EMPLOYER GROUP ADMINISTRATIVE GUIDE

FOR

ASSOCIATED EMPLOYERS TRUST
ALLTECH HEALTH ALLIANCE FOR TECHNOLOGY
GREATER VANCOUVER CHAMBER OF COMMERCE
EMPLOYEE BENEFIT PROGRAMS

The most current version of this document can be found on the web at: www.aetbenefits.com or www.alltechbenefits.com The contents of this guide are for informational purposes only and in no way supersedes any insurance contract. In cases of conflicting information, the insurance contract and Trust provisions prevail.

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From our Associated Employers Trust Staff

Hello. Our Associated Employers Trust (AET) staff is pleased to welcome you. We look forward to working with you as you take advantage of everything our member-driven organization can offer your company and employees.

Our staff is ready to support all of your healthcare plan administrative needs – from enrollment and COBRA to billing. You now have access to people who are happy to assist you and your employees with your benefit needs.

If there is anything we can do to help you realize the full value of your AET experience, please let us know. We look forward to working with you.

Sincerely,

Your AET Staff (left to right)
Misty Ortiz, Deb Brady, Joyce Anderson, Maureen Smith and Michelle Walczak

Participating Vendors

Welcome to Associated Employers Trust (AET)

Thank you for choosing AET as your choice for employee benefits. We have designed this Guide to provide a useful tool in making administration elections and changes as easily and efficiently as possible.

This Guide is a summary of terms and conditions set forth for participation in all of AET's* benefit programs. It includes brief descriptions of plan administration and is intended to help member companies' administrative representatives through the day-to-day management of their benefits program. While all attempts have been made to provide accurate information, this is not a contract, booklet of insurance or a certificate of coverage. In all cases, the information provided by the insurers or program manager in your benefit booklets, contracts and certificates of insurance govern the conditions and limitations of coverage.

About Associated Employers Trust (AET)

Associated Employers Trust was founded in 1952 as an innovative, cost-effective alternative for small employers to purchase medical coverage for their employees. Since then, AET* has grown to offer numerous benefit plans covering medical, dental, vision, life insurance, disability, wellness, long-term care, accidental death and dismemberment and more. This coverage extends to hundreds of companies insuring over thousands of members. Some of our members have been with the Trust for more than forty years.

Associated Employers Trust handles all of the administration including enrollment, COBRA administration, eligibility updates, consolidated billing, customer service and more. Our unique single billing system has been developed for simplicity and accuracy.

Program Management Contact Information:

Wells Fargo Insurance Services USA, Inc.
Two Union Square
601 Union Street, Suite 1300
Seattle, WA 98101

Paul Baker
Ph: 206.892.9573
Tf: 866.869.6356
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TPA Contact Information:

Associated Employers Trust
1206 North Lincoln, Suite 200
Spokane, WA 99201-2559
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Fx: 509.328.6832
Wb: www.aetbenefits.com
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ALLtech
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Spokane, WA 99201-2559
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Fx: 509.777.2667
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Online Contact Information:

Associated Employers Trust
Staff Contact Information

Please refer to the online contacts list.

Eligibility and Enrollment Guidelines

Web Tools

Save time and be confident you are using the most up-to-date forms, documents and resources. Visit www.aetbenefits.com or www.alltechbenefits.com to access up-to-date forms, summaries, booklets and comparisons on your AET* benefits including medical, dental, life and disability and
EAP coverage.

Visit www.aiin.com to access up-to-date information, news and events regarding Associated Industries.

Employer Eligibility Guidelines

To be eligible for coverage through the AET* Benefit Program an employer must meet the following requirements:

- The employer must be an active member of Associated Industries in good standing.
- The employer is required to be based in, or have a clearly defined division in Washington State with 51% or more employees living in the state of Washington or working at an employer location located within Washington State.
- The employer must be a corporation, partnership, proprietorship, or other organization unit or entity that is engaged in business and that employs at least five (5) regular full-time employees who work a minimum of 20 hours per week and are paid on a regular basis through a payroll system. "Employees" do not include seasonal, temporary, or contract employees or independent contractors.
- The employer must sponsor the plan meaning it must contribute no less than 50% of the employee cost of coverage and 75% of the eligible employees must participate in the plan. *Note: employees enrolled on a spouse's group plan or federal employee plan are not considered eligible for the participation percentage.* The employer is not required to contribute toward the dependent cost.
- Groups of 10 or fewer subscribers must have "common eligibility" for all lines of coverage. Groups of 11 or more subscribers, with less than 100% employer/dependent contribution, may have "uncommon eligibility" between Medical and Dental.
- "Common Eligibility" is defined as follows: Enrollment is consistent across all lines of coverage for employees and their benefit eligible dependents.
- Employer participation in the Vision and Dental plans is optional. Only one Vision and one Dental plan may be offered.

Employee Eligibility Guidelines

In order to participate in the Program the employer must agree to define the enrollment requirements on their annual Group Master Application and then apply these requirements in a non-discriminatory fashion for all employees in determining their eligibility, enrollment, waiting period, and contribution.

These requirements can be changed at renewal. These may not be changed during the year without a formal request submitted to AET* and a written approval is made. If your group, as a result of an acquisition, merger, or other circumstance, wishes to add a new group or expand the group of eligible employees to the plan, please contact your producer (broker).

Eligible employees are those who have completed the waiting period, sometimes known as a probationary or introductory period, with the employer **and** have worked at least an average of twenty (20) or more hours per week.

Each employer will note minimum hours for benefits on the Group Master Application, but the minimum must be at least twenty (20) hours. At least two (2) employees need to work thirty (30) or more hours per week for an employer. Employees must be receiving compensation from the employer. The employer must be reporting Federal Income Tax Information to the IRS. All other persons must be canceled at the time they cease to work the required number of hours. Retired employees are NOT eligible. Employees must be actively employed with the employer.

Eligibility of Owners, Partners, and Corporate Officers: Owners, partners, and corporate officers of an employer will be considered eligible for the insurance only if they work the required number of hours or more per week. Spouses are not eligible (as subscribers) unless they are bona fide employees working the minimum hours required. They may qualify as dependents, however. Persons providing professional services, such as attorneys, accountants, etc. are not eligible unless they are bona fide employees of the firm. The employer must provide for workers' compensation coverage for all eligible employees not otherwise specifically excluded from such coverage.

Dependent Eligibility Guidelines

The employer is not required to contribute toward the dependent cost. Dependent participation is optional.

Eligible dependents include:

- The lawful spouse of the subscriber, unless legally separated. However, if the spouse is an owner, partner or corporate office of the employer who meets the requirements in "Subscriber Eligibility" the spouse can only enroll as a subscriber.
- The domestic partner of the subscriber. Washington State Senate Bill 5688, originally signed into law in May 2009 and recently upheld by the vote on Referendum 71, grants registered domestic partners the same rights and responsibilities under Washington State law as held by lawful spouses.

  Associated Employers Trust will not require, as a condition of enrollment, proof that domestic partners are registered, nor limit coverage to registered domestic partners. We do, however, reserve the right to do so as part of an eligibility audit.

  Enrollment procedures for domestic partners are the same as for spouses. An enrollment form is required.

  PLEASE NOTE: For employers subject to COBRA, federal COBRA rights, including subsidy rights pursuant to the American Recovery and Reinvestment Act of 2009 are available for spouses. However, because federal law does not recognize

domestic partnerships, even when employer-sponsored plans cover such partners, federal COBRA rights, including subsidy rights; do not apply to domestic partners.

For employers not subject to COBRA, state law requires insurance policies to include provisions that allow for three (3) months of continuation coverage. It is not required that employers make this coverage available to employees or dependents, but under SB 5688, those provisions would need to apply to domestic partners.

- The natural or adopted child of a subscriber's spouse or domestic partner.
- A natural offspring of either or both the subscriber or spouse, a legally adopted child of either or both the subscriber or spouse, a child legally placed with the subscriber for adoption in accordance with state law. "Placed for adoption" means assumption and retention, by the subscriber, of a legal obligation for total or partial support of a child in anticipation of adoption of such child, a legally placed ward of the subscriber or spouse living permanently in the home of the subscriber. Foster children are not eligible for coverage.

Enrollment Guidelines

Employer Enrollment Guidelines

Please refer to the "How to Enroll" section of this document for instructions on new group submission, renewal, employee and dependent enrollment process requirements.

The employer must complete an annual Group Master Application and agree to the terms, conditions, and limitations of coverage as set forth in the insurer's contracts. The employer's request for coverage through the AET* Employee Benefit Program must be accepted by the program prior to the coverage effective date.

See "Benefit Election Guidelines" section for requirements on plan benefits to be elected by the employer to employees.

The employer selects the hours an employee must work per week in order to be eligible for benefits. This must be no less than twenty (20) hours per week and no more than 40 hours per week.

The employer selects the benefit waiting period, sometimes called a probationary or introductory period. Benefit waiting period is a period of time between the employee's date of hire and the date coverage becomes effective under the plan. New groups must specify their intention with regard to the waiting period for employees transferring from a part-time to a full-time status. The employer may either apply the employee's date of hire retroactively to their original date of hire, thus, eliminating the waiting period OR; the period would apply following the date of transfer, no matter how long the employee has worked with the company as a part-time employee. All waiting periods are stated as "First of the month following" – Date of hire, 30 days, 60 days, etc.

Waiting periods may not be waived except in the event an employee is re-hired within 90 days, then the waiting period is waived. Employers should not make the waiver of waiting period a term of employment. When the participating employer selects a waiting period, it applies to all coverage under the program. However, in some instances, they may be

waived for KEY employees with prior approval from AET*. All eligible employees, who do not enroll for coverage, must complete the Waiver of Coverage form.

