BUSINESS HEALTH TRUST

GROUP ADMINISTRATIVE GUIDE

FOREWORD

Welcome to Business Health Trust. We are delighted to present our Group Administrative Guide. This guide will assist you in administering your benefit program through the Business Health Trust. It will serve as a valuable reference to you as an employer who participates in Business Health Trust.

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

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

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

Maud Daudon	Sarai Childs	Emmy Jordan
Trustee, BHT	Trustee, BHT	Trustee, BHT

This guide was developed by the following advisors with a collaboration of efforts of Carriers & BHT Stakeholders:
Benefit Administration Company (BAC) - Billing & Eligibility Administrator
Wells Fargo Insurance Services USA – Benefit Consultant and Program Manager

Please Note: This Group Administrative Guide is only a summary for informational purposes. It is not a contract. The actual terms conditions and limitations of coverage are set forth in the Group Master Application and Trust Adoption Agreement as well as the applicable Evidence of Coverage, Benefit Booklets, Certificate of Insurance, Service Agreement, or Group Policy.

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INTRODUCTION:

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

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

- ❑ Consolidated Administration: one point of contact for billing and eligibility
- ❑ Cobra Administration *(provided through BAC)*
- ❑ On-Line Access: 24 hours access to forms, booklets, and summaries on our website www.businesshealthtrust.com
- ❑ Premium Only Plans *(provided through BAC)*
- ❑ Worksite Wellness Programs: Through Regence BlueShield & Asuris Northwest Health
    - o Care Enhance
    - o Special Beginnings
    - o Personal Health Coach
    - o Case Management

This guide is designed to assist you in the administration of your employee benefits through Business Health 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 thru the day-to-day administration of their benefits thru Business Health Trust. It is not a contract, booklet of insurance, summary plan description, or a certificate of coverage.

All attempts have been made to provide accurate information. In all cases the information provided by the insurers or program manager in the benefit booklets, contracts, and certificates of insurance will govern the conditions and limitations of coverage.

Participating Companies:
Regence BlueShield (RBS)
Asuris Northwest Health (ANH)
Group Health Options Inc (GHO)
Washington Dental Service (WDS)
Dental Health Services (DHS)
VSP (Vision Service Plan)
LifeMap
Wellspring Family Services EAP (WFS)
21st Century Legal Plan
AIG

MAINTAINING ADMINISTRATIVE RECORDS

Your group is responsible for keeping accurate records of plan beneficiaries relating to eligibility, enrollment, payroll deductions, hours worked, premium payments, and other records necessary to administer the benefit plan. Business Health 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 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.

GROUP ENROLLMENT

FOR NEW AND RENEWING BUSINESS

Rates are guaranteed for a 12-month period for individual member groups 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.

Groups must not have any other medical or prescription plans, other than that provided through the Business Health Trust. A group may select medical coverage provided by Regence BlueShield/Asuris Northwest Health or Group Health Options Inc.

MEDICAL

Pre-existing waiting period: Waiver of the 3-month pre-existing condition clause (waiting period) applies to all enrollees with comparable prior coverage. The waiting period will be credited month for month as long as there is no more than a 63-day break in coverage.

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.

LONG-TERM DISABILITY

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

RENEWAL PROCESS

All renewal information is sent to the credentialed producer. BHT does not send any renewal rates or other renewal information to the group. The producer is responsible for contacting the group regarding the new rates and any benefit changes. A renewal proposal is sent to the producer 45-60 days prior to the renewal date.

A 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 USA) no later than 15-days before the renewal date.

EMPLOYEE ENROLLMENT

EMPLOYEE ENROLLMENT

In order to participate in Business Health 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, 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 your group, as a result of an acquisition, merger, or other circumstances, wish to add a new group or expand the group of eligible employees to the plan, please contact your producer.

ELIGIBLE EMPLOYEE

Active, full-time employees of the group who satisfy the weekly hours requirement 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.

ELIGIBLE DEPENDENT

Eligible dependents include:

- ❑ The subscriber's lawful spouse.
- ❑ The domestic partner of the subscriber. If all requirements are met, as stated in the signed Affidavit of Qualifying 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.
- ❑ If applicable, the employer's contribution that is attributable to the coverage for the domestic partner or domestic partner's child will be taxable income to the employee. Similarly, if an employee is contributing some or all of the contribution for coverage of a non-dependent domestic partner or domestic partner's child, that portion of the employee's contribution may not be contributed as a pre-tax salary reduction through an Internal Revenue Code section 125-cafeteria plan. Whether a domestic partner or domestic partner's child is a tax dependent of an employee is a legal tax question. BHT, its' Program Manager (Wells Fargo Insurance Services USA) and its Billing Administrator (BAC, LLC) cannot provide legal or tax advice. If the employer covers domestic partners as dependents, the employer should consult legal counsel for advice on the taxability of the contributions for domestic partner or domestic partner's child coverage.
- ❑ A natural child, an adopted child, a child legally placed with the subscriber for adoption including a child for whom the subscriber has assumed a total or partial legal obligation for support in anticipation of adoption, a stepchild, or a child for whom the subscriber is the legal guardian (the subscriber will need to provide a court order showing legal guardianship), and dependent on the subscriber, spouse, or non-covered legal parent for total or partial support. In addition, a child of the subscriber will be eligible for coverage under this plan when required by a court order. A child must be under age 25 to be eligible for coverage under this plan. Legal documentation may be required.
- ❑ Children who are incapacitated due to developmental disability or physical handicap and chiefly dependent upon the subscriber, spouse, or non-covered legal parent for support and

maintenance are also eligible for benefits, provided the dependent child was covered on the day before the 25th birthday and the incapacity occurred prior to the 25th birthday. Benefits will be provided for the duration of the incapacity unless coverage terminates. Proof of the incapacity and dependency will be required within 31 days after the child's 25th birthday, and not more frequently than one time per year after the child's 27th birthday. If the incapacitated child's coverage ends for any reason after the 25th birthday, the child will not be eligible for coverage under this Dependent Eligibility provision.

