GROUP ADMINISTRATIVE GUIDE

Effective January 1, 2015

FOREWORD

Welcome to the Information Technology Industry Health Trust. We are pleased to present our Group Administrative Guide for participating employers. This guide will assist you in administering your benefit program through the Trust and it will serve as a valuable reference.

Detailed information is included on benefits, eligibility, enrollment, and monthly billing statements to assist you in answering your employees' questions.

Upon completion of the Group Master Application and Trust Adoption Agreement for the Trust, you acknowledge and agree to the Terms and Conditions of Participation, and to follow the guidelines established in the Group Administrative Guide, the benefit service contract, insurance policies, and other contracts between the Trust, Endorsed Sponsors and each respective carrier.

Thank you for your participation in the Trust. We look forward to continuing to provide you and your employees with excellent services and benefits.

Trustees

This guide was developed by the following advisors with a collaboration of efforts of the carriers and Trust partners:

- Benefit Solutions, Inc. (BSI) - Billing & Eligibility Administrator
- Wells Fargo Insurance Services USA – Benefit Consultant and Program Manager

Please Note: This Group Administrative Guide is a summary of the terms, conditions and limitations by which the Trust and any service contractors or insurance companies administer the eligibility rules and the benefit plans (i.e. "coverage.") While we have attempted to make this Group Administrative Guide as accurate and complete as possible, it is not to be construed as an insurance contract, a booklet, or a certificate of insurance. The contracts between the Trust and the service contractors or insurance companies, and the benefit booklets and certificates of insurance set forth the actual terms, conditions and limitations of coverage. In all cases the information provided by the carriers or Program Manager in the benefit booklets, contracts, and certificates of insurance will govern the conditions and limitations of coverage.

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DIRECTORY OF CONTACTS

Benefit Solutions, Inc. (BSI) – Third Party Administrator – Billing and Eligibility Questions	
Customer Service Phone: 425.771.7359 or 206.859.2600 Fax: 866.422.1264 Email: BHT@bsitpa.com P.O Box 6 Mukilteo, WA 98275	**BSI COBRA Administration** Phone: 425.771.7359 or 206.859.2600 Fax: 425.771.1226 Email: cobra@bsitpa.com P.O. Box 65 Mukilteo, WA 98275
For forms and resources, please visit www.businesshealthtrust.com	

Please contact the appropriate carrier below for questions regarding claims, benefits, and services.

Premera Blue Cross – ***Medical Insurance***	**Group Health Options, Inc. –** ***Medical Insurance***	**Delta Dental of Washington –** ***Dental Insurance***
Customer Service Phone: 800.722.1471 7001 220th St SW Mountlake Terrace, WA 98043 www.premera.com	**Customer Service** Phone: 888.901.4636 320 Westlake Avenue, Suite 100 Seattle, WA 98109-5233 www.ghc.org	**Customer Service** Phone: 800.554.1907 9706 4th Avenue NE Seattle, WA 98115 www.deltadentalwa.com
Dental Health Services, Inc. – ***Dental Insurance***	**Vision Service Plan –** ***Vision Insurance***	**Wellspring Family Services –** ***Employee Assistance Plan***
Customer Service Phone: 800.248.8108 936 N 34th Street, Suite 208 Seattle, WA 98103 www.dentalhealthservices.com	**Customer Service** Phone: 800.877.7195 600 University St, Ste 2004 Seattle, WA 98101 www.vsp.com	**Customer Service** Phone: 800.553.7798 Fax: 866.495.0441 1900 Rainier Avenue South Seattle, WA 98144 www.wfseap.org
LifeMap Assurance Company – ***Life/AD&D and Disability Insurance*** **(formerly Regence Life and Health)**	**Chartis –** ***Personal Accident Insurance***	**21st Century Legal Plan –** ***Group Legal Plan***
Customer Service Phone: 800.794.5390 100 SW Market St., M/S E3A Portland, OR 97207 www.lifemapco.com	**Customer Service** Phone: 877.802.5246 Fax: 415.546.3100 121 Spear Street, 5th Floor San Francisco, CA 94105	**Customer Service** Phone: 425.742.0300 Fax: 206.542.5107 David Sadick, Attorney Phone: 206.443.0800 dj@djlawgroup.com

Endorsed Sponsor Benefit Programs	Endorsed Sponsor Website
Seattle Metropolitan Chamber of Commerce	**www.seattlechamber.com**
Greater Spokane Incorporated	**www.greaterspokane.org**
Bellingham/Whatcom County Chamber of Commerce	**www.bellingham.com**
South Sound and Tacoma Pierce County Chamber	**www.tacomachamber.org**

INTRODUCTION

The Trust is a funding mechanism for accessing health and other employee benefits. By taking advantage of the collective purchasing power of the Trust, your business has access to comprehensive and competitive benefits. A complete range of services are available to your employees.

The Trust is a consolidation of available products put together specifically for the members of the Trust and its endorsed sponsors. It includes employee benefits for medical, dental, vision, basic life and accidental death & dismemberment, supplemental life and accidental death & dismemberment, long-term disability, personal accident insurance, legal services, and employee assistance programs for employer groups with 2 - 149 employees.

Advantages include:

- Consolidated Administration: one point of contact for billing and eligibility (*through BSI*)
- COBRA Administration *(provided through BSI)*
- 24-hour access to forms and summaries on www.businesshealthtrust.com
- Flexible Spending Accounts *(provided through BSI)*
- Online enrollment, eligibility and billing access through BSI's online platform, "SIMON"

This guide is designed to assist you in the administration of your employee benefit plans through the Trust. It is also a summary of terms and conditions set forth to participate in the program. It includes brief descriptions of plan administration and is intended to help the member company's administrative representative through the day-to-day administration of their benefits through the Trust. It is not a contract, booklet of insurance, summary plan description, or a certificate of coverage.