During the open enrollment period employers may change their Probationary Periods and number of hours by submitting a written request to Associated Employers Trust. They will need to stipulate if the change applies to the employees hired after the request or all current employees.

The Employer must include all other work site locations where enrolled employees may be located. Out of state employees will have coverage based on the network in the state they are located. If you have a child needing care outside the standard network area, please advise AET* of the member's information so we can set up this benefit for your member.

Employee and Dependent Enrollment Guidelines

To become covered under this plan, an employee must first complete an application for themselves and include each family member they wish to cover. For employees, coverage begins on the first day of the next month after the application has been accepted by AET* and they have completed any probationary period required. For dependents that are eligible, and are included on the subscriber's application, coverage begins on the subscriber's effective date.

If a subscriber has a child who has sustained a disability rendering him or her physically or mentally incapable of self-support, that child may be eligible for coverage even though he or she is over 26 years old. To be eligible, the child must be unmarried and principally dependent on the subscriber for support. The incapacity must have arisen before the child's 26th birthday.

The subscriber must provide ODS with a written physician's statement that confirms these conditions existed continuously prior to the child's 26th birthday. Documentation of the child's medical condition must be reviewed and approved by ODS' medical consultant. Periodic review by the medical consultant will also be required on an ongoing basis except in cases where the disability is certified to be permanent.

Employees must provide salary information on an annual basis when electing life and disability benefits that premiums are billed based on salary.

Any deductibles satisfied under the prior carrier for the current calendar year may be credited by completing a "Credit of Deductibles" form and copy of the "Explanation of Benefits" from the prior carrier. The deductible carry-over only applies when the entire group is transferring to AET* from another carrier. **The "Request for Deductible Credit" form and "Explanation of Benefits" from the prior carrier must be submitted within three (3) months of the employer's effective date with AET*.**

Newborn and Adopted Child Enrollment

For the subscriber's natural newborn child, coverage will be retroactive to the date of birth provided AET* receives the subscriber's application for the new dependent's coverage within sixty (60) days following birth.

For the subscriber's adopted child, coverage will be retroactive to the date of placement for adoption or the date the subscriber assumed total or partial legal obligation for the child's

support in anticipation of adoption. AET* must receive the subscriber's application for the new dependent's coverage, within sixty (60) days, following placement or the subscriber's assumption of legal obligation for the child's support.

For the subscriber's natural newborn, adoptive child under age eighteen (18,) or child placed for adoption under age eighteen (18), none of the preexisting limitations or preexisting condition waiting periods of this plan (if applicable) will apply to such child, if enrolled for coverage under this plan within 60 days of birth, adoption, or placement for adoption. For both newborns and adopted children, AET* should receive applications within 60 days to prevent delays in claims processing.

Special Enrollment Rights

If a participant declines enrollment for themselves or their dependents (including spouse or domestic partner) because of other health insurance coverage or if the eligible employee's or dependent's prior coverage was under Medicaid or a children's health insurance program (CHIP) and such coverage was terminated due to loss of eligibility they may - in the future - be able to enroll in this plan, provided that they request enrollment within 60 days after the other coverage ends. In addition, if they have a new dependent as a result of marriage, birth, adoption, or placement for adoption, they then may be able to enroll themselves (or their dependents) provided that they request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

- In order to have Special Enrollment Rights:
  - Participant must have previously declined coverage in writing.
  - Participant must notify administration within 60 days of event and submit Enrollment/Change form.
  - Participant must have a qualified event such as:
    - **Loss of coverage**
      - Effective 1st of the month following loss of coverage
    - **Marriage**
      - Effective 1st of the month following marriage date
    - **Birth**
      - Effective on the date of birth
    - **Death**
      - Effective the first of the month following date of death
    - **Divorce**
      - Effective first of the month following divorce decree date
    - **Adoption**
      - Effective on the date of adoption, or the date in which the child(ren) are placed with the employee for adoption.

Participants can then enroll themselves (if not previously enrolled) and their dependents in available coverage.

Effective Dates

Effective dates begin the first day of a month following the addition of a new employee or dependent, and the last day of the month for a cancellation. Rates and coverage cannot be pro-rated. Newborns are enrolled in coverage as of their date of birth. The premium for a newborn applies the first of the month following date of birth.

Eligibility Audits

Employers are responsible for keeping accurate and complete records of plan beneficiaries relating to eligibility, enrollment, payroll deductions, hours worked, premium payments, and other records necessary to administer the benefit plan.

The Program and its plan sponsors, have the right to request, inspect or audit the employer's records or the records of any third party entity engaged by the employer to administer portions of the employer's business related to the information necessary to administer the benefit plan at any time during the employer's regular business hours.

Employer Benefit Election Guidelines

All plans are open to member companies of AET*. Certain guidelines must be followed when electing plan options through AET*. Certain carrier guidelines must be followed when electing plan options.

- Compulsory benefits (required when electing medical)
  - Medical plan and Prescription Drug plan
  - $15,000 basic life and AD&D

- Buy-up benefits
  - Compulsory benefits are required to purchase any buy-up options
  - Dental
  - Vision
  - Buy-up basic life and AD&D options
    - Option A - Additional $15,000 for an overall $30,000 benefit
    - Option B - Additional $35,000 for an overall $50,000 benefit
    - Option C - 1x Annual Salary to a maximum of $100,000 for employers
    - Option D - 2x Annual Salary to a maximum of $100,000 for employers
    - Dependent basic life
  - Short-term Disability (Product not available to ALLtech groups)
    - Option A - 60% salary to $100 a week maximum (core benefit)
    - Option C - 60% salary to $235 a week maximum (must purchase Option A to elect this benefit, $235 maximum is combined and not in addition to Option A)
  - Long-term Disability (Product not available to ALLtech groups)
    - Option A - 60% salary to $3,000 fully integrated with social security a month maximum
  - Voluntary (Supplemental) Life and AD&D

- Stand Alone Options
  - Dental
  - No vision benefits will be offered on a stand alone basis
  - No life benefits will be offered on a stand alone basis

ODS Health Plans
Benefit Plan Guidelines

- Rates are guaranteed for a 12-month period for individual employers except in the case of:
  - Government mandated benefit change
  - New or revised government taxes imposed
  - An amendment of the benefit plan or contracts
  - Addition or deletion of a subsidiary, corporate division, or affiliated companies
  - Any change in employer contribution, employee eligibility, or probationary period
  - Enrollment change of 10% in any single month or a 25% in any three consecutive months
  - COBRA enrollment exceeds 10% of the total membership
- Employers must not have any other medical or prescription plans, other than that provided through the AET* Benefit Program
- Plan election is effective for 12 months from initial or renewal election. No plan changes will be permitted off anniversary of the group effective date
- HRA Plans must be paired with a Prescription Drug Plan
- HSA Plans already include a Prescription Drug Plan

Consumer Driven Health Plans (Health Savings Account and Health Reimbursement Accounts)

- Employer contribution may not exceed 50% of the plan deductible
- Employer must contribute an equal percentage of the employee cost for both the CDHP and non-CDHP plans when dual choice offerings are elected (see dual choice guidelines)

Dual Choice Guidelines

- Employers may offer two plans **(*Dual Choice*)** to their employees based on the following guidelines:
  - Minimum group size of 10 enrolled employees
  - No minimum requirement for each plan
- Plans offered through dual choice are limited in pairing. Please refer to the "Dual Choice Matrix" which can be found on the website at www.aetbenefits.com or www.alltechbenefits.com

Washington Dental Service Dental Plans

- If employer offers both medical and dental with AET*, the employee enrollment must be the same for both plans. Dependent enrollment can differ from medical/vision enrollment.
- Requires 75% participation of eligible employees for employers with **AET* dental only**
- Employers with 5 or more employees may purchase a stand-alone dental plan
- Current AET* employers (as of 12/31/06) will be grandfathered in on either the Composite or Tiered Premium billing method
- All new employers enrolling in an AET* dental structure will be billed on a tiered rate structure
- Employers may choose a $1000 or $2000 calendar year maximum benefit for either plan
- Employers may choose either an Adult/Dependent or Children only Orthodontia Rider

Vision Service Plan Vision Hardware Plans

- Requires 75% participation of eligible employees
- Enrollment must match medical enrollment

Standard Life Insurance Company Plans

Basic Life and AD&D

- The compulsory basic life and AD&D benefit of $15,000 is required for all member companies. Premiums for this benefit are built into the overall medical rate billed
- Employers may elect buy-up options of an additional $15,000 to an overall $30,000 (Option A) benefit or an additional $35,000 to an overall $50,000 benefit (Option B)
- Employers may elect buy-up options of 1 time (Option C) or 2 times (Option D) annual salary for employees. The compulsory basic life benefit is required to purchase these buy-up options. All employees will be enrolled on this benefit and must supply current salary information on an annual basis or at time of salary changes

Dependent Life

- Requires 100% participation of eligible employees
- Requires participation in an AET* medical plan
  Employee enrollment must match medical
  Only those employees with dependents enrolled in medical coverage will be billed for the benefit
- Employers are not required to purchase voluntary employee life in order to purchase dependent life
- No evidence of insurability requirements

Group Short Term Disability (STD) (Product not available to ALLtech groups)

- Requires 100% participation of eligible employees
- Requires participation in an AET medical plan
  Employee enrollment must match medical
- Rates are based on per $10 of coverage
  Employers will be billed the benefit maximum for all employees
- Member companies of the AET prior to 12/1/2007 are required to carry the base Short-term Disability benefit (Option A)
- Employers who purchase the buy-up Short-term Disability (Option C) are required to also purchase the base Short-term Disability benefit (Option A)

Group Long Term Disability (LTD) (Product not available to ALLtech groups)

- Requires 100% participation of eligible employees
- Requires participation in an AET medical plan
  Employee enrollment must match medical
- All employees will be enrolled on this benefit and must supply current salary information on an annual basis or at time of salary changes

Voluntary (Supplemental) Life and AD&D

- Employer must elect to offer this benefit to its employees
- Requires no less than 20% of the eligible employees to enroll
- Evidence of Insurability will be required for any amounts over the Guaranteed Issue amount of $25,000
- Spouse benefit amount will be half the amount of the employee and premiums are based on the employee's age
- Dependent children benefit is $10,000

How to Enroll and Renew

NEW GROUP SUBMISSIONS

The employer's producer is to submit new group paperwork to WFIS by the 15th of the month prior to the effective date to ensure eligibility is loaded on the carriers' systems prior to the first of the month effective date.