MEDICARE SECONDARY PAYER

The Program is subject to the 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 as their primary coverage.

If a participant is on COBRA and is entitled to Medicare based on age or disability, Medicare is primary for any period in which the participant continues with their COBRA coverage.

ENROLLMENT APPLICATION

To become covered under this plan, an employee must first complete an application for themselves and 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 the Administrator 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 they or their dependent is not enrolled 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. If they declined enrollment in writing, for themselves or their dependents, due to other health coverage, they and any eligible dependents may apply for coverage under this plan, or any other plan offered by the group, prior to the next anniversary date if the Administrator receives their application for coverage within 30 days of exhaustion of COBRA continuation coverage, loss of eligibility for the prior health coverage, or loss of an employer's contribution to the rate for the prior health coverage.

For LifeMap, Evidence of Insurability is required for late enrollees. They would be made effective the first of the month following date of approval from LifeMap.

Coverage will begin on the first day of the month after the Administrator has accepted and/or approved the application. If an employee acquires a dependent through adoption, placement for adoption, birth of a child, or marriage, they and their dependents may apply for coverage either under this plan or any other plan offered by the group, prior to the next anniversary date. The Administrator must receive their application within 31 days of marriage, or within 60 days of birth, placement for adoption, or date of assumption of total or partial legal obligation for support of a child in anticipation of adoption. Coverage will begin retroactive to either the date of birth of a natural newborn, the date of placement

of an adoptive child, the date of assumption of total or partial legal obligation for support of a child in anticipation of adoption, or in the case of marriage, on the first day of the month after the Administrator has accepted the application. Please submit a new Employee Enrollment & Change Form if there is any change in the family's eligibility.

SPECIAL ENROLLMENT RIGHTS

If a participant declines enrollment for themselves or their dependents (including spouse) because of other health insurance coverage, they may in the future be able to enroll in this plan, provided that they request enrollment within 30 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 may be able to enroll themselves or their dependents, provided that they request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption

- In order to have Special Enrollment Rights:
  - Participant or dependent must have previously declined coverage in writing.
  - Participants must notify administration within 30 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 application
    - Marriage
      - Effective 1st of the month following application
    - Birth
      - Effective on the date of birth
    - Death
      - Effective on the date of death
    - Divorce
      - Effective 1st of the month following application
    - Adoption
      - Effective on the date of adoption, or the date in which the child(ren) are placed with the employee for adoption.
  - Participant can then enroll themselves (if not previously enrolled), and their dependents in available coverage.

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 following events occur (for Life and LTD coverage: coverage ends the day employment ends):
  - 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 Program's continued participation requirements

- the participating employer notifies the Program 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

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

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

- ❑ For a spouse/dependents:
  - o when his or her marriage to the employee is annulled
  - o when he or she becomes legally separated or divorced from the employee.
  - o For a domestic partner when his or her domestic partnership relationship with the subscriber is ended. (See Appendix).
  - o For a child when he or she no longer meets the requirements for dependent coverage.

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 billing administrator, BAC, within 30 days of the date the participating employer was notified of such event. Retroactive adds are available for 30-days plus the current month. Retroactive terminations are only available back to the last day of the preceding month. Those retroactive cancellations may be acceptable as long as (1) the plan covers only active employees (or those on COBRA), (2) the employee or member has paid no premium for coverage after the effective date of the cancellation, and (3) the employee or member had no expectation of coverage after the requested effective date of cancellation.

When an individual's coverage terminates, the employer (or its designated representative) must distribute HIPAA certificates of creditable coverage. If the insurance carrier sends the certificate, the employer is still responsible to ensure that the certificates satisfy HIPAA's requirements. If the plan is subject to COBRA, very specific notice obligations apply to the employee or affected qualified beneficiary if coverage is lost due to divorce, legal separation or a child's losing dependent status (see the following sections). In addition, if the plan is not subject to COBRA (generally the employer had less than 20 employees in the preceding calendar year), the employer must be aware of the continuation of Group Health Options Inc. coverage rights that are available to terminated employees. These rights are described in the next section.

For complete details about coverage termination, please refer to the appropriate benefit booklet.

BENEFIT EXTENSION

The employer must inform participants that there is a benefit extension for medical, dental, and vision plans for up to 6-months for participating employees. This is available to groups who are **not subject to COBRA** (typically defined as having less than 20 employees in the prior calendar year). The employee must submit an Enrollment/Change form and elect the benefit extension. The premium may be charged to the employee on a self-payment basis. The premiums for employees on benefit extension will be reflected on the monthly group invoice and group must pay the premium via company check. Personal Checks or payments directly from the participant will not be accepted. This coverage cannot extend beyond 6-months.

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 Non-COBRA continuation of coverage and the maximum COBRA continuation period, except as prohibited under the FMLA (Family and Medical Leave Act of 1993). For LTD Coverage, Leave of Absence ends as of the end of the next month.

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 program 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 affected employer or their agent/producer should contact BAC. Requests may not be directly submitted by employees or dependents. Requests for review must be in writing and must be submitted to BAC 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.

ENROLL A NEW EMPLOYEE

Use the BHT Employee Enrollment/Change form. A copy of the form can be found in our form library, which can be located at www.businesshealthtrust.com. Alternatively, contact customer service at BAC to have a copy of the form sent to you.