EMPLOYER ELIGIBILITY AND REQUIREMENTS

NEW AND RENEWING BUSINESS

Rates are guaranteed for the contract period as sold for individual member groups except in the case of:

- Government mandated benefit changes;
- New or revised government taxes imposed;
- An amendment of the benefit plan or contracts;
- Addition or termination of an employer subsidiary, corporate division, or affiliated companies;
- Any change in employer contribution, employee eligibility, or probationary period;
- Enrollment change of 10% or more in any single month or a 25% in any three consecutive months;
- COBRA enrollment exceeds 10% of the total membership

MEDICAL

The insurers reserve the right to adjust rates for potentially new member groups if any information differs from the original quote and/or to decline the group if it does not subsequently meet underwriting guidelines.

Groups must not have any other medical or prescription plans, other than that provided through the Trust.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Employers may not select the EAP plan if the employer does not participate in one of the medical plans offered by the Trust.

LONG-TERM DISABILITY

There is a pre-existing condition exclusion for LTD coverage. The pre-existing condition limitation can be 6/12/24 months for groups with less than 25 employees and 3/6/12 months for groups with 25 or more employees. Exclusion period is either 12 or 24 months from the employee's effective date. If the employee is treatment free for six consecutive months during the exclusion period, the pre-existing provision is waived. Pre-existing is anything that's treated in the look-back period prior to the effective date. Please refer to the group certificate for complete details.

ELIGIBILITY AND ENROLLMENT REQUIREMENTS

In order to participate in the Trust, 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, minimum hours and contribution. These requirements can be changed at renewal. These may not be changed during the year without a formal request submitted to the administrator and written approval from the Trust. If the employer, as a result of an acquisition, merger, or other circumstances, wishes to add a new group or expand the group of eligible employees to the plan, they should contact their producer.

RENEWAL PROCESS

All renewal information is sent to the employer's producer. The Trust does not send any renewal rates or other renewal information to the group. The Trust sends a renewal proposal to the producer 45-60 days prior to the renewal date. The producer is responsible for contacting the group regarding the new rates and any benefit changes.

A completed Group Master Application is required for all renewing groups, regardless of any plan or benefit changes. Open enrollment occurs during the month prior to the renewal date (i.e. the open enrollment for January would be the month of December). Renewals must be returned to Wells Fargo Insurance Services USA no later than 15 days before the renewal date.

MAINTAINING ADMINISTRATIVE RECORDS

The employer is responsible for keeping accurate records of any information relating to eligibility, enrollment, payroll deductions, hours worked, premium payments, plan beneficiaries, and other records necessary to administer the benefit plan. The Trust and its affiliated contractors have the right at any time during the employer's regular business hours to request, inspect, or audit the employer's records related to the administration of the benefit plan, and any records retained by a 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.

EMPLOYEE AND DEPENDENT ELIGIBILITY

ELIGIBLE EMPLOYEE

Active, full-time employees of the group who satisfy the minimum hour requirement, are paid on a regular basis, and have satisfied the appropriate probationary period (as set forth in the group's annual Group Master Application) are eligible for coverage under this plan. Temporary, Seasonal, Contract, or Employees paid via 1099 are not eligible.

EMPLOYEES PERFORMING EMPLOYMENT SERVICES IN HAWAII

For employers other than political subdivisions, such as state and local governments, and public schools and universities, the State of Hawaii requires that benefits for employees living and working in Hawaii (regardless of where the participating Trust Employer is located) be administered according to Hawaii law. If the participating Trust Employer is not a governmental employer as described in this paragraph, employees who reside and perform any employment services for the participating Trust Employer in Hawaii are not eligible for coverage. When an employee moves to Hawaii and begins performing employment services for the participating Trust Employer there, he or she will no longer be eligible for coverage.

ELIGIBLE DEPENDENT

Eligible dependents include:

- The employee's lawful spouse. However, if the spouse is an owner, partner or corporate officer of the group, who meets the requirements in "Employee Eligibility" (above), the spouse can only enroll as a subscriber.
- The domestic partner of the employee. Domestic partnerships that are not documented in a state domestic partnership registry must meet all requirements as stated in the signed "Affidavit of Domestic Partnership." All plan provisions stated as applicable to a spouse will also be applicable to a domestic partner. For the purpose of this plan, the use of the term "marriage" will also be applicable to a domestic partnership.
- An eligible dependent child under 26 years of age who meets one of the following requirements:
  - 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 placed with the subscriber for the purpose of legal adoption in accordance with state law. "Placed" for adoption means assumption and retention by the employee of a legal obligation for total or partial support of a child in anticipation of adoption of such child.
  - A legally placed ward or foster child of the employee or spouse. There must be a court order or other order signed by a judge or state agency, which grants guardianship of the child to the employee or spouse as of a specific date. When the court order terminates or expires, the child is no longer an eligible child.
- A dependent child age 26 or older who cannot support himself or herself because of a developmental or physical disability, provided the dependent child was covered on the day before the 26th birthday and the incapacity occurred prior to the 26th birthday. Benefits will be provided for the duration of the disability unless coverage terminates. Within 31 days of the child reaching age 26, the employee will need to furnish the medical carrier with a Request

for Certification of Handicapped Dependent form. The medical carrier must approve the request for certification in order for coverage to continue. If the medical carrier approves the request for certification, they will notify BSI to proceed with the enrollment. The enrollment will be completed with the effective date the first of the month following the child's 26th birthday to provide continuous coverage. Proof of the incapacity and dependency will be required by the medical carrier not more frequently than one time per year after the child's 28th birthday.

TAX IMPLICATIONS FOR DOMESTIC PARTNER COVERAGE

Federal tax rules govern the tax treatment of domestic partner benefits. Generally, if a domestic partner or his/her dependents are defined as an employee's Internal Revenue Code (Code) Section 105(b) tax dependents, the value of the health coverage is not subject to federal income and employment taxes, and the benefits provided will be tax-free. If a domestic partner or his/her dependents are not Code Section 105(b) tax dependents, generally the employee will be taxed on the premium cost of the insurance provided to the domestic partner.