Required materials must be submitted complete and include all of the following (no partial submissions will be accepted).

☑ **Binder Check**

- Make check payable to "Associated Employers Trust" or "ALLtech", as applicable.

☑ **Group Master Application**

- The Group Master Application must be completed to indicate the Compulsory Benefit Selection(s), Bundled Product Selections, Eligibility and Participation Requirements, TEFRA, COBRA and FMLA Designation, Prior Coverage Information, Health Risk Questionnaire and the Wellness Program designation. The Group Master Application must be signed by both the group and the producer.

☑ **Updated Group Health Risk Questionnaire**

- All new group paperwork must include an updated AET* Group Health Risk Questionnaire (HRQ). No groups will be processed without this information provided.
  - The HRQ must be the AET* HRQ (alternative or outdated AET* HRQs **will not** be accepted).
  - The updated HRQ must be signed by the same group representative and producer who sign the Group Master Application (GMA). We will not accept the name and title of the group representative and that it was a phone interview in lieu of the signature for new group submissions.
  - It must be dated the same date as the GMA.
  - The HRQ will not be accepted without all questions answered. If an answer is zero ("0"), then include that in the field. If the group or the producer has no knowledge of the information being requested, include "Not available" in the comment field of each such question.
  - Include any and all information already provided and that may have been vetted out during the quoting process.
  - Please be sure that you are using the most current HRQ (found in the forms library at: (www.aetbenefits.com or www.alltechbenfits.com) as **old versions will not be accepted**.

☑ **Groups Electing 100% Participation**

- For all groups indicating 100% participation of eligible employees, a copy (all pages, including grand totals) of the most recent state Quarterly Wage and

Tax Report (QWR)/Form 5208 is required for all sold groups, unless eligible to submit payroll records as stated below.

- Employer must indicate employment or eligibility status for each employee listed on the submitted Form 5208: A (any employee submitting an Application), W (Waiving), P/T (Part-Time), T (Terminated/including termination date), S (Seasonal) and WP (Waiting Period).
- All newly sold groups must submit a copy of their prior carrier bill in order to have prior coverage credits applied appropriately.

  - **Payroll Records**
    - For groups that have not yet filed a Form 5208 or have been in business more than one year, a current two-week payroll statement (all pages, including grand totals) may be submitted in lieu of a Form 5208. Indicate employment or eligibility status for each employee listed on the submitted payroll: A (any employee submitting an Application), W (Waiving), P/T (Part-Time), T (Terminated/include termination date), S (Seasonal) and WP (Waiting Period). If a two-week pay period date/payroll statement is submitted (listing all employees), it must include totals of employee wages paid, withholdings and grand totals. Separate sheets or individual pay stubs are not acceptable.
  - **Proof of Ownership**
    - In addition to the above wage and tax information, owner-only groups (without a QWR) would require proof of ownership/tax documentation for all owners/officers/partners enrolling.

Type of Business	Required Documentation
Corporations	○ In business < 1 year: Articles of Incorporation listing all enrolling officers' names ○ In business > 1 year: S-Corps: IRS Schedule K-1 (Form 1120s) for all enrolling Owners/Officers ○ C-Corps: IRS Form 1120 (pages 1 & 2) which includes "Schedule E"
Partnership/LLP	○ In business < 1 year: Partnership Agreement signed by all partners. ○ In business > 1 year: IRS Schedule K-1 (Form 1065) for all enrolling partners or a Partnership Agreement signed by all partners
Limited Liability Company (LLC)	○ In business < 1 year: LLC Agreement signed by all managers/members parties ○ In business > 1 year: LLC Agreement signed by all managers/members/parties or copies of appropriate tax returns (follow the guidelines for a Partnership or Sole Proprietorship based on how the LLC was formed)
Sole Proprietorship	○ In business < 1 year: Business License ○ In business > 1 year: IRS Schedule C (Form1040)
Farms	○ IRS Schedule F (Form 1040)
Common Ownership	○ Group's attorney or CPA must complete a ODS Health Plans standard form regarding Common Ownership

- ☑ **Enrollment & Waiver Forms**
  - Use the enrollment form to waive coverage by marking appropriate boxes provided.
  - Due to new CMS requirements, Social Security Numbers for all Employees and their dependents must be included. No "Dummy" numbers will be accepted and the group will not be processed until all are present.
  - When COBRA carry-over enrollees are eligible, the COBRA Carry-Over Election Form must be completed by each COBRA participant electing coverage with AET*. The form must be submitted in a timely manner to prevent delays.
- ☑ **Deductible Credits** can be applied with proof of Deductible payment through the latest EOB.
- ☑ **Associated Industries Membership Application & Dues (All counties except Clark County and ALLtech)**
  - Make check payable to "Associated Industries"
    - **Basic Service Membership**:
      Application can be found at www.aetbenefits.com
    - **Full Service Membership**:
      Application can be found at www.aetbenefits.com
    - **For employers located in Clark County, membership with the Greater Vancouver Chamber of Commerce is required.
      For more information visit: www.vancouverusa.com**

Renewing Group Submissions

All renewing groups are required to complete the renewing year's group master application found in the forms library at www.aetbenefits.com and www.alltechenefits.com.

Renewal dates depend on the type of coverage and inception date.

- ODS Health Plans: The medical renewal date will be 12 months from the effective date of issue. If coverage begins on August 1st, the renewal will be August 1st of the following year.
- Dental, Vision, voluntary Life, STD and LTD: The renewal date will be 12 months from the effective date of issue. If a group adds a line of coverage during the year other than the medical effective date, the renewal for these lines of coverage will be effective at the time of the medical renewal. All groups must have common effective dates for all lines of coverage within the year that the new coverage has been elected. For example, a group's effective date for medical is January 1st and the group adds dental on August 1st of the same year, the renewal for the dental will be the following January 1st to coincide with the medical renewal.

All renewal information is sent to the employer designated AET* credentialed producer. The producer is responsible for contacting the group regarding the new rates and any benefit changes.

A renewal workbook is sent to the producer 45-60 days prior to the renewal date. Wells Fargo will send the packets as soon as the information is available to us. It is always the goal to send them at least 45 days prior.

The packet includes a letter explaining any benefit and administrative changes to the plans, the renewal rates for all plans and benefits. A new Group Master Application is required for all renewing groups. This is regardless of any plan or benefit changes. Open enrollment is the month before the renewal date (i.e. the open enrollment for January would be the month of December.)

Renewals must be returned to the Program Manager (Wells Fargo Insurance Services) no later than twenty (20) days before the renewal date.

COMPLETING FORMS FOR ENROLLMENT

All updated forms can be found in the, "Forms Library" at www.aetbenefits.com and www.alltechbenefits.com. Forms are clearly labeled with the year in the title in which the enrollment is taking place. Non-current forms will not be accepted in any circumstance.

Group Master Application

(New and renewing groups - three pages)

- Section 1 - Company Information (ALL FIELDS REQUIRED)
  - Please provide the complete company and include "DBA" if applicable. Also mark which name provided you would like to have on the medical ID cards
  - Employer Tax ID#, business type and nature of business. SIC is required
  - "Group Benefit Administrator." Group contact information for all AET* correspondence pertaining to eligibility, programs, updates and communications
  - "Endorsed Sponsor Membership" Preferred rating under Endorsed Sponsor. Membership ID and date membership paid through is required to obtain Preferred rating.
  - "Billing Contact" Group contact information for all premium payments, delinquencies or issues. Please mark "Same" if the same as group benefits administrator
  - Street and billing addresses
  - Contact Emails: This is extremely important as a majority of AET*-related correspondence and updates is via email
- Section 2 - Base Product Selections
  - Choose the medical and Rx plan that you wish to elect for the upcoming year.
  - Mark Wellness Participation, "Yes" or "No" depending on your intent. Marking "Yes" will enroll you in the program and subsequent materials will be delivered upon launch of the program
  - Mark EAP election, "Yes" or "No" depending on your intent.
- Section 3 - Buy-up Selections
  - Choose any Life, Disability, Dental or Vision Hardware plans that you wish to elect for the upcoming year
  - Please be sure to review and abide by the enrollment guidelines stated in this document
- Section 4 - Eligibility and Participation Requirements
  - Please provide the necessary information that is to be administered to all employees of the company
    - Minimum Hours to define an eligible employee (minimum 20 hours)
    - Probationary/Introductory Period Election (no longer than 12 months)
    - Class differentiation can be applied to the above two elections

- Indicate how probationary period is to be applied to part-time employees who become full-time employees
- List the percentage of premiums that the employer will pay toward the overall premiums of each employee and dependent (no less than 50% contribution by the employer is allowed)

- Section 5 - Employee Enrollment
  - Follow the formula to determine the participation percentage of enrolled versus waiving or ineligible employees. The total number of eligible employees enrolling cannot be less than 50% of the total number of eligible employees (Line D)
- Section 6 - Current Medical Plan Information (new groups only)
- Section 7 - COBRA/TEFRA/OBRA/FMLA Designation
  - Please mark your designation.
- Section 8 - Rates (REQUIRED)
  - Please include the rates as provided on the quoting or renewal materials released by Wells Fargo Insurance Services for all lines of coverage elected. This is acknowledgement of what will be billed for the upcoming year
- Section 9 and 10 - Adoption of the Trust Agreement and HIPAA and Fraud Statements
  - Please read carefully
- Section 11 - Signature Section
  - Provide Producer information. This is your appointment for the year that will supersede all previous producer designations until a subsequent producer of record letter is received by our office
  - Producer must indicate legal name for the 1099 commission payment
  - Please read the agreement and review the entire document for completeness
  - Sign and date

Employee Enrollment and Change Form

(Required for new groups, new employees, changes to current enrollment and terminations 2 pages)

No other enrollment forms will be used except the specific AET* Enrollment & Change Form. Make sure you complete the form accurately and legibly. Enrollments with errors, ambiguities and/or illegible information will take longer to process and are more likely to cause errors. Forms with any missing information, such as date of birth, date of hire or enrollment reason will not be processed and will be returned. You must print clearly or type the form.