Coverage Enrollment Rules		
Medical	**Regence BlueShield**	EE can waive
	Asuris Northwest Health	EE can waive
	Group Health Options Inc	EE can waive
Dental	**Dental Health Service**	EE can waive
	WDS - 100% Employer Paid	If coverage 100% ER paid then ALL employees must be enrolled.
	WDS - 75-99% Employer Paid	If coverage less than 100% ER paid then EE must complete form to waive.
Basic Life and AD&D	**LifeMap**	If the group offers it, ALL employees must be enrolled
LTD	**LifeMap**	If the group offers it, ALL employees must enroll - Small groups may have to complete and qualify thru EOI
Vision	**VSP**	If the group offers it, ALL employees must be enrolled
EAP	**Wellspring Family Services**	If the group offers it, ALL employees must be enrolled.
Supplemental Life and AD&D	**LifeMap**	Voluntary
Dependent Life	**LifeMap**	Voluntary
Personal Accident (PAI)	**AIG**	Voluntary
Legal Plan	**21st Century Legal**	Voluntary
Groups must satisfy carrier minimum participation rules.		

FILLING OUT THE 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 in the future. Forms with any missing information, such as birth date, date of hire, enrollment reason, will not be processed. You must print clearly or type the form.

Write the company name in the "Employer Name" box.

In the "Hire/Event Date" box, write the date of the employee's hire or other qualifying event. If the qualifying event is not a new hire, note what the qualifying event is. If the employee is transitioning from part time to full time employment, note both dates. Additionally, write the number of hours the EE works each week.

EFFECTIVE DATE

Consult your Group Master Application for the length of your probationary period. Most probationary periods are 0, 30, 60, or 90 days long. The period begins on the employee's date of hire. Their effective date 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, 2013 and the group had a 30-day probationary period, the effective date would be February 1. If the same employee were hired January 8, 2013, the probationary period would end February 6 and the employee's effective date would be March 1. If an employee's probationary period ends on the 1st of the month, that will be the effective date.

- ❑ Check the "Hire/Rehire" box in the "Reason for Enrollment" section.
- ❑ Enter the employee's name, date of birth, gender, Social Security Number, and mailing address in the "Employee information" section.
- ❑ Check the boxes in the "Plan Selection" section that match the coverage you have through the BHT. If you are unsure of your coverage, consult your Group Master Application or Producer.
- ❑ Have your employee enter information about their dependent coverage and any prior coverage.
- ❑ On the signature page the employee sign and date the left box and the group administrator sign and date the right box.

DEPENDENT ENROLLMENT RULES

If Employee has Coverage Below…	**Apply corresponding coverage rules.**	
Medical	**Dental**	**Vision**
EE Only	EE only	EE only
Dependents Covered	MUST cover same dependents	MUST cover same dependents
EE Waived	May enroll; MUST cover same dependents	May enroll; MUST cover same dependents
Dental	**Medical**	**Vision**
EE Only	EE only	EE only
Dependents Covered	May cover dependents	MUST cover same dependents
EE Waived *(Cannot be Waived if Employer pays for Employee Coverage)*	May enroll and cover dependents	May enroll; MUST cover same dependents
Vision	**Medical**	**Dental**
EE Only	EE only	EE only
Dependents Covered	May enroll and cover dependents	May enroll; MUST cover same dependents
EE cannot waive if Vision is offered by group		

HOW TO ENROLL A DEPENDENT

Using the Business Health Trust Consolidated Enrollment Form

- ❑ Put the first day of the first month of intended coverage in the "Effective Date" box.
- ❑ In the Hire/Event date box, put the event date.
  - o This is the date that the dependent lost coverage, married the employee, was born, etc.
- ❑ Indicate the qualifying event in the "Reason for Enrollment" box.
- ❑ Enter the employee's information in the "Employee Information" section.
- ❑ Enter the dependent's information in the "Dependent Information" section.
  - o Circle "add" next to the dependent's name.
- ❑ On the signature page have the employee sign and date the left box
- ❑ Sign the group administrator line and date the right box.

NEWBORN & ADOPTED CHILD ENROLLMENT

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

ERIN ACT: Regular Benefits for this plan will be provided for routine care, illness, accidental injury, or physical disability, including congenital anomalies, for the newborn child for up to 21 days following birth when the subscriber, or subscriber's spouse is eligible for maternity benefits of this plan.

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 if the Administrator receives the subscriber's application for the new dependent's coverage within 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 18, or child placed for adoption under age 18, none of the preexisting limitations or preexisting condition waiting periods of this plan 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, the administrator should receive applications within 31 days to prevent delays in claims processing.

HOW TO ENROLL A NEWBORN

Using the Business Health Trust Consolidated Enrollment Form

- ❑ Follow the same procedure for enrolling a dependent, putting the newborn's date of birth in the effective date box and the event date box.
- ❑ What if the newborn doesn't have a Social Security Number yet?
    - o Send in the enrollment without the SSN. When one is assigned, notify BAC so it can be added to the file.
- ❑ Check the birth/adoption box in the "Reason for Enrollment" section.

HOW TO TERMINATE COVERAGE FOR AN EMPLOYEE

Using the Business Health Trust Consolidated Enrollment Form

- ❑ Put the last day of the last month of coverage in the effective date box.
- ❑ Put the employee's actual last day of work/date of termination in the "event date" box.
- ❑ Check "Termination" in the "Reason for Enrollment" box.
- ❑ Enter all of the employee information.
- ❑ Sign the right box of the 3rd page and date it.
    - o You do not need an employee signature when an employee terminates employment or you can send other written documentation providing information on the termination.