Whether a domestic partner or domestic partner's child is a tax dependent of an employee is a legal tax question and the employer may need to consult legal counsel for advice on the taxability of the contributions for domestic partner or domestic partner's child coverage as the Trust, its Program Manager (Wells Fargo Insurance Services USA), and its Billing and Eligibility Administrator (BSI) cannot provide legal or tax advice.

ELIGIBLE EMPLOYEES AND DEPENDENTS AGE 65 AND OLDER

The Trust is subject to Medicare Secondary Payer rules for the working aged, even for those employers who had fewer than 20 employees in the prior calendar year. The employer must offer its employees, who are age 65 and older (and their spouses and dependents of any age) the same coverage the employer offers to its employees who are under the age of 65. The employer cannot offer any financial incentive or encouragement for the participant to reject the employer's plan and select Medicare coverage. Should an employee with coverage under the Trust choose to enroll in Medicare as well, the Trust will always pay primary and Medicare will pay secondary. However, if a participant is on COBRA and is entitled to Medicare based on age or disability, then Medicare is primary for any period in which the participant continues with their COBRA coverage.

PROBATIONARY PERIOD

The probationary period (sometimes referred to as a waiting period) is determined by the employer and is the specified period of time that employees must work for the employer before they become eligible for coverage under the group plan. The period begins on the date the employee is hired or the date the employee entered an eligible class if they did not meet the definition of an eligible employee when they were hired. The probationary period may be 0, 30, or 60 days long.

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

WAIVING THE PROBATIONARY PERIOD

A probationary period generally cannot be waived. However, it may be waived, at the discretion of the Trust, for key employees only for groups with more than 10 employees. To do this, the employer must submit a letter on company letterhead stating that the employee is indeed a key employee and that the waiver is a condition of employment. Be sure to include the employee's name, date of hire, and requested effective date.

Key employees are defined as those employees who are at or above the highest paid 10% of all employees employed by the employer and who reside within 75 miles of the employer's worksite.

A waiver request is not a guarantee of enrollment. As such, benefits should not be offered as a condition to employment without written approval from the Trust. These requests will need to be reviewed and approved on a case-by-case basis. Requests should be submitted to BSI, who will notify the group if the request has been approved or denied.

EFFECTIVE DATE OF COVERAGE

An employee's effective date of coverage is the first day of the month following or coinciding with the end of the probationary period. For example, if an employee was hired on January 1, 2014 and the group had a 30-day probationary period, the effective date would be February 1st. If the same employee were hired January 8, 2014, the probationary period would end February 6th and the employee's effective date would be March 1st. If an employee's probationary period ends on the 1st of the month, that will be the effective date.

ENROLLMENT

ENROLLING EMPLOYEES AND DEPENDENTS

The employer can enroll employees and/or dependents one of two ways:

1. Through SIMON*, BSI's online enrollment tool; or
2. By submitting a signed copy of the Trust Enrollment / Change Form to BSI via mail, email, or fax.

*Employers using online enrollment must still require and maintain enrollment forms to be completed and signed by all employees in the event of a Trust audit or the need for beneficiary designation information.

EMPLOYEE AND DEPENDENT COVERAGE ENROLLMENT RULES

The chart below describes the employee and dependent coverage enrollment rules. Groups must satisfy the carrier minimum participation rules.

Coverage	Carrier	Employee Rule	Dependent Rule
Medical	Premera Blue Cross	Employee can waive	Dependents can waive
Dental	Dental Health Service	Employee can waive	If Employee elects dental, dependents may not waive if they're enrolled in medical.
	Delta Dental - 100% Employer Paid	ALL employees must be enrolled	Dependents may not waive if they're enrolled in medical.
	Delta Dental - 75-99% Employer Paid	Employee can waive	If Employee elects dental, dependents may not waive if they're enrolled in medical.
Vision	Vision Service Plan	If the group offers it, ALL employees must enroll	Dependents may not waive if they're enrolled in medical or dental.
Basic Life / AD&D	LifeMap	If the group offers it, ALL employees must enroll. Required benefit with Premera medical.	N/A
Long-Term Disability (LTD)	LifeMap	If the group offers it, ALL employees must enroll. Some groups may have to complete and qualify through Evidence of Insurability	N/A
Employee Assistance Program (EAP)	Wellspring Family Services	If the group offers it, ALL employees must enroll. Required benefit with Premera medical.	Dependents automatically covered
Supplemental Life and AD&D	LifeMap	Voluntary	N/A
Dependent Life	LifeMap	N/A	Voluntary
Personal Accident	Chartis	Voluntary	N/A
Legal Plan	21st Century Legal	Voluntary	N/A

ENROLLMENT/CHANGE FORM

To become covered under this plan, employees must first complete an enrollment form for themselves and include each family member they wish to cover. A copy of the form can be found in the Form Library, which is located at www.businesshealthtrust.com. Alternatively, contact BSI for a copy.

Upon receipt and acceptance of a timely submitted enrollment form, coverage will begin for employees on the first day of the month following or coinciding with the date the probationary period ends. The completed enrollment form must be submitted to BSI within **60 days** from the date a new employee becomes eligible for coverage. Coverage for eligible dependents who are included on the employee's enrollment form begins on the employee's effective date.

If the employee or their dependent does not enroll for coverage when initially eligible, coverage will not be available until the next open enrollment period, except when required by court order or special enrollment provisions.

Enrollment will only be accepted for effective dates as of the current or immediately preceding month.

Employers must maintain a signed copy of the Enrollment / Change form in their records, even if they process the enrollment through SIMON in the event of a Trust audit or the need for beneficiary designation information.