- **To be completed by the Group Benefit Administrator**
  - Section 1 - Group Information
    - Group name as indicated on the Group Master Application
    - Effective date of the enrollment or change to be designated by this form
    - Date of hire of the employee
    - Rate of Pay for all benefits that premium is determined based on salary information
    - Mark purpose of the form and applicable fields
    - Enter the employees worksite state (Section 2), if other than Washington state, where medical services may be rendered.
- **To be completed by the Employee**
  - Section 2 - Employee Information
    - Name, Marital Status, Gender, Date of Birth (Required for enrollment for both employee and dependents), SSN (Due to new CMS requirements, Social

Security Numbers for all Employees and their dependents must be included. No "dummy" numbers will be accepted and the enrollment form will not be processed until all are provided), home phone and addresses
    - Enter the employees' worksite state if other than Washington state, where medical services may be rendered.
- Section 3 - Enrollment Information
    - Choose whether to elect or waive from the medical plan and indicate the name of the plan chosen
    - Choose whether to elect or waive from the dental plan and indicate plan chosen (if employee is enrolling in the medical, the dental must also be elected if offered by the employer with less than 25 employees).
    - Choose whether to elect or waive from the Vision plan and indicate plan chosen.
    - Voluntary employee and dependent life and AD&D are to be chosen if the employer has chosen to offer the benefits to the employees. Specify the amount of coverage for Voluntary (Supplemental) Life and AD&D
    - List all enrolling parties within the family. Mark Add, Drop or COBRA
    - Also mark Medical and/or Dental. The SSN and Date of birth is required for all dependents, if incomplete the enrollment will not be processed.
- Section 4 - Prior Medical Coverage
    - Mark and provide necessary information
- Section 5 - Coordination of Benefits
    - Provide information if employee is insured with coverage elsewhere
- Section 6 - Designation of Beneficiary
    - Complete information
- Section 7 - Read disclaimer and sign and date the form

Domestic Partnership

See page 7 for details.

Waiver Form

If an employee is waiving coverage on the enrollment and change form, this supplemental form must be completed to list reason for waiving and sign below the disclosure language.

Deductible Credit Form

For employees who have eligible deductible payments that can be credited with the new AET* coverage **(not available to new employees, only newly enrolling groups with AET*)**, complete all fields of this form and accompany it with the latest explanation of benefits from the prior carrier. Must be submitted within 90 days of the group effective date.

COBRA Administration

All COBRA eligible member companies are automatically enrolled in Associated Industries COBRA Administration program free of charge. See page 22 for more detail

How to Terminate Coverage

HOW TO TERMINATE COVERAGE FOR AN EMPLOYEE:

Use the AET* Employee Enrollment & Change Form

- Mark the box next to “Termination” near the top of the form in Section 1
- Fill in the “Last Day Worked”, “Last Day Compensated” and “Date Coverage Ends” in Section 1 and indicate Voluntary or Involuntary
- Put the employee’s actual last day of work in the Date of Termination and note the qualifying event in the “Reason Section”
- Enter all of the employee information in Section 2
- Sign the Employer signature box and date it
  - You do not need an employee signature when an employee terminates employment

TO TERMINATE COVERAGE FOR A DEPENDENT ONLY:

Use the AET* Employee Enrollment & Change Form.

- Enter the last day of the last month of coverage in the effective date box in Section 1
- Mark the box next to “Change” near the top of the form in Section 1
- Choose “Remove dependents” and fill in the “Date” and “Reason” fields immediately following
- Enter the employee information in Section 2
- Enter the dependent information in Section 3, marking the “Drop” box to the left of the dependent name
- The employee must sign the left box on the last page. The group administrator should sign the right box on the last page
- Please note that if you terminate coverage for a dependent, you cannot re-enroll them in coverage without a qualifying event or open enrollment period

WHEN COVERAGE ENDS

Coverage Termination

Coverage will end without notice, on the last day of the month for which premiums have been paid, when any of the following events occur:

- The contract between the Program and the insurance carrier is terminated
- The next month for which premium is not paid when due
- The employee dies or is otherwise no longer eligible as an employee (for example, the employee’s employment terminates)
- The participating employer ceases to meet the Program’s continued participation requirements
- The participating employer notifies their Producer that it no longer wishes to participate in the Trust. Such notice must be received prior to the next premium due date, otherwise the participating employer will be charged for an additional month’s premium
- For a spouse/dependents:
  - When his or her marriage to the employee is annulled
  - When he or she becomes legally separated or divorced from the employee
  - For a domestic partner, when his or her domestic partnership relationship with the subscriber is ended (See Appendix)

- For a child when he or she no longer meets the requirements for dependent coverage
- Employee can voluntarily cancel spouse and children at any time

Employees who are rehired within ninety (90) days of termination will not have to re-satisfy their probationary benefits period.

It is the responsibility of the employee to notify the participating employer when an enrolled dependent is no longer eligible to be covered as a dependent under the Program. The participating employer must then notify the AET* within thirty (30) days of the date the participating employer was notified of such event. Retroactive adds and terminations are only available for sixty (60) days from the date of effective date to notification to the carrier, not when received by Associated Industries.

Leave of Absence

Coverage for a subscriber and enrolled dependents may be continued for up to ninety (90) days when the employer grants the subscriber a leave of absence and subscription charges continue to be paid.

The ninety (90) day leave of absence period counts toward the maximum COBRA continuation period, except as prohibited by the Family and Medical Leave Act of 1993.

Certificate of Health Coverage

A participant will receive a "Certificate of Health Coverage" when they terminate. The certificate will provide information about their coverage period under this Plan. They will need this certificate for their new health plan to receive credit toward any waiting period for preexisting conditions (if applicable.) More information can be found in the Plan booklet(s) under the Section titled "Certificate of Health Coverage."

COBRA Administration

Overview of COBRA Law

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce and other life events. Qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost to the plan.

COBRA generally requires that group health plans sponsored by employers with twenty (20) or more employees in the prior year offer employees and their families the opportunity for a temporary extension of health coverage (called continuation coverage) in certain instances where coverage under the plan would otherwise end.

COBRA outlines how employees and family members may elect continuation coverage. It also requires employers and plans to provide notice.

COBRA applies to group medical, dental and vision benefits. COBRA does not apply to benefits that are not group health plan benefits (i.e. LTD, STD, AD&D.)

Legal Responsibilities Under COBRA

It is the responsibility of the plan administrator to properly administer COBRA. The employer is the plan administrator for the group coverage, and no other entity. Employers may elect to delegate the COBRA administration responsibilities to a COBRA Administrator, but the full legal responsibility under law remains with the employer.

Please review the Department of Labor's *"Employer's Guide to Group Health Continuation Coverage Under COBRA – The Consolidated Omnibus Reconciliation Act of 1986"* [View] for more information regarding COBRA responsibilities and laws (or visit the Department of Labor website for the most current version.)

AET* COBRA Default Administration

Associated Employers Trust refers to the current, in-force Group Master Application for each member company for COBRA eligibility. It is the responsibility of the group to indicate their COBRA eligibility and ensure they are compliant.

All COBRA eligible member companies are automatically enrolled in Associated Industries' COBRA Administration program free of charge.

Employers who wish to opt out of COBRA Administration through Associated Industries must complete and submit the "Voluntary Waiver of COBRA Services" to Associated Industries thirty (30) days prior to the effective termination of COBRA services or at new group installation with the Group Master Application.

Contact Associated Industries (A.I.) for more information about A.I.'s COBRA services.

COBRA Election

Qualified Beneficiaries have sixty (60) days from the later of the date of the qualifying event letter or the date benefits are terminated to inform the Trust COBRA Administrator of their desire to continue coverage. Once notified, the Trust COBRA Administrator will see that the Qualified Beneficiaries receive the necessary COBRA applications (which are included in the AET* election letter) required by each Insurer. The completed applications should be forwarded to the appropriate Insurer.

If the person requesting continued coverage is deemed "ineligible" for COBRA, the unavailability of COBRA notice shall be sent within fourteen (14) days from the date the person expresses their desire to continue.

PLEASE NOTE: For employers subject to COBRA, federal COBRA rights, including subsidy rights pursuant to the American Recovery and Reinvestment Act of 2009 are available for spouses. However, because federal law does not recognize domestic partnerships, even when employer-sponsored plans cover such partners, federal COBRA rights, including subsidy rights; do not apply to domestic partners.

Termination - AI must receive an AET* Enrollment and Change Form for the termination of the employee from the group administrator.

COBRA Enrollment - Within the allowed 60 days from the termination, AI must receive an AET* Enrollment and Change Form for the electing COBRA beneficiary.