Life, AD&D and LTD coverage does not extend to end of month. It is terminated the same day employment terminates.

TO TERMINATE COVERAGE FOR A DEPENDENT ONLY

Using the Business Health Trust Consolidated Enrollment Form

- ❑ Enter the last day of the last month of coverage in the effective date box.
- ❑ Choose "delete dependents" in the "Reason for Enrollment" section.
- ❑ Enter the all employee information.
- ❑ Enter the dependent information, circling "delete" next to 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.

HOW TO ENROLL A NEW SPOUSE

Enroll a new spouse like you would a dependent, entering the date of marriage in the event date box and the 1st of the month after the event date in the effective date box. Check the "Other" box in the "Reason for Enrollment" section, and write "marriage" in the blank. A domestic partner is enrolled similarly to a spouse, though a signed affidavit is necessary.

PROBATIONARY PERIOD

A probationary period cannot generally be waived. However, it may be waived, at the discretion of the insurer, for key employees only for groups with more than 10 employees. To do this, you will need to write a letter on company letterhead stating that the employee is indeed a key employee and that the waiver is a condition of employment.

Key employees are defined as those employees who are at or above the highest paid 10% of all the 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 Business Health Trust and/or insurer. Be sure to include the employee's name, date of hire, and requested effective date. These requests will need to be reviewed and approved by the insurer on a case-by-case basis. BAC will notify the group if the request has been denied.

HOW TO CHANGE A NAME OR ADDRESS

Send an email or fax to BAC that includes the current information and, in the case of a name change, the previous name. This information should be changed with the administrator and they will then update the insurer's files.

REQUEST A NEW ID CARD

The member can order replacement ID Cards from Regence at www.myregence.com. Click on the "My Navigator Tab" and then Member Cards.

Alternatively, you can send an email to BAC listing the names of the employees who need new ID cards. If you have already ordered new cards and have not received them, please note it can take 12-14 business days for cards to arrive. You may request a new card directly from customer service at the insurer. If an employee needs to obtain care prior to receiving their card, they can generally use their social security number and the group number.

WDS does not issue individual cards, but you can register online for a temporary one at www.deltadentalwa.com. Click on the 'Patients' tab. They will ask for a member ID, which is your social security number.

VSP does not issue individual 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.

HOW TO TRANSITION AN EMPLOYEE FROM PART-TIME TO FULL-TIME EMPLOYMENT

Fill out a 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.

HOW TO TERMINATE COVERAGE THROUGH BHT AT A GROUP LEVEL

Send a letter on company letterhead to BAC and Wells Fargo Insurance Services USA. The letter should indicate the last day of coverage and list all coverage being terminated. 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 check to cover any overpayments prior to plan termination.

BILLING

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

When payment is remitted you can submit a change form, which outlines the credits you feel, should be reflected the following month. Premiums should not be adjusted for these changes. Credits or Charges will be reflected on your following months invoice.

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

Bills included both detail page(s) and a summary of the premiums due. The summary page will reflect any past due premiums and their delinquency period. The tiering structure for benefits and the codes reflecting these are listed below.

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

Medical				**Dental**				**Vision**	
RBS/ANH		**GHO**		**WDS**		**Dental Health**		**VSP**	
RE	Employee Only	HE	Employee Only	DE	Employee Only	DE	Employee Only	VE	Employee Only
RS	Employee + Spouse	HS	Employee + Spouse	DS	Employee + Spouse	D1	Employee + 1 Dependent	VS	Employee + Spouse
RC	Employee + Child(ren)	HC	Employee + Children	DC	Employee + Child(ren)	D2	Employee + 2 Dependents	VC	Employee + Child(ren)
RSC	Employee, Spouse + Child(ren)	HSC	Employee, Spouse + Children	DSC	Employee, Spouse + Child(ren)	D3+	Employee + 3 or more Dependents	VSC	Employee, Spouse + Child(ren)

BILLING TIME FRAMES & DELINQUENCY POLICY

It is Business Health 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 also be in good status in or to maintain participation in the program. If you are delinquent on your membership dues, your premium may not be considered to have been paid and your coverage may be pended or delayed. If you are invoiced monthly for your dues, your premium will not be posted without your dues payment.

Groups may be termed for non-payment per the delinquency policy. Checks returned for Non-Sufficient Funds (NSF), Account Closure, or Payment Stopped will not be considered as having been paid in terms of the delinquency timeline. If any of these events occur, a group must provide a Cashier's Check or Wire Transfer with proof that the business is still active. If payment is not received within the payment due period, the groups coverage will be pended. If payment is not received by the end of the coverage month, coverage will be terminated retroactively to the last paid-thru date.

Employers who collect employee deductions 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 your former employees' behalf. Their coverage is dependent on being in good standing with their coverage premiums. If either situation applies to your group please contact your legal advisor for more information. Business Health Trust, its Program Manager, and its Billing Administrator are not tax or legal consultants and cannot provide further information on your responsibilities.

There are two steps followed for cancellation due to lack of premium payment

1. Letter sent requesting payment
2. Letter sent notifying group of cancellation

Example for May Invoice

April 1-10	May invoice is calculated and mailed
April 20	May payment is due – payments after this date are considered late
May 5th	Group is considered delinquent if May premium is not received. ❑ Letter is sent to the group requesting payment of all past due premiums within 20 days, broker is also included on this communication
May 31st	Notification of retroactive termination sent to group, broker, program manager, endorsing sponsor, and all applicable carriers

If a group is delinquent three times in a calendar year, the third notification will instruct the group to pay in full within 10 days. If a group is delinquent four times within a calendar year, they may be terminated.