Additionally, LifeMap requires an Evidence of Insurability form to be completed for late enrollees and for any amounts above the group's guarantee issue amount for voluntary life coverage. Coverage will be made effective the first of the month following the date of approval from LifeMap. Forms are available at www.businesshealthtrust.com.

Completing the Enrollment Form For a New Employee

Employers must make sure the enrollment forms are completed accurately and legibly. Errors, ambiguities, and illegible information will require research and will delay employee eligibility. Forms with missing information (such as signature, birth date, date of hire, enrollment reason, etc) will not be processed. It is the employer's responsibility that the employee plan selections adhere to the rules of the Trust.

1. Write the company name in the "Employer Name" box
2. Write the effective date of the enrollment being requested in the" Effective Date" box
3. Write the date of the employee's hire in the "Date of Hire" box
4. Check the appropriate box in the "Event Description" section
5. Enter the employee's information, including name, date of birth, gender, Social Security Number, mailing address, and phone number in the "Employee Information" section. Annual salary and class need to be completed only if applicable.
6. Complete the "Dependent Information" section, if applicable. Include full name, date of birth, gender and social security number.
7. Check the appropriate coverage boxes in the "Plan Selection" section on the second page. If you are unsure of your coverage, consult your Group Master Application or Producer.
8. Complete the "Beneficiary Information" section.
9. On the signature page, the employee **must** sign and date the left box. Forms without a signature will be returned and delay employee eligibility.
10. On the signature page, the group administrator must sign and date the right box and check the appropriate boxes in the section "For Employer Use Only"

Completing the Form For a New Dependent

1. Write the company name in the "Employer Name" box
2. Write the effective date of the enrollment being requested in the" Effective Date" box
3. Indicate the qualifying event in the "Event Description" section
4. Enter the employee's information in the "Employee Information" section
5. Enter the dependent's information in the "Dependent Information" section
    - If the employee is enrolling a newborn and they don't have a Social Security Number (SSN) yet, the enrollment can be sent in without the SSN. When one is assigned, notify BSI so it can be added to the file.
    - If the employee is enrolling a new domestic partner, a signed affidavit is also required
6. Circle "add" next to the dependent's name
7. In the "Plan Selection" section, indicate the coverage the dependent is being enrolled in.
8. On the signature page, the employee must sign and date the left box and the group administrator must sign and date the right box

CARRIER ID CARDS

Medical ID Cards

Premera Blue Cross will issue ID cards and generally take 10-12 business days for cards to arrive once the carrier has received the enrollment. Replacement ID cards can be ordered directly from the medical carrier by calling their customer service phone number or visiting the carrier's website and registering. However, if a new ID card is needed due to a name or address change, the ID card request (along with the updated name/address information) MUST be processed through BSI at BHT@bsitpa.com.

If an eligible employee needs services prior to receiving their ID cards and providing it is a covered treatment or service, the employee or their provider may contact the carrier's Customer Service directly to obtain the employee's ID number and confirm benefits. If the eligible employee needs a prescription and providing it is a covered drug and treatment, the employee has the option of paying for the medication and submitting the paperwork to the carrier for reimbursement.

Dental ID Cards

Delta Dental of Washington will issue ID cards and generally takes 10-14 business days for the cards to arrive once they receive the enrollment. Employees can also register online at www.deltadentalwa.com and print a paper ID card by clicking on the 'Patients' tab. It will ask for a member ID, which is the employee's social security number.

Vision ID Cards

VSP does not issue individual ID cards. VSP members and their covered dependents simply provide the last 4 digits of the member's SSN and complete name to a VSP Provider to access benefits.

SPECIAL ENROLLMENT

An employee and/or their dependent may be able to enroll outside of the annual open enrollment period if they experience one of the following special enrollment events. Employees can then enroll themselves (if not previously enrolled), and their dependents, as applicable, in available coverage.

INVOLUNTARY LOSS OF COVERAGE

If an employee declines enrollment for themselves or their dependents when initially eligible due to having other coverage, and they then lose that coverage, they may be eligible to enroll in this plan provided that they submit an Enrollment/Change form within 60 **days** of the date of loss of coverage. Loss of other coverage may include exhaustion of COBRA continuation coverage, loss of coverage due to divorce, legal separation, termination of employment, reduction of hours, or loss of an employer's contribution toward the coverage. Coverage will be effective the 1st of the month following the date the other coverage was lost. If application is not made within 60 days, the employee and/or dependent(s) must wait until the next open enrollment period to enroll.

NEW DEPENDENT DUE TO MARRIAGE, BIRTH, OR ADOPTION

If the employee has new dependents as a result of marriage, birth, adoption, or placement for adoption, they may be eligible to enroll themselves and/or their dependents, as applicable, provided that they submit an Enrollment/Change form within **60 days** after the marriage, birth, adoption, or placement for adoption. Coverage will be effective the 1st of the month following timely receipt of application due to marriage. Coverage will be effective as of the date of birth, date of adoption, or date the child was placed with the employee for adoption due to birth or adoption/placement for adoption. If application is not made within 60 days, the employee and/or dependent(s) must wait until the next open enrollment period to enroll.

Automatic Newborn Coverage: A newborn child will automatically be provided coverage available under the plan for routine care, illness, accidental injury, or physical disability, including congenital anomalies, for up to 21 days following the birth when the employee or the employee's spouse is eligible for maternity benefits under this plan.

STATE MEDICAL ASSISTANCE AND CHILDREN'S HEALTH INSURANCE PROGRAM

If the employee and/or dependent(s) qualify for premium assistance through the state's medical assistance program or Children's Health Insurance Program (CHIP), or they no longer qualify for health coverage under the state's medical assistance program or CHIP, they may be able to enroll themselves and/or their dependents, provided they submit an Enrollment/Change form within 60 days from the date they qualify for premium assistance or no longer qualify for health coverage under the state's medical assistance program or CHIP. Coverage will be effective 1st of the month following application. If application is not made within 60 days, the employee and/or dependent(s) must wait until the next open enrollment period to enroll.