COBRA Rollover - COBRA beneficiaries electing to continue with the COBRA when a group transfers into the AET* must complete an AET* COBRA Carryover form. For immediate enrollment, COBRA premium must be included in the first month's binder check. Enrollment will not be processed until COBRA premium is received.

Monthly Premiums

COBRA Beneficiaries will be charged the group rate, less miscellaneous group charges such as basic life and AD&D, plus an administration charge (between 0% and 2% of premiums). COBRA Premiums are not changed other than the annual insurance renewal, a change in Dependents or if a COBRA Beneficiary is determined by Social Security Administration to be "Disabled."

If a COBRA Beneficiary is deemed disabled, the Trust COBRA Administrator ***may*** charge an increased administration fee (between 0% and 50% of premiums.) Upon receiving renewal rates, the Trust COBRA Administrator will notify the COBRA Beneficiaries of the new premiums. The Trust COBRA Administrator does this, annually, during the renewal period, as the AET* is notified of plan and rates elected by each participating company for the coming year.

If the individual deemed disabled elects not to continue during the eleven month extension, the remaining family unit should be charged the standard administration fee (and not the 50% for disabled COBRA Beneficiaries.)

*All noted AET forms, benefits, guidelines and procedures provided by the TPA Associated Industries also applies to both ALLtech and GVCC, unless otherwise noted.**

Monthly Premium Tier Calculation

COBRA Rates under the AET* Plan are as follows:

- Employee only or Dependent only (Spouse or Child) will be billed the Employee only rate
- Employee & Spouse will be billed the Employee/Spouse rate
- Employee & Child(ren) will be billed the Employee/Child(ren) rate
- Employee, Spouse and Child(ren) will be billed the Employee/Spouse/Child(ren) rate
- Spouse & Dependent Child(ren) separate from the participating employee will be billed the Employee/Child(ren) rate
- Dependent Children (2 or more together) separate from the participating employee will be billed the Employee/Child(ren) rate

Premium Due Date

COBRA Beneficiaries must make timely premium payments to continue under the Company's group plan. There are two (2) different grace periods that will be offered to COBRA Beneficiaries prior to termination from any plan.

Initial Grace Period - Upon notifying the Trust COBRA Administrator of their desire to continue, the COBRA Beneficiary will have a **forty-five (45) day** grace period (commencing on the later of the date the Trust COBRA Administrator was notified of the continuation or the date premiums are due to the Insurer) to make their first premium payment.

Subsequent Grace Period - For all remaining COBRA premium payments, the COBRA Beneficiary will have a **thirty (30) day** grace period.

In the event a Beneficiary's premium is short by an "insignificant amount," a notice will be sent requiring the additional premium or the Trust COBRA Administrator may deem the payment as paid-in-full. The Trust never deems any short payment as "paid-in-full."

The Trust COBRA Administrator will use the postmark date as the determination if a payment is made in a timely fashion.

Termination From COBRA

The Trust COBRA Administrator shall terminate COBRA Continuation Coverage upon one or more of the following events:

Insurance Plan Termination - If a participating Member company (or the Trust, itself) terminates a group insurance plan for active employees, COBRA Beneficiaries will be notified and terminated from that plan only. If the participating Member company offers a new similar type of Insurance Plan ***or*** decides to go with a new carrier, the Trust COBRA Administrator will inform the COBRA Beneficiaries of their right to transfer their COBRA coverage to the new plan directly through the participating company. **The Trust COBRA Administrator is no longer responsible for premium, eligibility or COBRA obligations for the effected COBRA Beneficiary.**

Nonpayment of COBRA Premiums - COBRA Beneficiaries will be terminated for nonpayment of premiums if premiums are not postmarked within the applicable 45-day (initial) or 30-day (subsequent) grace period.

Coverage Under Another Group Plan - For COBRA Beneficiaries that obtain similar coverage under another group plan, the Administrator will notify the COBRA Beneficiary of their termination from the Company's Insurance Plan.

Prior to termination, the Administrator will review with the Beneficiary, the new group plan's preexisting condition limitations (if applicable.) If the COBRA Beneficiary's new group plan does not cover a preexisting condition (if applicable), the COBRA Beneficiary may continue under AET*'s COBRA plan until the end of the COBRA term.

Medicare Entitlement - Once a COBRA Beneficiary becomes entitled to Medicare ***(Part A and/or B),*** the Administrator may terminate COBRA Continuation Coverage. NOTE: For purposes of COBRA Administration, Part A of Medicare is as valid an enrollment as Part B, per ERISA rulings and DOL recommendations.

Prior to termination, the Administrator shall contact the COBRA Beneficiary and establish a date of termination so that there will be no lapse in coverage. Dependents already enrolled on Medicare, at the time of enrollment in the COBRA plan, may continue to the end of their COBRA term.

Insurance Company's Service Area - If a COBRA Beneficiary is enrolled in an insurance plan that requires members to reside in a specific geographical area and they move from that area, the Administrator shall notify the COBRA Beneficiary and terminate coverage. If another similar plan is available in that area, the Administrator can offer the plan to the COBRA Beneficiary. This is not, generally, used by AET* as ODS Health Plans and WDS have national networks.

Coverage may be terminated "for cause" due to fraudulent claims or other activities in which a similarly situated active employee would be terminated. Any "for cause" termination will be conveyed to the Administrator by the carrier.

If a disabled COBRA Beneficiary is deemed to no longer be disabled during the eleven-month extension, the entire family unit may be terminated. It is the beneficiary's responsibility to notify the Administrator of this cessation of disability and, if it is within the 11-month period, coverage under the COBRA plan will then terminate.

End of COBRA Term - Once the COBRA Beneficiary has reached the end of their COBRA time frame (either 18, 29 or 36 months), the Trust COBRA Administrator will send a termination notice. The COBRA Beneficiary has the right to convert to an individual plan (where available) that has no preexisting condition limitations. The Trust COBRA Administrator will provide a "Certificate of Coverage" detailing the completion of COBRA.

COBRA Beneficiaries have the right to a hearing if they disagree with any termination. At the COBRA Beneficiary's request, the Administrator will set up a hearing and have the appropriate Company managers attend to review the termination and decide on its validity.

COBRA Documentation

The Administrator will document every qualifying event, every qualified beneficiary electing COBRA, the selected plans and plan changes, and premium payments. Reports will be completed on a monthly basis, filed and **maintained for a minimum of seven (7) years.** Files shall be maintained for all qualified beneficiaries and will include copies of all COBRA-related notifications, correspondence, applications and election notices.

COBRA Notice Duties

On May 26, 2004 the Department of Labor (DOL) issued final regulations on the notice requirements for health care continuation coverage under the *Consolidated Omnibus Budget Reconciliation Act of 1985* (COBRA.) The regulations provide two safe harbor notices as well as create requirements for two new notices to be provided by employers or administrators. The regulations also clarify the timing requirements for providing the various notices. The regulations will become effective for years beginning on or after November 26, 2004, but may be relied on now.

Six notices are addressed in the DOL's regulations:

- The General Notice of Continuation Coverage;
- The Employer's obligation to provide notice to the plan administrator of certain qualifying events;
- The qualified beneficiary's obligation to provide notice to the administrator of certain qualifying events;
- The qualified beneficiary's Notice of Right to Elect Continuation coverage;
- The Notice of Unavailability of Continuation Coverage (a new notice requirement); ***and***
- The Notice of Early Termination of Continuation Coverage (also a new notice requirement.)

Notices

General Notice of Continuation Coverage

The General Notice must be provided to each new employee and his or her spouse within 90 days following the date the employee or the spouse, as applicable, first becomes eligible for coverage under the employer's group health plan (or, for a new plan, the General Notice must be distributed within 90 days following the adoption of the new plan.)

Furthermore, if a small employer crosses the 20 employee threshold test and becomes subject to federal COBRA, it must provide the General Notice to all employees covered under its group health plan by the 90th day of the calendar year in which it first becomes subject to COBRA. (Associated Industries does not provide initial General Notices and will remain the employer's responsibility.)

The General Notice may, and should, be incorporated in the Summary Plan Description (SPD) for the health plan.

The General Notice may be distributed to employees by means of electronic media. However, because the General Notice must be provided to each employee's spouse, it should be mailed to the last known address of each employee's spouse. Providing the General Notice to the spouse by mailing is an important step to avoiding future COBRA issues, especially in the event of a subsequent legal separation or divorce.

Therefore, the better form of distribution of the General Notice may be a mailing or other physical delivery to the employee's home if the spouse also lives at the same address. In such a case, only one notice must be provided.

Also, if the employee adds the spouse to the health plan after the date on which the employee is first covered, a COBRA notice must be sent to the spouse at that later date.

This notice to a newly added spouse is easy to overlook and can result in liability to the employer for failure to timely provide the COBRA notice.

The General Notice must include the following information:

- The name of the plan and the name and contact information for the person from whom additional information may be obtained;
- A general description of COBRA coverage;
- A description of the notice requirements in the event of divorce or a child ceasing to be a dependent and any special rules of the plan for providing such notice;
- An explanation of the disability extension of the COBRA continuation period;
- A statement of the importance of keeping the administrator informed of the employee's and dependent's current addresses; and
- A notice that more information is available from the administrator or from the SPD for the plan.

The DOL has provided a model safe harbor notice for this purpose.

Employer's Notice Requirements

The employer must notify the plan administrator of certain qualifying events if the COBRA responsibilities are outsourced and an outside administrator provides COBRA services for the plan. The employer must provide such notice to the outside plan administrator within thirty (30) days following any of these qualifying events: death of the employee, termination of service or reduction in hours of the employee, entitlement of the employee to Medicare, or for retired employees, bankruptcy of the employer.