Payment in full is due by the 20th of the prior month; for example, payment for May benefits is due April 20. Payment received after the cutoff period is considered late and may be subject to late fees and the temporary pending of coverage by the carrier until payment is received. If payment is not received

by the last business day of the coverage month, the group will be considered delinquent. The group will be notified in writing that if payment is not received within 10 days from the date of the letter the group will be terminated for non-payment. If a group is delinquent four times within a calendar year, they may be terminated.

If a group is terminated for non-payment, they have one reinstatement opportunity, which must occur within 60-days of the last paid thru period. Reinstatement will be at the discretion of the insurers and must be requested in writing and submitted to the billing administrator. If group is not reinstated, they cannot reapply for coverage thru the program for 12 months.

LATE FEE POLICY

The Business Health Trust has a late fee policy for all premiums remitted after the due date of the 20th.

Here's an example of the late fee schedule for illustrative purposes:

May 20th June payment is due.

June 1-10th During the calculation of your July invoice, if your June payment was not received by the premium deadline (May 20th), a late fee may be added to the July invoice based on the fee structure below.

Late Fee Structure	
Company Size	**Amount**
< 15 employees	$55.00
15 - 25 employees	$75.00
26 - 50 employees	$125.00
51 - 75 employees	$200.00
76+ employees	$225.00

All 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 "NOT PAID AS BILLED".

BILLING FAQS

I know my payment is going to be late. Whom do I call?
If your payment will be late, contact BAC. Please be aware that late payment may result in your coverage being pended.

I sent in a change and it is not reflected on my invoice. Why?
Changes received by BAC after 3:00 pm on the 20th of the month will not be reflected on the next invoice. For example, if a termination notice was received on March 24 that change would be reflected on the June invoice. BAC will issue retroactive charges and credits for enrollments and terminations on future invoices.

When do I need to submit changes to ensure that they are on my next invoice?
Please submit enrollment changes as soon as possible. To ensure they are on the next invoice, changes must be received by BAC no later than 3:00 pm on the 20th two months prior to the month of coverage.

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 enrollment forms to BAC and pay as billed. BAC will make the adjustments on the next invoice, and the employee's coverage will be effective immediately.

I believe my invoice is incorrect. What should I do?
If you believe the rates are incorrect or you are owed a credit that was not issued, please contact BAC to discuss possible inaccuracies. Please do not make adjustments without first contacting BAC. Incorrect or unexplained adjustments could result in 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 BAC and are not yet reflected on your bill, please remember that bills are prepared approximately 6 weeks in advance of the month of coverage, and anything not received by the 20th two months before the coverage period will not be reflected on the invoice (that is, for a change to be reflected on the May invoice, BAC must receive notification no later than March 20th). If you have not submitted the enrollments or terminations to BAC yet, please do so.

I have been told my coverage is "pended." What does that mean?
Usually this has something to do with payment information that is inconsistent between the insurer and administrator. Pended coverage is not cancelled. However, when coverage is pended rather than cancelled, this does not guarantee payment of claims. If you are told your coverage is pended and you believe your premium payments are current, please contact BAC to verify that all payments have been received.

I did not receive an invoice this month.
Please contact BAC to request that an invoice be resent to you.

How do I change the billing/administrative contact or address for the group?
Please send BAC 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 20th of the month, it is possible your next invoice will show a balance forward. If you have specific questions about a balance forward, please contact BAC.

How is the money I remit going to be applied? Will I be notified?
Each payment is applied to the most dated outstanding month. If you remit payment for your November invoice but have not paid your October invoice, 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 BAC for adjustment on a future invoice.

What is an eligible employee?
Any employee of a BHT participating company who satisfies the terms set forth in your Group Master Application is an eligible employee. Your Group Master Application outlines how many hours per week an employee must work as well as the length of the probationary period.

What is an eligible dependent?
Spouses and children under the age of 25 are considered eligible dependents. Under some circumstances, domestic partners (with signed affidavits) and former spouses of employee are also eligible.

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 regarding probationary periods, part-time to full-time transfer, and domestic partner coverage. If you do not have a copy of your Group Master Application, please contact your producer.

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 Regence/Asuris and five digits for Group Health Options Inc. If you are unsure of your group number feel free to contact BAC and we will be happy to provide that information to you.

What is my location number?
This number is assigned to you by BAC. It is a four digit number. If you do not know your location number, please check your most recent invoice. It is located on the payment stub.

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 BAC received the enrollment form January 5, the employee would not be added to the invoice until March. On that invoice, there would be a charge for the January and February premiums in addition to the March premium. Please pay as billed and allow BAC to make premium adjustments for you.

What is an effective date?
This is the date that an employee's coverage though the BHT goes into effect. The effective date is the first of the month following the end of the probationary period or, for groups with no probationary period, the first of the month following date of hire. If an employee's date of hire is the first working day of the month and the group does not have a probationary period, the effective date is the first of the month. If you have questions about what an employee's effective date should be, please contact BAC.

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.

FAQs

What is a qualifying event?

It is an event that qualifies an employee or a dependent for a change in coverage other than open enrollment. In general, an employee cannot change (add or drop) coverage for him or herself or dependents, except at open enrollment. Some common examples of qualifying events 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.