COVERAGE TERMINATION

Coverage will end without notice on the last day of the month for which premiums have been paid and in which ONE (1) of the events listed below for employees and/or dependents occur. For complete details about coverage termination, please refer to the appropriate benefit booklet.

Please note Basic Life insurance, Voluntary Life insurance and Long Term Disability coverage ends on the day employment ends.

EMPLOYEE AND DEPENDENT TERMINATION OF COVERAGE

Coverage will end for the employee and dependents when ANY of the following occur:

- The contract between the Trust and the insurance carrier is terminated
- The next monthly premium is not paid when due or within the grace period
- 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 Trust's continued participation requirements
- The participating employer notifies the Trust that it no longer wishes to participate in the Program. 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.

DEPENDENT SPOUSE / CHILDREN TERMINATION OF COVERAGE

Coverage will end for a spouse and/or dependent(s) when ANY of the following occur:

- The spouse legally separates or divorces from the employee, or the marriage is annulled
- The domestic partner's relationship with the employee ends
- The child no longer meets the requirements for dependent coverage.

LIMITATION OF RETROACTIVE TERMINATIONS

0 – 30 Days from the Requested Coverage Termination Date
Employers may request to terminate members' coverage retroactively if the request is received within 30 days from the requested date of coverage termination.

30 – 60 Days from the Requested Coverage Termination Date
If BSI receives a request to retroactively terminate a member's coverage between 30 – 60 days from the requested date of coverage termination, the Employer must submit a Member Coverage Termination Request Form to BSI (available on the Trust's website). Retroactive termination of the employee and/or dependent coverage will be considered only if all of the following ACA conditions are met:

- Premium has not been paid by the employee/dependent for coverage after the requested effective date of termination of coverage;
- There was no expectation of coverage by the employee/dependent after the requested effective date of termination of coverage;
- The group health plan only covers those who are considered either active or COBRA employees.

The Member Coverage Termination Request Form must be submitted regardless of how you submit your termination request (i.e. via the monthly invoice, email, fax, or SIMON). Please note, if you submit the termination request via SIMON, you must send the completed form separately to BSI via mail, email, or fax. BSI will not be able to process the retroactive termination without it.

If you fail to provide a Member Coverage Termination Request Form or if the above three conditions are not satisfied, member coverage termination will only be approved for the last day of the month the request is received. No retroactive termination will be allowed.

Over 60 Days from the Requested Coverage Termination Date
Any requests received to terminate coverage over 60 days from the requested date of coverage termination will not be allowed. Instead, the coverage will be terminated at the end of the month in which the request is received.

Important Consideration: All companies is subject to COBRA under the Trust, therefore you should submit a termination request that is more than 30 days after the coverage termination date, and you may possibly jeopardize the COBRA rights of your employee and/or their dependent.

It is the responsibility of the employee to promptly notify their employer when an enrolled dependent is no longer eligible to be covered as a dependent under the Trust. The employer must then notify BSI as soon as possible, but no later than 30 days from the date the participating employer was notified of such event.

HOW TO TERMINATE COVERAGE

An employer can terminate coverage for an employee and/or their enrolled dependents through one of the following ways:

- ❑ Submit the termination through BSI's online enrollment tool SIMON. Be sure to indicate the reason for termination and confirm the employee's address is current
- ❑ Send an email to BSI at BHT@bsitpa.com
    - Make sure to include the employee's name, termination date, termination reason, and an updated address, if applicable
- ❑ Mail or fax a letter on the company's letterhead to BSI
- ❑ Make a notation on the monthly Trust invoice and return the invoice with your payment. The notation must include the reason for termination and termination date.
- ❑ Dependents Only: In addition to the ways listed above, a dependent's coverage may also be terminated by submitting a completed Trust Enrollment/Change form. The form should be completed as follows:
    - Enter the date coverage should terminate in the "Effective Date" box
    - Choose "Other" and write in the event in the "Event Description" section (i.e. divorce, other coverage, etc.)
    - Enter the employee's information
    - Enter the dependent's information, circling "Delete" next to the dependent name
    - On the signature page, have the employee sign and date the left box and the group administrator sign and date the right box

Please note that if an employee terminates coverage for a dependent, they cannot re-enroll them in coverage until the next open enrollment period unless a special enrollment qualifying event occurs.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

All employees and their dependents covered through the Trust who experience a qualifying event are eligible for COBRA continuation coverage, regardless of the number of employees the employer employs. An employer cannot opt out of COBRA.

It is the employer's legal responsibility to notify BSI in writing within 30 days from the date an employee experiences a COBRA qualifying event. Neither the Trust nor BSI will be held liable for an employer's failure to provide accurate and timely notification of COBRA qualifying events.

COBRA qualifying events include:

- ❑ Termination of employment (for any reason other than gross misconduct)
- ❑ Reduction in hours (falling below the minimum required hours worked for coverage)
- ❑ Employee death
- ❑ Loss of dependent status (reaching age 26 for children)
- ❑ Divorce or legal separation

COBRA ADMINISTRATION BY BSI

The Trust's benefits administrator, BSI, will automatically provide COBRA administration for the medical, dental, vision, and EAP coverage offered by the Trust at NO cost to employers. BSI will handle all COBRA administration and notices for the Trust plans that the employer has enrolled in, ensuring compliance with the regulations and guidelines required by COBRA. This includes sending the initial COBRA notice to newly eligible employees and spouses. Please note BSI cannot offer COBRA administration services for non-Trust plans at this time.

Should an employee or dependent elect COBRA coverage, BSI will send a monthly billing statement to the COBRA participant and they will remit premiums directly to BSI. Therefore, the COBRA participants will not appear on the employer's monthly Trust invoice.