Notice Requirements for Covered Employees and Beneficiaries

The regulations discuss the requirements for covered employees and beneficiaries to notify the plan administrator upon the occurrence of certain qualifying events, such as divorce, legal separation, a beneficiary ceasing to be covered under the plan as a dependent child, the occurrence of a second qualifying event, or notice of a Social Security determination of disability within sixty (60) days following the latest of:

- The date of the qualifying event;
- The date of the loss of coverage; ***or***
- The date on which the individual is informed, by means of the plan SPD or the general notice, of the individual's obligation to provide notice and the procedure for providing the notice.

The regulations require that a plan establish reasonable procedures for the provision of these required notices and communicate the procedures to the covered employees and beneficiaries. The notice procedures will be deemed to be reasonable if the procedures:

- Are described in the SPD for the plan;
- Specify who at the plan or the employer is to receive the notice;
- Specify how notice may be given; ***and***
- Describe what constitutes a qualifying event.

The regulations also describe the more lenient default procedures that will apply if a plan fails to establish reasonable procedures for meeting such notice requirements. The regulations also describe the timing requirements for such notices, including the required disability extension notification.

Notice of Right to Elect Continuation Coverage
This notice must be provided by the employer or the administrator, as applicable, to the covered employee or qualified beneficiary within fourteen (14) days following notice of a qualifying event. This notice must inform the covered employee or beneficiary that he or she has a right to elect COBRA continuation coverage.

The content requirements for the Notice of Right to Elect Continuation Coverage were not changed substantially by the new regulations. However, the following new content is required to be included in the Notice:

- An explanation of the consequences of failing to elect continuation coverage or waiving continuation coverage, including the effect on the future rights of qualified beneficiaries to portability of coverage and guaranteed access to coverage under HIPAA;
- A description of the plan's procedures for revoking a waiver of continuation coverage during the election period;
- An explanation of the importance of keeping the administrator informed of any address changes; ***and***
- A statement that the notice does not fully describe COBRA and that additional information is available from the administrator or the SPD.
  The DOL has provided a model safe harbor notice for this purpose.

NEW NOTICE REQUIREMENTS

The regulations also create two new notice requirements: the Notice of Unavailability of Continuation Coverage and the Notice of Termination of Continuation Coverage.

a) **Notice of Unavailability of Continuation Coverage**
The Notice of Unavailability of Continuation Coverage must be provided when the employer or administrator receives a notice of the occurrence of a qualifying event or a second qualifying event and then determines that the individual whose coverage is affected by the event is not eligible for the continuation coverage requested.

In such a situation, the administrator or employer must provide to the individual an explanation of why the individual is not eligible for the coverage. The notice must be provided within the same time period as applies to the Notice of Right to Elect Continuation Coverage.

No specific content is required for the Notice of Unavailability of Continuation Coverage other than that it must be written in a manner calculated to be understood by the average plan participant.

b) Notice of Termination of Continuation Coverage
The Notice of Termination of Continuation Coverage is required if the continuation coverage terminates earlier than the maximum continuation period available. The notice must be written in a manner calculated to be understood by the average plan participant and must identify the reason that the continuation coverage is terminating early, the date the continuation coverage will end and any rights the covered employee or qualified beneficiary may have to elect an alternative group or individual coverage, such as a conversion right.

The regulations do not specify a time frame for providing the Notice of Termination of Continuation Coverage other than it must be provided as soon as practicable following the administrator's determination that the continuation coverage will terminate.

Although the DOL regulations do not require a notice of the end of continuation coverage in the normal course, there is a requirement in the Internal Revenue Code to notify the covered individual of any right to convert to individual coverage.

This conversion right notice must be provided within 180 days prior to the date the continuation coverage is scheduled to end. In addition, state law may require a notice to be provided of the regularly scheduled end of continuation coverage.

For example, California law requires that individuals on continuation coverage receive notice of the upcoming termination of federal COBRA and be informed of any conversion rights as well as the right to extended coverage under Cal-COBRA for those qualified beneficiaries whose federal COBRA continuation coverage did not extend for 36 months.

Notice Delivery Requirements

The regulations provide guidance on the form of delivery of the various notices. Notice may be provided to the employee and spouse by mailing the notice, addressed to the employee and spouse, at the employee's home if, based on the most recent information available to the employer, the employee and spouse live at the same address.

The administrator may provide notice to dependent children who are qualified beneficiaries by providing notice to the employee or the spouse, if, based on the most recent information available, the dependent children live at the same address as the individual to whom the notice is provided.

Notices may be delivered in any manner generally accepted by the DOL for delivery of other ERISA-required notices, including the use of electronic media. However, while delivery to the employee by electronic media, for example, via the employee's e-mail at his or her worksite, will suffice for notice to the employee and to any dependent children living with the employee, such delivery will not meet the notice requirements for delivery to the spouse.

Unless the employer or administrator has the spouse's e-mail address and can confirm that the spouse received the relevant COBRA notice by e-mail, a mailing by U.S. mail or some other form of written delivery still must be used for notices that are required to be provided to the spouse.

Other COBRA Administration Options

Employers who wish to opt out of COBRA Administration through Associated Industries must complete and submit the "Voluntary Waiver of COBRA Services" to Associated Industries thirty (30) days prior to the effective termination of COBRA services or at new group installation with the Group Master Application.

Once the Voluntary Waiver of AET* COBRA Administrative Services has been received, AET* will provide plan information and rates directly to the assigned Third-party COBRA Administrator through the AET* COBRA Employer Specification Worksheet.

All communications, enrollment updates, eligibility changes and premium payment must be directed to Associated Employers Trust only. Change requests or payments made directly to the carriers will delay enrollment and cause disruption in COBRA beneficiaries' coverage.

COBRA Election

When notified by the employer, member terminations will be processed by AET* (no notifications or forms will be sent to the termed employee by AET*.) AET* COBRA Enrollment Forms must be sent by the Third-party COBRA Administrator to the termed employee (no alternate forms can be accepted.)

Please submit completed COBRA Enrollment Forms in an accurate and timely fashion. Copies of the COBRA election forms must be sent to the AET* COBRA Administrator. AET* will ensure enrollment information is forwarded to the appropriate carrier(s.)

Open Enrollment

When employer groups renew, the AET* will provide the Third-party COBRA Administrator an updated AET* COBRA Employer Specification Worksheet. In the event new plan selections are required, the COBRA Enrollment Forms must be submitted to the AET* in a timely manner.

Monthly Premium Payment

The AET* will bill the Third-party COBRA Administrator directly for COBRA beneficiaries. Invoices will be provided to the group, listing all active COBRA participants and the premium due. The invoice is generated on the 15th of the month for the next coverage month. Should there be any questions on the invoice, contact Michelle Walczak.

In the event premium payment is not received by AET* by the due date, coverage will be terminated and notice will be sent to the Third-party COBRA Administrator. No reinstatements will be allowed after the third request.

AET* COBRA Contact Information

Click here to access a list detailing AET staff contacts or visit our website at www.aetbenefits.com and www.alltechbenefits.com.

Understanding Your AET* Invoice

Invoices are generated on the 15th of each month for the next month's coverage. The AET* program is a pre-paid program.

Group Invoice Summary:

The Group Invoice Summary page lists your current monthly premium amount, premium and billing information for prior months and any past due amounts. Also reflected are credit or charge adjustments for late additions/terminations and balance due amounts for each, if applicable. **Please pay the total amount due as shown on the statement page**. Any adjustments will be reflected on your next invoice. **Premium payments are due the 1st of each month for the current month. If payment is not received by the 10th, coverage may be retroactively terminated to the paid through date.** A reasonable late fee of 12% per annum will be charged for payments not received by the 10th of the month due. In the event a non-sufficient funds check is received, a $30.00 fee will be charged to your account.

Group Invoice Summary

Invoice Period: September 1 - 30, 2010
Invoice Number: 44790
Invoice Date: August 20, 2010
Page 1 of 1

Sample Company
Sample Street

Sample City, WA 99999

Balance from Previous Invoice Summary	6,367.88
Payments and Adjustments posted since previous Invoice Summary	-6,367.88
Balance Forward	.00

Employee Name	L4-SSN	Policy Number	Current Premium Billed
LastName,First	3984		927.67
LastName,First	2763		927.67
LastName,First	3734		306.14
LastName,First	3948		927.67
LastName,First	1758		927.67
LastName,First	3975		927.67
LastName,First	2570		306.14
LastName,First	8265		306.14
LastName,First	9237		635.87
LastName,First	0702		306.14
LastName,First	9246		306.14
LastName,First	7233		927.67
LastName,First	2272		572.29
Total Current Premium			8,304.88
Balance Forward			.00
Total Amount Due September 1, 2010			8,304.88

*COBRA

* Please Note *

Your invoice is due and payable the first of the month. Unpaid accounts as of the tenth of the month are subject to cancellation according to contracts with the insurance carriers. Please pay your invoice as billed. Failure to pay as billed may result in a delay of posting your payment. Thank you.

INVOICE DETAIL PAGE

The invoice page reflects those employees who are currently enrolled and the premium billed. It is very important to review who is listed to ensure our records reflect only those who should be enrolled. Do not make any changes on the invoice page.

Any changes in enrollment should be noted on the Billing Reconciliation Adjustment Form. The total current month premium is listed on the statement page and is included in the total amount due.