Quick Reference Table of Authorized Change of Election Events	**Insurance Plan**
Change in Legal Marital Status or Number of Dependents:	
Marriage, Divorce, Legal Separation, Annulment	Yes
Death of Spouse or Dependent	Yes
New Child (birth, adoption or placed for adoption)	Yes
Gain or Loss of Employment	Yes
Going from Full-Time to Part-Time or Part-Time to Full-Time	Yes
Change in Work Schedule Due to Strike or Lockout Resulting in a Loss of Eligibility	Yes
Return from or Commencement of Unpaid Leave of Absence	Yes
Significant Change in Employed Spouse's Health Plan	Yes
Gain/Loss of Coverage under Participant or Dependent's Health Plan	Yes
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:	
Plan Receives Qualified Medical Child Support Order	Yes
Employee/Dependent Medicare or Medicaid Eligibility Change	Yes
Significant Change in Health Insurance Premiums or Coverage	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
Dependent wants to enroll because they were previously uninsured	No – Not without other qualifying event.

Incomplete Forms

Will I be notified if I send in an incomplete form?

Generally, yes. Benefit Administration Company and the Business Health Trust Administration Team will attempt to contact you if you have not completed a form or if there are discrepancies. If BAC is unable to contact the group, incomplete forms will be returned with a letter explaining why the form could not be processed.

What are some common processing issues?

- ❑ 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 for an employee the Business Health Trust Administration Team at BAC will be happy to help you and answer any questions you may have.

- ❑ Illegible handwriting: If handwriting is hard to decipher, it is more likely an error will 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 need to sign the enrollment form.

- ❑ Outdated Forms: Please check the BHT 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

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. For Regence Life & Health, coverage EOI is required for late enrollment. For employer paid coverage's all eligible employees are to be enrolled from their effective date. For employee paid coverage's satisfactory evidence of insurability is required. Once approval is provided by RLH insured would be effective first of the month following date of approval.

WHERE DO I FIND…

Enrollment forms?
Enrollment forms can be found on the BHT website www.businesshealthtrust.com. To locate the forms, go to the "Employer" section and choose the "Forms Library" link. Alternatively, you can contact BAC and request one be emailed or mailed to you.

Plan Information
Plan information is available on the BHT website, www.businesshealthtrust.com. Plan information is also included in benefit booklets.

Benefit Booklets
If you are in need of materials, please contact your producer. The program website, www.businesshealthtrust.com, will have plan highlights and booklets for download as well.

Benefit Summaries
Benefit Summaries are available online at www.businesshealthtrust.com they are listed under the line of coverage, and then select "Highlights". If you have addition questions about your coverage, please contact the insurer or your producer.

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.

Whom do I ask about my bill?
Billing questions should be directed to BAC.

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 USA 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

Where do I find out about the status of quote?
Please contact your producer for the status of your quote.

How do I verify that my enrollment has been processed?
Please contact BAC for enrollment questions. BAC will be able to confirm if enrollment has been processed and what the effective date of coverage is. However, BAC is unable to answer premium rate or quote questions.

Enrollments/changes?
Please send enrollment/change questions to BAC. Enrollments should be submitted no later than the 20th of the month in order to be reflected on the following months billing. For example, changes that you want reflected on your May invoice need to be submitted to BAC by March 20.

Claims?
Questions about claims should be asked of the insurer. Please note that neither BAC nor Wells Fargo Insurance Services USA adjudicate claims nor do they have any information about pending, denied, or approved claims.

Pre-existing conditions?
Generally, pre-existing condition claims questions are handled by the insurer. If the insurer has told an employee there is a "prior coverage" issue, BAC can confirm with the insurer that prior coverage information submitted on the enrollment form has been communicated accurately with the insurer.

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.

GLOSSARY OF TERMS

Asuris Northwest Health: Non-BlueShield subsidiary of Regence BlueShield. Provides healthcare coverage to people in Adams, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Grant, Kittitas, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla, and Whitman Counties where Regence BlueShield does not have approval from the Blue Cross and Blue Shield Association to use the BlueShield brand and logo.

Benefit Extension: For Groups who are not subject to COBRA there is a 6-month employee paid benefit extension available for health plan coverage.

Blue Cross and Blue Shield Association (BCBSA): A nonprofit corporation formed by Blue Cross and Blue Shield plans to act as the national coordinating agency for independent licensees of BCBSA. Located in Chicago, Illinois.

Carrier: Term used to describe the insurance company.

Centers for Medicare and Medicaid Services (CMS): A division of the federal Department of Health and Human Services that is responsible for the administration of the Medicare and Medicaid Contracts.

CHAMPUS: The federal health care program for military dependents and retirees.

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 Options Inc care coverage when specific events occur that would normally result in loss of coverage.

Coinsurance: The member's percentage cost share for any benefits provided at less than 100%.

Coordination of Benefits (COB): A provision designed to avoid duplicate payments or payments in excess of charges for benefits covered under more than one individual or group contract.

Copay: The amount, in addition to the rate, that the member is required to pay for certain services and supplies provided under the contract. The member is responsible for the payment of any copay directly to the provider of the service or supply.

Cost Sharing: Provisions of a health insurance contract that require the covered individual to pay some portion of covered medical expenses. Forms of cost sharing are deductibles, coinsurance, and copays. In addition to being used to reduce rates, cost sharing is used to manage utilization of covered services (for example, by requiring copay for a service that is likely to be overused).

Deductible: Members' stated portion of the cost of care before certain contractual benefits are paid.

Dependent: the subscriber's lawful spouse or domestic partner; a natural child, adoptive child, a child legally placed for adoption, stepchild, or legally designated minor ward of the subscriber who is primarily dependent on the subscriber, spouse, or non-covered legal parent for support. Dependent children of or over a certain age (to age 25) can be excluded from coverage, unless they are incapacitated.

Diagnosis: The statement of a medical condition or disease, the cause of which may not be determined.

Effective Date: The date coverage begins.

Eligible Out-of-Pocket Expenses: a member's share of payment for benefits covered by a plan that is used for the accumulation of a stop-loss provision.