COBRA ADMINISTRATION BY ANOTHER THIRD-PARTY ADMINISTRATOR

Although BSI COBRA administration is free to employers and automatically available, the Trust understands there may be employers who have non-Trust products as well and prefer to contract with another COBRA Third-Party Administrator (TPA) to do the COBRA administration of all their plans. If an employer wants to waive BSI COBRA services and they have contracted with another TPA to do the COBRA administration, the employer **must** complete a Waiver Form and return it to BSI as soon as administratively possible.

If the TPA elects to remit the collected COBRA premiums to BSI directly, the employer will not see COBRA participants on the monthly Trust invoice. If the TPA elects to remit the collected COBRA premiums to the employer, BSI will bill the COBRA participant's premiums to the employer on the monthly Trust invoice along with their active employees.

Please note the Trust has determined that BSI COBRA administration can only be waived if the employer has contracted with another TPA to do COBRA administration. The employer cannot waive BSI COBRA administration of the Trust plans and do it themselves.

Important: Even if an employer waives BSI COBRA administration services and uses another TPA, please be aware that BSI must continue to be advised of all Trust COBRA elections, terminations, or changes so that BSI can notify the carrier(s). The carriers will only accept eligibility updates and premium payments from BSI. Failure to notify BSI of these elections/changes will result in a delay of coverage for the participant.

FAMILY MEDICAL LEAVE ACT (FMLA)

The Family Medical Leave Act (FMLA) provides that covered employers must grant an eligible employee up to a total of 12 work weeks (26 for military caregiver leave described below) of job-protected, unpaid leave during any 12-month period, or substitute paid leave if the employee has accrued it, for one or more of the following reasons:

- ❑ for the birth and care of the newborn child of the employee
- ❑ for placement with the employee of a child for adoption or foster care
- ❑ to care for an immediate family member (spouse, child, or parent) with a serious health condition
- ❑ to take medical leave when the employee is unable to work because of the employee’s serious health condition
- ❑ any qualifying exigency during a family member's active duty service of the family member being called to active duty in a foreign country
- ❑ military caregiver leave to care for a qualifying service member who has a serious injury or illness. The employee must be the service member’s spouse, sibling, child, parent or next of kin.

All private sector employers with 50 or more employees in 20 or more work weeks in the preceding calendar year are subject to FMLA. FMLA also applies to all public agencies, including state, local and federal employers and local education agencies (e.g., school districts).

An employee is eligible for FMLA if:

- ❑ the employee was employed for at least 12 months with the employer (not necessarily consecutively),
- ❑ the employee worked at least 1,250 hours during the 12-month period before the leave, and
- ❑ the employee must notify his or her employer that FMLA leave is being requested

During FMLA leave, the employer must continue to pay the employee’s benefit coverage as if they were still actively working. The employer's obligation to provide health coverage under FMLA ceases if an employee's portion of the premium payment is more than 30 days late, after providing the employee a 15-day written notice.

According to FMLA regulations, if an employer changes the health plan during the employee's leave, the change applies to the employee as if he or she is still working.

NON-FMLA LEAVE OF ABSENCE

Coverage for an employee and enrolled dependent(s) may be continued for up to 90 days when the employer grants the employee a leave of absence and full premium rates continue to be paid. The 90-day leave of absence period counts toward the maximum COBRA continuation period, except as prohibited under the FMLA (Family and Medical Leave Act of 1993). For LTD, coverage ends as of the end of the next month in which the leave of absence begins.

LIFE INSURANCE CONVERSION

The group life insurance conversion privilege is explained in the LifeMap Summary Plan Description. Employers have an obligation to make employees aware of the life insurance conversion privilege at the time of termination. Employees have 31 days from the date of termination to apply with LifeMap for an individual life insurance policy without submitting evidence of insurability.

ADMINISTRATIVE REVIEW

The Trust has established procedures for employers, members, and their dependent(s) to request a review of non-claim decisions affecting their coverage. If the request for review involves eligibility, enrollment, disenrollment, waiting periods, late payment, reinstatement of delinquent employers, and similar issues concerning the day-to-day administration of the Trust, the employer or their agent/producer should contact BSI. Requests may not be directly submitted by employees or dependents, but must come through the employer. Requests for review must be in writing and must be submitted to BSI within 180 days of the event.

Upon the receipt of a request for review, a review committee will consider the matter and notify the employer and agent/producer in writing of its decision.

TERMINATING GROUP COVERAGE THROUGH THE TRUST

To terminate participation in the Trust, send a letter on company letterhead to Wells Fargo Insurance Services USA. Please indicate the last day of coverage. Your coverage can only terminate at the end of a coverage month. Mid-month termination dates are not allowed. After your plan has been cancelled you will be provided with a final billing that will outline any additional funds needed for adjustments prior to the plan termination, or with a refund check for any overpayments made prior to plan termination.

SIMON

WHAT IS SIMON?

SIMON is a cloud-based platform that supports online enrollment, employee communication, and benefits education, that may be accessed at any time.

SIMON was designed to help our clients meet their goals. Whether they want to increase participation, simplify enrollment, improve employee communication or support defined contribution plans, SIMON provides a better way to provide a comprehensive program while engaging and educating employees.

WHAT CAN AN EMPLOYER DO USING SIMON?

Using SIMON, employers can centrally administer and manage their employee benefits programs, including being able to:

- Enroll new employees
- View benefits data for an existing employee
- Add or change benefits for an existing employee or dependent
- Add dependents for an existing employee
- Change demographic data for an existing employee
- View and/or print benefits-related forms and documents
- Use SIMON Tiles to access important websites and view important messages
- View and pay invoices
- Generate reports

REGISTERING FOR SIMON

Access to SIMON requires the employer and their designated employees or contractors to register. The employer must agree to provide BSI with accurate, complete registration information and it is their responsibility to inform BSI of any changes to that information.

BSI will send an email inviting the Group Master Application Signer and/or to the person designated to register.