Sample Company

Invoice Detail 44790

Page 1 of 1

For the Month of September 2010

Name	L4-SSN	Medical	Spouse	Dep	Plan	Vision	Spouse	Dep	Dental	Spouse	Dep	Plan	Life	Plan	Dep Life	AD&D	STD	LTD	Total
LastName,First	3984	799.44	☑	2		0.00	☐	0	128.23	☑	2	00155	0.00		0.00	0.00	0.00	0.00	927.67
LastName,First	2763	799.44	☑	2		0.00	☐	0	128.23	☑	2	00155	0.00		0.00	0.00	0.00	0.00	927.67
LastName,First	3734	260.92	☐	0		0.00	☐	0	45.22	☐	0	00155	0.00		0.00	0.00	0.00	0.00	306.14
LastName,First	3948	799.44	☑	2		0.00	☐	0	128.23	☑	2	00155	0.00		0.00	0.00	0.00	0.00	927.67
LastName,First	1758	799.44	☑	3		0.00	☐	0	128.23	☑	3	00155	0.00		0.00	0.00	0.00	0.00	927.67
LastName,First	3975	799.44	☑	3		0.00	☐	0	128.23	☑	3	00155	0.00		0.00	0.00	0.00	0.00	927.67
LastName,First	2570	260.92	☐	0		0.00	☐	0	45.22	☐	0	00155	0.00		0.00	0.00	0.00	0.00	306.14
LastName,First	8265	260.92	☐	0		0.00	☐	0	45.22	☐	0	00155	0.00		0.00	0.00	0.00	0.00	306.14
LastName,First	9237	543.00	☑	0		0.00	☐	0	92.87	☑	0	00155	0.00		0.00	0.00	0.00	0.00	635.87
LastName,First	0702	260.92	☐	0		0.00	☐	0	45.22	☐	0	00155	0.00		0.00	0.00	0.00	0.00	306.14
LastName,First	9246	260.92	☐	0		0.00	☐	0	45.22	☐	0	00155	0.00		0.00	0.00	0.00	0.00	306.14
LastName,First	7233	799.44	☑	2		0.00	☐	0	128.23	☑	2	00155	0.00		0.00	0.00	0.00	0.00	927.67
LastName,First	2272	491.71	☐	1		0.00	☐	0	80.58	☐	1	00155	0.00		0.00	0.00	0.00	0.00	572.29
* COBRA		7,135.95				0.00			1,168.93				0.00		0.00	0.00	0.00	0.00	8,304.88

Note: Please pay by the Invoice Summary

PAYMENTS AND ADJUSTMENTS PAGE

The adjustment page reflects any retroactive additions and/or terminations processed between the prior invoice and the current invoice. These adjustments are reflected on the statement page. The balance due, if any, is reflected on the statement page and is included in the total amount.

Retro Adjustment Guidelines (Late Additions or Terminations): It is very important that enrollment changes, additions and terminations are submitted to the AET* in a timely manner. This ensures accurate billing and minimizes claims and eligibility issues with the carriers.

All enrollment additions, changes or terminations must be reported to the AET* within 60 days of the intended effective date. Notices received outside this timeframe will not be processed as requested and may result in additional premium owed.

Sample Company

Payments and Adjustments for the Month of September 2010

Page 1 of 1

Inv No.	Date	Amount	Code	Reason	Subscriber	L4-SSN	Plan
17700	08/09/2010	-6,367.88		Payment			
	Net	-6,367.88					

Remittance Copy

When submitting your monthly premium payment, please include with your payment a completed copy of the Remittance Form (sample below) that comes with your Invoice.

Please return this page with your payment. In the event the invoice is not paid as billed, note any changes that modify the amount of the invoice and payment.

Remittance Copy - Return with Payment

Sample Company
Sample Street

Sample City, WA 99999

Invoice Period:	September 1 - 30, 2010
Invoice Number:	44790
Total Premium Due:	8,304.88
Payment Due Date:	September 1, 2010
Amount Enclosed:	

Please attach the Enrollment/Change form for any additions/changes

All approved changes will post to next month's invoice - PLEASE PAY TOTAL DUE NOTED ABOVE

Subscriber Name	SSN	Coverage Tier E, ES,EC,FAM	Effective Date	Last Day Worked	Voluntary/ Involuntary	Insurance End Date	Premuim Change (+ or -)

PAY AS BILLED - APPROVED PREMIUM ADJUSTMENTS WILL POST NEXT BILLING PERIOD

Remit to: Associated Employers Trust
1206 N. Lincoln St., Ste 200
Spokane, WA 99201

Your invoice is due and payable the first of the month. Unpaid accounts as of the tenth of the month are subject to cancellation according to contracts with the insurance carriers. Please pay your invoice as billed. Failure to pay as billed may result in a delay of posting your payment. Thank you.

Eligibility Timing and Processing

- Medical Eligibility is sent to ODS Health Plans electronically on a weekly basis.
- Dental Eligibility is sent to WDS electronically on a weekly basis.
- Vision Eligibility is sent to VSP electronically on a weekly basis.

The Member Enrollment and Change Forms can be sent via ***email*** to aet@aiin.net or alltech@aiin.net ***faxed*** to 509.328.6832 or by ***US Mail***.

Applicable Laws

HIPAA Portability

If an employee and/or dependent had insurance coverage within thirty (30) days of becoming eligible for coverage under the Trust, the time spent on that plan will count toward satisfaction of the Trust's pre-existing condition waiting period.

If the participating employer has a probationary period and the employee and/or dependent had coverage within the prior thirty (30) days, the probationary period will be counted toward the pre-existing condition waiting period upon enrollment in the plan. This is called "creditable coverage," and is defined as Medicare, Medicaid, TriCare, FEHBP, Indian Health Service, State Health Benefits risk pool, Peace Corps plan, other public health plan or prior group or individual coverage. There are certain prior coverages that do not apply. Please contact your legal counsel or producer for more information.

Benefits portability does not apply to the six (6) month transplant waiting period, unless the prior coverage was with another ODS Health plan.

HIPAA Privacy Rules

The AET* Benefit Program and its insurance carriers are subject to all federal privacy restrictions effective April 14, 2003. Procedures are in place to process protected health information as required.

> *Please note: Due to the restrictive nature of these federal requirements, Administration Office and carrier personnel will not be able to respond to unauthorized inquiries and requests for information.*

FMLA Administration

The FMLA applies only to employers that employed fifty (50) or more employees during each of the twenty (20) or more calendar work weeks in the current or preceding calendar year and that are required by federal law to comply with FMLA provisions. Under this provision, eligible employees may receive up to twelve (12) weeks of leave during a twelve (12) month period, as provided by FMLA, under the following circumstances:

- The birth of an employee's child
- The placement of a child with the employee for adoption or foster care
- Care for the employee's seriously ill spouse, parent or child
- The employee's own serious physical or mental health condition

Benefits must be continued for employees on FMLA leave. Any payroll deduction must continue to be paid by the employee. Please contact your legal counsel or producer for more information.

To assist the employer in its FMLA obligations, the Trust will continue to receive premium payments as if the employee was actively at work.

Medicare Secondary Payer (MSP) Rules

The AET* Benefit Program will be primary over Medicare coverage for active employees and dependents.

Qualified Medical Child Support Orders (QMCSO)

The AET* Benefit Program will comply with any court ordered enrollment of a child for benefits, whether it be as a result of divorce or governmental requirements.

USERRA Administration

USERRA (Uniformed Services Employment and Re-Employment Rights Act) has provisions that allow an employee, who is called up to military service, the right to continue coverage for up to eighteen (18) months by paying the monthly premiums. This is true even for employers that are too small to comply with COBRA.

There are other employment-related issues that go along with this legislation, including (but not limited to) having to hold the employee's position until he/she returns from service. For further information on USERRA, please contact your legal counsel or producer.

Frequently Asked Questions

QUALIFYING EVENT FAQS

WHAT IS A QUALIFYING EVENT?

It is an event that qualifies an employee or a dependent for a change in coverage. Some common examples are loss of other coverage, marriage, birth/adoption, or change in employment status. Below is a chart of qualifying events and what action is allowed.

Table of Authorized Change of Election Events	**Insurance Plan**
Change in Legal Marital Status or Number of Dependents: Marriage, Domestic Partnership, Divorce, Legal Separation, Annulment, Death of Spouse or Dependent, New Child (birth, adoption or placed for adoption)	Yes
Gain or Loss of Employment Going from Full-Time to Part-Time or Part-Time to Full-Time Change in Work Schedule Due to Strike or Lockout Resulting in a Loss of Eligibility Return from or Commencement of Unpaid Leave of Absence Gain/Loss of Coverage under Participant or Dependent's Health Plan Change of Employment Status Impacting Eligibility for Health Plan	Yes
Dependent Satisfies, or Ceases to Satisfy, Requirements for Dependents	Yes
Change in Residence or Work Site That Affects Eligibility	Yes
Judgment, Decree or Order resulting in the Plan Receiving a Qualified Medical Child Support Order	Yes
Employee/Dependent Medicare or Medicaid Eligibility Change	Yes
Employee Entitled to Special Enrollment Rights under HIPAA	Yes
A Change in Status Occurs that Entitles an Employee, Spouse or Dependent to COBRA Coverage	Yes

Incomplete Forms FAQs

Will I Be Notified if I Send In an Incomplete Form?

Generally, yes. Associated Employers Trust will attempt to contact you if you have not completed a form or if there are discrepancies. If AET* is unable to contact you; incomplete forms will be returned with a letter explaining why the form could not be processed.

What are some common pitfalls?

- Effective date: Please consult the "How to Enroll" section for information on effective dates. If you have questions about your probationary period or what the effective date should be, the Associated Employers Trust team at Associated Industries will be happy to help you and answer any questions you may have.
- Illegible handwriting: If handwriting is hard to read it is more likely to cause an error, resulting in coverage problems. Please ensure all forms are completed legibly or typed.
- Mailing address: Employees should include their street address, city, state, and zip code in the "Employee Information" section. Employees frequently write their street address but neglect to include a city, state, or zip code.
- Signature: Both the employee and employer need to sign the enrollment form.
- Outdated Forms: Please check the AET* Benefit Program website for the most up-to-date forms. Forms are located in the Forms Library in the "Employers" section of the website: www.aetbenefits.com or www.alltechbenefits.com

Miscellaneous FAQs

What Is Open Enrollment?