Emergency: The sudden and unexpected onset of a condition or the exacerbation of an existing condition requiring medically necessary care to safeguard the patient's life or limb immediately after the onset of the emergency. For the purpose of benefit determination, consideration will be given to the symptoms of the condition and to the actions that would have been taken by a prudent person under such circumstances.

Employee Assistance Program (EAP): is a comprehensive program that helps employees resolve personal problems that may adversely impact their work performance, conduct, health and well-being.

Enrollment: The act of becoming covered under a contract; also the total number of members covered under a contract.

ERISA – Employee Retirement Income Security Act of 1974: A federal law primarily enacted to affect pension equality, ERISA also contains provisions to protect the interests of group insurance plan participants and beneficiaries. It requires, among other things, that insurance plans be established pursuant to a written instrument that describes the benefits provided under the plan, names of the persons responsible for the operation of the plan, and spells out the arrangements for funding and amending the plan.

Exclusions: Provisions in the contract stating situations, services, or conditions, for which benefits are not provided.

General Practitioner – GP: A licensed physician who is engaged in general practice including surgery, medicine, and obstetrics, but who does not specialize in a particular branch of medicine.

Group Health Options, Inc.: Group Health Options, Inc was incorporated in 1990 as a wholly owned subsidiary of Group Health Cooperative. It offers a variety of health plans in Washington and Idaho that provide choice and flexibility to meet the needs of large and small employers. These range from a defined physician-network plan to point-of-service plans in which members can get care from outside the network for higher out-of-pocket costs.

HIPAA: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides expanded rights and protections for participants and beneficiaries in Group Health Options Inc 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 that:

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

HIPAA Certificate: A HIPAA certificate is provided to verify continuous coverage. 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.

Identification Card: The ID card presented to providers by participants to establish positive coverage identification. It does not give authorization for services nor is it a guarantee of payment.

Inpatient: A person confined overnight in a hospital or other facility as a regularly admitted bed patient to whom a charge for room and board is made in accordance with the hospital's or facility's standard practices.

Mandated Benefit: A benefit required by either State or Federal law to be included in the health care contracts.

Maximum Amount: Total dollar amount allowed under a contract.

Medically Necessary: A service or supply that is required to diagnose or treat the condition; is consistent with the symptoms of diagnosis and treatment of the condition; is the most appropriate supply or level of service that is essential to the need; when applied to an inpatient, it cannot safely be provided on an outpatient basis, including diagnostic studies; is not an investigational service or supply; is not primarily for the convenience of the patient or provider. Medical necessity is determined by the insurer.

Medicare – Title XVIII of the Social Security Act: The portion of the Social Security Act that provides health care benefits to citizens age 65 and older and to citizens who are disabled. Includes Medicare Part A (hospitalization) and Medicare Part B (medical and surgical benefits supplementary to Part A).

Medicare Beneficiary: An individual, who has attained the age of 65, is a resident of the United States and is either a citizen or an alien lawfully admitted as a permanent resident who has resided in the United States continuously during the five years immediately preceding the month in which he or she applies for enrollment under Medicare. The individual must also be eligible to enroll in the insurance program established by Medicare, and be entitled to hospital insurance benefits of the Medicare Program. May also be a disabled individual under age 65.

OBRA: 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. 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 SHPS in writing of the determination before the

expiration of the 18 months of COBRA and within 60 days of receiving it. 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 OBRA period.

Open Enrollment Period: The period once each year (usually 30-days prior to the groups' anniversary date) when employees can enroll for coverage or add dependents to their coverage. Coverage is usually effective on the anniversary date of the group's contract.

Out-of-Area Provider: A provider outside of the service area, acting within the scope of that provider's license who belongs to a category of providers whose services or supplies would be covered if furnished in the service area. The out-of-area provider must have qualifications and license or certification equivalent to the qualifications and license of certification required for comparable provider category inside the service area.

Outpatient: A patient who is not officially admitted as an inpatient, but who receives hospital care without occupying a hospital bed overnight.

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

Participating Provider: A provider who entered into a current participating agreement with the insurer and whose name is included on the current updated list of participating providers for that contact as prepared by the insurer.

Probationary Period: The period of time during which a new employee is not yet eligible for benefits.

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 has identified information). It also includes health information with data items, which reasonably could be expected to allow individual identification.

Provider: An individual, institution, or organization, qualified to provide medical care services or supplies (e.g., hospital, physician, or skilled nursing facility).

Regence BlueShield: A health care service contractor in Washington State. Also an affiliate of the Regence BlueShield Group. It provides medical, surgical, hospital, prescription drug, vision, and or dental benefits on a prepaid basis to individuals and groups in Clallam, Columbia, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Klickitat, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, Walla Walla, Whatcom, and Yakima Counties. Corporate headquarters are located in Seattle, Washington.

Registered Nurse: A nurse who has passed the state board qualifying examination and who has been registered and legally licenses to practice by state authority.

Renewal: The period each year when benefits and or rates may be adjusted for the next contract year. The renewal date is usually the same as the contract anniversary.

TEFRA: A federal law that amends the Age Discrimination in Employment Act of 1967 by requiring any company with 100 or more employees to offer the same health benefits to employees and spouses aged 65 and over that is provided to younger employees.

Third-Party Administrator: An organization that provides certain administrative services to group benefit plans, including premium accounting, consolidated billing, and maintenance of employee eligibility records in the case of Business Health Trust.

TRICARE: Nationwide Department of Defense (DOD) managed care program, operated in partnership with civilian contractors, that is designed to ensure high-quality consistent health care benefits; preserve beneficiaries' choice of health care providers; improve access to care and contain care costs. The program offers a choice of health maintenance organization, a preferred provider organization, or a fee-for-service program (the former CHAMPUS program).