Each registration is for a single person only. BSI does not permit a) any other person using the registered sections under your name; or b) access through a single name being made available to multiple users on a network. The employer is responsible for preventing such unauthorized use and any unauthorized use must be reported to BSI immediately. BSI reserves the right to terminate SIMON access if BSI determines these rules are not being followed.

Please contact BSI at bht@bsitpa.com or 425.771.7359 to request a registration invite.

ACCESSING SIMON

Employers can access SIMON by going to https://www.simon365.com/.

BILLING AND PAYMENTS

Employer groups are billed the first week of the month prior to the month of coverage, and payment is due on or before the 20th day of the month prior to the month of coverage. Please pay as invoiced. Credits or charges for enrollment changes that were received after the monthly cutoff period will be reflected on the following month's invoice. Premiums that are not paid as billed may result in a delay of claim processing resulting in pended coverage.

If you feel that your billed amount is incorrect, please contact BSI. They will review your account with you and ensure that any issues are resolved promptly.

The first page of the billing statement is used for reconciliation purposes and shows the billed amount for the previous month, prior period coverage adjustments, and payments received. If there is an unpaid balance or credit on the account, it will also be shown on this page. Subsequent pages of the billing statement list the current month's billing detail of employees and corresponding premiums.

Employers are required to audit the billing statement each month to ensure that any changes that have been submitted to BSI in a timely manner prior to the monthly cutoff are reflected on the bill. Eligibility errors that persist due to the failure of the employer to audit the billing statement and notify BSI immediately upon discovery may not be corrected retroactively.

Your bill may also include membership dues or fees owed to the plan sponsor or an endorsed sponsor. The Trust collects these amounts and pays them directly to the plan sponsor or endorsed sponsor.

BILLING TIME FRAMES & DELINQUENCY POLICY

It is the Trust's policy to receive premium payments prior to the coverage effective date. This document outlines the billing time frames and the subsequent delinquency policy if payment is received outside of the timelines.

Membership dues must be in good status in order to maintain participation in the program. If you are delinquent on your membership dues, your premium may not be considered as paid and your group's coverage may be pended or delayed.

Groups may be terminated for non-payment as per the delinquency policy. Checks returned for Non-Sufficient Funds (NSF), Account Closure, or Stopped Payment will not be considered as having been paid in terms of the delinquency timeline. If any of these events occur, the group must provide a Cashier's Check and may be required to provide proof that the business is still active. If payment is not received by the due date, the group's coverage will be suspended until received. If payment is not received by the end of the coverage month, coverage will be terminated retroactively to the last month in which payment was made in full.

If payment has not been received by the 1st day of the coverage month, the group will be sent an email requesting payment. If payment has not been received by the end of the coverage month, a letter will be sent to the group notifying them of the cancellation of their coverage through the Trust.

If a group is terminated for non-payment, they have one reinstatement opportunity, which must occur within 60 days of the last month in which payment was made in full. Reinstatement will be at the discretion of the insurers and must be requested in writing and submitted to BSI. If the group is not reinstated, they cannot reapply for coverage through the Trust for 12 months.

LATE FEE POLICY

The Trust imposes a late fee for premiums remitted after the 1st of the coverage month. The late fee will be the greater of 1.5% of the unpaid balance or $20.

Late fees are assessed each month. If a group's balance is past due, the late fee will be charged for each period in which the invoice was outstanding. If a late fee is assessed on an invoice and the premium is remitted without the late fee, payment may be returned due to not paying as billed.

EXAMPLE OF BILLING AND DELINQUENCY TIME FRAMES FOR MAY INVOICE

April 7	May invoice is calculated and mailed
April 20	May payment is due
May 1	The group is considered delinquent if the May premium is not received and they will be assessed a late fee. An email requesting payment of all past due premiums to be remitted by the 20th is sent to the group. The group's producer is included on this communication.
May 7	BSI calculates the June invoice. If the May premium was not received by May 5th, the June invoice will reflect the unpaid balance and any assessed late fees.
May 31	If payment has not been received, a letter advising that coverage has been retroactively terminated is sent to group, producer, program manager, endorsing sponsor, and all applicable carriers

Employers who collect employee contributions for employee or dependent coverage and do not promptly pay those premiums towards coverage may be in violation of ERISA and subject to penalties. The timeliness of payments may also affect COBRA coverage if you are responsible for forwarding COBRA premium on the COBRA participant's behalf. COBRA coverage is dependent upon the participant being in good standing with their coverage premiums. If either situation applies to your group, please contact your legal advisor for more information. The Trust, Wells Fargo Insurance Services USA, and BSI are not tax or legal consultants and cannot provide further information on your responsibilities.

HOW TO MAKE PAYMENTS

Payments may be made via any of the following methods:

- Company Check – Remit **one** check that reflects the company name and is payable to Business Trust (or BHT). The employer should list their Trust account number on the check.
- ACH - through BSI's online enrollment tool "SIMON"
- Check by Fax/Email – A $15 fee is assessed for each payment processed. To utilize this method, two checks will need to be sent to BSI by fax or email: 1) Company check payable to BHT for the invoiced amount, and 2) Company check payable to BSI for $15.

BILLING FAQS

I know my payment is going to be late. Who do I call?
If your payment will be late, contact BSI. Please be aware that a late payment may result in your coverage being suspended until payment is received. Late fees may still apply.

I sent in a change and it is not reflected on my invoice. Why?
Changes for the month being billed may not be reflected on the bill if the changes were received by BSI after the 1st of the prior month. For example, if a dependent termination notice was received on March 8th, the April bill would already have been generated and the change would not be reflected until the May invoice. Retroactive charges and credits for enrollments and terminations will be reflected on the following month's invoice.

When do I need to submit changes to ensure that they are on my next invoice?
Please submit enrollment changes as soon as possible. Generally, changes received by BSI by the 1st of the prior month will be reflected on the next month's invoice.