Open enrollment is the month before the plan renews. During this period, employees may add and drop coverage with no other qualifying event. Employers may also change the coverage that is offered. To find out which month your group renews, consult your Group Master Application or your producer.

WHERE DO I FIND…

- **Enrollment Forms** Forms can be found here: http://www.aetbenefits.com/em_forms.html or http://www.alltechbenefits.com/em_forms.html

- **Benefit Booklets**

  Employers obtain access to medical benefit booklets through a secured website using a password supplied by the medical insurer when the group is initially enrolled. If you need additional materials, please contact Associated Employers Trust. The AET* website also has various plan highlights at: http://www.aetbenefits.com/employers.html or http://www.alltechbenefits.com/em_forms.html

I DO NOT UNDERSTAND WHAT MY PLAN OFFERS. WHOM CAN I CALL TO GET FURTHER CLARIFICATION?

For information relating to what types of services are covered, reimbursement, and claims, please contact customer service at the insurer or your producer.

MY RENEWAL?

Specific questions about your renewal, including definition of terms and the difference between options should be directed to your producer. Renewal information is provided by Wells Fargo Insurance Services directly to your producer. If you believe you should have received renewal paperwork and have not yet received it, please contact your producer.

NEW GROUPS FAQS

HOW DO I VERIFY THAT MY MEMBER ENROLLMENT & CHANGE FORM HAS BEEN PROCESSED?

When submitting your enrollment forms, please send them to aet@aiin.net or alltech@aiin.net and you will receive a message verifying that your enrollment form has been received. To verify the accuracy of the enrollment information on the AET* files, please review your monthly premium invoice. In the event of an urgent inquiry, please contact AET* for enrollment questions. AET* will be able to confirm if enrollment has been processed and the effective date of coverage.

ENROLLMENTS/CHANGES?

Please send enrollment/change questions to Associated Employers Trust. Enrollment requests should be submitted prior to the 15th of the month in order to be reflected on the following month's billing. Enrollment forms can be emailed to aet@aiin.net or alltech@aiin.net

CLAIMS?

Questions about claims should be directed to the insurer. Please note that neither Associated Employers Trust nor Wells Fargo Insurance Services adjudicate claims nor do they have any information about pending, denied, or approved claims.

Credit for Deductible Paid to Prior Provider?

This question would be handled by the insurer.

Certificate of Prior Coverage?

If you need a Certificate of Prior Coverage, please contact the insurer of that coverage. In general, Certificates of Prior Coverage will be sent to employee's homes directly after the termination of coverage for a qualified plan.

I Sent an Enrollment But I Have Not Received an ID Card. How Can I Make Sure I Am Enrolled?

Associated Employers Trust communicates enrollment information with the insurer. Identification cards may take an additional 12-14 business days to be printed and mailed. If you have not received a card, please contact AET* to verify enrollment.

How Can I Transition an Employee From Part-Time to Full-Time Employment?

Fill out an Enrollment and Change Form as you would for a new employee, including both the original date of hire and the date of transition from part-time to full-time employment. Please note the event next to each date. Check your Group Master Application for information regarding probationary periods for part-time to full-time transitions.

Billing FAQs

I Know My Payment is Going to be Late. Whom Do I Call?

Contact AET*. You may also want to ask about setting your firm up for ACH payments on a monthly basis.

My check was returned for non-sufficient funds. What is going to happen to our coverage?

A $30 fee will be charged for NSF checks. Replacement funds must be paid by Cashier's Check within 10 business days of notice in order to retain coverage.

Is There a Grace Period?

Premium invoices are generated the 15th of the month for the next month's coverage and are due by the 1st of each month. There is a grace period of 10 days. In the event payment is not received by the 10th, your coverage can be terminated. Any claims incurred between the 1st and the termination date will be the individual's responsibility. Upon termination HIPAA certificates will be sent to all covered employees.

I Sent In a Change and It Is Not Reflected on My Invoice. Why?

Your request was probably received after generating the billing statement. Please contact AET* to confirm the change.

When Do I Need To Submit Changes To Ensure That They Are On My Next Invoice?

Prior to the 15th each month.

***All noted AET forms, benefits, guidelines and procedures provided by the TPA Associated Industries also applies to both ALLtech and GVCC, unless otherwise noted.**

I Have A New Employee That Should Have Coverage This Month But I Have Already Paid This Month's Bill. What Should I Do? What Is the Effect On the Employee's Coverage?

Send in the Member Enrollment and Change form as soon as possible. Email it to aet@aiin.net or alltech@aiin.net for processing. Adjustments for the prior months invoice will appear in the Adjustment Section of the next billing statement.

I Believe My Invoice Is Incorrect. What Should I Do?

Contact AET*.

I Did Not Receive An Invoice This Month.

Contact AET*. You may sign up to have your monthly invoice emailed to you. This will eliminate all the mail time and give you more time to review your invoice.

How Do I Change the Billing/Administrative Contact Or Address For the Group?

Send written confirmation to AET* by sending an email to aet@aiin.net or alltech@aiin.net

What Is My Balance Forward? I Thought I Paid My Bill Last Month. Why Is a Balance Forward Showing Up?

This usually is reflective of an amount left over from the previous month. Contact AET* for further information.

How Do I Request A Billing Adjustment?

Contact AET*.

What Is My Group Number?

This is a number assigned to you by the insurer to identify your company. Medical group numbers are eight digits for ODS Health Plans. If you are unsure of your group number feel free to contact AET* and we will be happy to provide that information to you.

What Is A Retroactive Adjustment?

This is an adjustment for a prior month that effects that month's billing figures.

What Is An Effective Date?

Date employee or dependent is enrolled in health insurance coverage.

What Is A Hire Date?

This is the first day that an employee actually worked for your company.

What Is A Termination Date?

This is the last day an employee worked for your company. In some instances, an employee will be terminated following a period of absenteeism. In this case, the last day that the employee worked is the termination date.

***All noted AET forms, benefits, guidelines and procedures provided by the TPA Associated Industries also applies to both ALLtech and GVCC, unless otherwise noted.**

Glossary of Terms

Carrier:
Term used to describe the insurance company.

Claim:
Service rendered to the participant that is sent to the insurance company for payment.

COBRA:
The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal regulation requiring certain employers to allow eligible employees and eligible family members to continue group health care coverage when specific events occur that would normally result in loss of coverage.

COBRA Disability Extension:
An 11-month extension (not to exceed a total of 29 months of coverage) provided to a qualified beneficiary who is currently on COBRA under an 18-month qualifying event term. This extension is granted to qualified beneficiaries who have been deemed disabled by the Social Security Administration. The disability date, as determined by the Social Security Administration, must exist either prior to the COBRA qualifying event or at any time during the first 60 days of COBRA coverage.

To take advantage of the extension, the qualified beneficiary must inform AET* Benefit Services Department in writing of the determination before the expiration of the 18 months of COBRA and within 60 days of receiving their SSD award letter. The extension would be granted to the qualified beneficiaries covered under COBRA, not just to the individual that was deemed disabled. Premiums may increase to 150 percent of the active premium during the COBRA disability period.

Effective Date:
The date coverage begins.

HIPAA:
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides expanded rights and protections for participants and beneficiaries in group health plans. Understanding this amendment is important to your decisions about future health coverage. If you find a new job that offers health coverage, or if you are eligible for coverage under a family member's employment-based plan, HIPAA includes protections for coverage under group health plans.

HIPAA Certificate:
This certificate is issued as documentation of your prior health insurance coverage. Give a copy of your HIPAA certificate to your new employer's health insurance plan administrator to offset any pre-existing condition clauses and to verify you had no lapse in coverage.

Initial Rights Notification:
Federal law requires that certain information about COBRA be provided to employees and their spouses at the time the employee is hired. This information is included in an Initial Rights Notification letter and/or your Summary Plan Description booklet.

Limit exclusions for pre-existing conditions:
These prohibit discrimination against employees and dependents based on their health status.

Paid through Date:
The date your coverage will terminate if you do not make subsequent payments.

PHI - Protected Health Information:
Protected health information (PHI) under HIPAA means individually identifiable health information. Identifiable refers not only to data that is explicitly linked to a particular individual (that's identified information). It also includes health information with data items, which reasonably could be expected to allow individual identification.

Qualifying Beneficiary (QB):
Generally, a qualifying beneficiary is any individual who, on the day before a qualifying event, is covered under a group health plan maintained by the employer of a covered employee by virtue of being: (1) the covered employee, (2) the spouse of the covered employee, or (3) the dependent child of the covered employee. Exceptions include certain nonresident aliens.

Qualifying Event (QE):
A qualifying event is any one of the following events that would result in the loss of health insurance coverage: (1) the death of the covered employee, (2) the termination (other than for reasons of gross misconduct) of a covered employee's employment, (3) a reduction in a covered employee's hours of employment, (4) the divorce or legal separation of a covered employee from the employee's spouse, (5) a dependent of a covered employee when that employee becomes entitled to Medicare benefits, (6) a dependent child ceasing to be a dependent child of the covered employee under the terms of the group health plan, and (7) with respect to certain retirees and their dependents, bankruptcy proceedings of an employer under Title 11 of the U.S. Code, commencing on or after July 1, 1986.

USERRA:
The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) provides for the continuation of health plan coverage for up to 18 months for those persons on military leave. Because this overlaps with COBRA, there was no functional difference between COBRA and USERRA.