active Duty

To reinstate coverage upon return from active duty:

- Submit a copy of the employee's discharge papers.
- Send a letter to Allied stating that full-time employment has resumed.
- Submit a fully completed employee enrollment form.

Note: The above information must be submitted to Allied within 31 days of the resumed employment date. Underwriting guidelines for a late enrollee (page 6) will apply if the request is received after 31 days from the resumed employment date.

Allied is Available to Provide a Variety of Services

You can call an Allied customer service representative to:

- Assist you with procedures for adding new employees to your self-funded plan
- Change your address
- Make modifications to your benefit design
- Request duplicate identification cards or Summary Plan Descriptions
- Check on the status of a reinstatement application
- Inquire how to add or delete coverage for a family member
- Get assistance with monthly cost and billing questions
- Get assistance with questions regarding the benefits provided by your self-funded plan
- Learn how to file a claim
- Obtain information on the status of a pending claim
- Obtain information on Assurant Health's Preferred Provider Organization (PPO) networks

Should you have a complaint about benefits or services, an Allied customer service representative works to resolve the complaint to your satisfaction. If the service representative is not able to immediately answer or resolve your questions or complaint, he or she will research the matter and promptly contact you.

Customer Service

Phone

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

312.906.8359

Mail

200 West Adams, Suite 500
Chicago, IL 60606

Website

assurantselffunded.com

Claim submission

Submit claims to the address indicated on the member ID card.

Website Portal

A member portal is available for agents, employers and members. Employers and members can access this portal through **assurantselffunded.com**. Below is an outline of information available on the website for employers and members.

Employers

- Invoices
- Claims fund reporting

The following member information is also accessible to employers

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

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.

Policy Form Numbers 27426, 27427, 28844 and 28845

50573 (New 02/2013)