Waiting Period: The period of time between the members' effective date of coverage and the date that the insurer will provide benefits for certain services.

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.

APPENDIX A

BUSINESS HEALTH TRUST

EMPLOYER CONTACT LIST

Benefit Administration Company (BAC) – Third Party Administrator – Billing and Eligibility Questions
Customer Service Billing Phone: 206.812.1325 ext. 319 Producer Commission Phone: 206.812.1325 ext. 285 PO Box 2735 Seattle, WA 98111-2735 bhtadmin@baclink.com
For forms and resources, please visit www.businesshealthtrust.com

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

Regence BlueShield & Asuris Northwest Health – Medical Insurance	Group Health Options, Inc. – Medical Insurance	Washington Dental Service (WDS) – Dental Insurance
Customer Service Phone: 888.370.6156 (RBS) Phone: 888.370.6162 (ANH) 1800 Ninth Avenue, PO 21267 Seattle, WA 98111-3267 Producer Support: 206.464.7822 www.regence.com www.asuris.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
LifeMap – Life/AD&D and Disability Insurance (formerly Regence Life and Health)	Wellspring Family Services EAP – Employee Assistance Plan	Vision Service Plan (VSP) – Vision Insurance
Customer Service Phone: 800.794.5390 100 SW Market St., M/S E3A Portland, OR 97207 www.lifemapco.com	Customer Service Phone: 800.553.7798 Fax: 866.495.0441 1900 Rainier Avenue South Seattle, WA 98144 www.wfseap.org	Customer Service Phone: 800.877.7195 600 University St, Ste 2004 Seattle, WA 98101 www.vsp.com
Dental Health Services – Dental Insurance	Chartis – Business Travel and Personal Accident Insurance	21st Century Legal Plan
Customer Service Phone: 800.248.8108 936 N 34th Street, Suite 208 Seattle, WA 98103 www.dentalhealthservices.com	Customer Service Phone: 877.867.3783 121 Spear Street, 5th Floor San Francisco, CA 94105 Fax: 415.546.3100	Customer Service 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
Tri-City Regional Chamber of Commerce	www.trcchamber.com

BUSINESS HEALTH TRUST

HIPAA PRIVACY & SECURITY POLICY

Dear Employer,

This letter will review Business Health Trust's obligations under the HIPAA Privacy and Security regulations.

HIPAA, the Health Insurance Portability and Accountability Act of 1996, was created (and further modified by the American Recovery and Reinvestment Act of 2009) in part to provide protection to individuals with regards to their health information. The regulations are enforced by the Office of Civil Rights and apply to covered entities such health plans, health care clearinghouses, and health care providers.

Under the current privacy and security regulations, the Trust does not have any compliance obligations:

- The Trust is not a "Group Health Plan" covered under HIPAA because it is not a welfare benefit plan under ERISA;
- The Trust does not use, create, transmit or otherwise disclose any Protected Health Information electronically, or otherwise;
- Your Insurance Carriers and other service providers may use or disclose Protected Health Information;
- The Trust is Not a "Business Associate" under HIPAA because it is a funding mechanism for securing access to group insurance.

Insurance Carriers and other companies that provide services to your group health plan must comply with the requirements that protect an individual's health information. You and your group health plan may have separate obligations with regards to the privacy and security regulations. The Trust cannot provide you with legal advice about compliance. For advice on the compliance obligations of your group health plan, please contact your legal counsel.

Sincerely,

Business Health Trust

APPENDIX B

PREMIUM ONLY PLAN

Business Health Trust does not offer flexible benefit plan services. However, you may contract for such services provided by BHT's partner, Benefit Administration Company.

Premium Only Plan Overview

Flexible benefit plans are covered under Section 125 of the Internal Revenue Code. Often referred to as cafeteria plans, they provide plan sponsors and their employees with a simple and convenient solution for paying out-of-pocket premium with pre-tax dollars. A cafeteria plan is a written benefit plan maintained by an employer for the benefit of its employees.

Who May Sponsor a Plan

- ❑ C-Corporation owners may sponsor and participate in a cafeteria plan.
- ❑ Subchapter S-Corporation shareholders of more than 2% ownership may not participate in a cafeteria plan, but they may sponsor a plan for their employees. In addition, the family members and certain relatives of the shareholder may not participate.
- ❑ Members of a LLC, LLP, and Sole Proprietorship may not participate in a cafeteria plan. However, they too may sponsor a plan for their employees. Additionally, in some cases, a member's spouse, if a bona fide employee of the company, may participate and benefit the other family members.

The term employee includes both present and former employees, but not self-employed individuals as described in section 401(c). The plan may not be established primarily to benefit key or former employees.

Employer Benefits

- ❑ Immediate tax advantages. The employer saves 7.65% - the employer share of FICA taxes on the employee elected pre-tax benefit amount.
- ❑ Delivers better control of payroll and benefit costs.
- ❑ Improves employee perception and appreciation of the company benefit package. The employer is offering tax breaks to employees that would otherwise be unavailable to them.

Employee Benefits

- ❑ Immediate tax advantages. The employee saves the 7.65% on their pre-tax benefit election as well as federal income tax (15% to 40% depending on the employee's tax bracket).
- ❑ Increased take-home pay.
- ❑ Increased awareness of their employer's benefits package.

Plan Compliance

- ❑ Premium Only Plans require the adoption of a formal plan document and delivery of certain required employee communication pieces. In addition, the plan is subject to various IRS rules dealing with non-discrimination.
- ❑ BAC is available to assist employers with all technical requirements.