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?
Please send the completed enrollment forms to BSI and pay as billed. Although adjustments will be reflected on the next invoice, the employee's coverage will be processed for submission to the appropriate carriers within two business days.

I believe my invoice is incorrect. What should I do?
If you believe the rates are incorrect or you are owed a credit that is not reflected, please contact BSI to discuss. Please do not make adjustments to your payment without first contacting BSI. Incorrect or unexplained adjustments could result in a delay processing your payment and the pending of your coverage. Checks remitted for amounts that differ from the billed invoice may be returned.

If there are additions or deletions that have been submitted to BSI and are not yet reflected on your bill, please remember that bills are prepared approximately 3 weeks in advance of the coverage month, and a change that was not received by the 1st of the prior month will not be reflected on the next month's invoice (that is, for a change to be reflected on the May invoice, BSI must receive notification no later than April 1st).

I have been told my coverage is "suspended." What does that mean?
This usually means payment has not been received by the due date and that the carrier is pending payment of claims until premium is received for the coverage month. Suspended coverage is not cancelled, but it delays payment of claims until payment is received and accepted. If claims have been pended and you believe your premium payments are current, please contact BSI to verify that all payments have been received.

What do I do if I did not receive an invoice this month?
Please contact BSI to request that an invoice be re-sent to you. You may also sign into SIMON to access your current invoice.

How do I change the billing/administrative contact or address for the group?
Please send BSI notification in writing of the new administrative contact or address for the group. An email is sufficient.

What is my balance forward? I thought I paid my bill last month. Why is it showing up?
If your payment was received after the 5th of the prior month, it is possible your next invoice will show a balance forward. If you have specific questions about a balance forward, please contact BSI.

How is the money I remit going to be applied? Will I be notified?
Each payment is applied to the earliest outstanding month. If you remit payment for your November invoice but have not paid for October, payment will be applied to October premiums.

How do I request a billing adjustment?
Please pay as billed. Submit enrollment changes and any billing adjustments you feel are necessary to BSI for adjustment on a future invoice.

What is a retroactive adjustment?
It is an adjustment applied to an invoice for past premiums that should be credited or charged. For example, if an employee was added effective January 1 and BSI received the enrollment form January 10^{h}, the employee would not be added to the invoice until March. On that invoice, there would be an adjustment charge for the January and February premiums in addition to the March premium. Please pay as billed and allow BSI to make premium adjustments for you.

MISCELLANEOUS FAQS

GENERAL

What is a Group Master Application?
This is the agreement the employer signs during the renewal or open enrollment process. It indicates the plan selected as well as the employer's policies such as probationary periods, part-time to full-time transfer, and required hours. If you do not have a copy of your Group Master Application, please contact your producer.

What is my BSI account number?
This number is assigned to you by BSI. If you do not know your BSI account number, please check your most recent billing statement. BSI account number may also be referred to as BSI locator number.

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 Premera Blue Cross and five digits for Group Health Options Inc. and are on your ID card. If you are unsure of your group number, feel free to contact BSI and they will be happy to provide that information to you.

What is a hire date?
This is the first day that an employee actually worked for your company, not the date of a job offer.

What is open enrollment?
Open enrollment is the month prior to the employer's annual plan renewal. During this period, employees may add and drop coverage and/or dependents with no other qualifying event or make coverage changes as allowed by the employer. Employers may also change the coverage that is offered. To confirm your renewal month, check your Group Master Application or ask your producer.

How do I change a name or address?
Send an email or fax to BSI that includes the current information and, in the case of a name change, the previous name. BSI will update the information and advise the carriers. In the case of a name change, the medical carrier will issue a new ID card.

Where do I find enrollment forms, benefit summaries, and other plan information and forms?
Those documents can be found on the Trust's website, www.businesshealthtrust.com or through SIMON. If you have any additional questions about your coverage, please contact the carrier or your producer.

How do I pay for my former employee's coverage per a severance agreement we have in place?
An employer may pay for their former employee's coverage due to a severance agreement. However, the terminated employee is not considered an eligible employee under the rules of the Trust and therefore cannot be left on active coverage. The former employee must be terminated from active coverage and the employer can pay for the former employee's COBRA coverage when elected. Please contact BSI's COBRA Department for additional information on how to administer this.

INCOMPLETE FORMS

Will I be notified if I send in an incomplete form?
Yes. BSI will attempt to contact you and/or your producer if there is a problem with an enrollment form. If BSI is unable to contact you, the incomplete form will be returned with a letter explaining why the form could not be processed.

What are some common problems with enrollment forms?

- ❑ *Effective date:* Please consult the "Employee and Dependent Eligibility" and "Enrollment" sections for information on effective dates. If you have questions about your probationary period or what the effective date should be for an employee, BSI will be happy to help you.

- ❑ *Illegible handwriting:* If handwriting is hard to decipher, it is likely an error may be made when enrolling an employee that will cause coverage problems later. 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. Frequently employees write their street address but neglect to include a city, state, or zip code.

- ❑ *Signature:* Both the employee and employer must sign the enrollment form.

- ❑ *Outdated Forms:* Be sure to check the Trust's website for the most up-to-date forms. Forms are located in the Forms Library in the "Employers" section of the website: www.businesshealthtrust.com.

- ❑ *"For Employer Use Only" section:* Please make sure that you check the appropriate plans the employee has elected. This is especially important when dual choice is offered within a carrier.

WHO DO I CALL ABOUT…?

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

Clarification on what benefits the plan covers?
For information relating to what types of services are covered, refer to the plan booklet, contact the carrier's customer service, or contact your producer.

Claims?
Questions about claims should be directed to the carrier's customer service. Please note that neither BSI nor Wells Fargo Insurance Services USA pay claims nor do they have any information about pending, denied, or approved claims.

Credit for a deductible paid to prior provider?
This question would be directed to the carrier's customer service.