

Group Services Guide

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Section 1. Employee Information

Eligible Employees

For an employee to be eligible, the following requirements must be met:

1. Has commenced working for the Employer at its usual place of business
2. Spends time and energy in the service of the Employer on a full-time basis for at least 30 or more hours per week. If an employer chooses, an employee who works on a full-time basis for at least 30 hours per week, 25 hours in Ohio can be considered however this must be applied uniformly for all employees regardless of health conditions; and
3. Is receiving Earnings, which are reportable to the Internal Revenue Service (IRS) as taxable income.

Partners and owners are eligible for coverage.

Continued Eligibility

The employee will no longer be eligible once the employee has ceased performing services for the employer for more than ninety (90) consecutive days.

New Employees

WAITING PERIOD is the period of time an employee must be continually employed before they become eligible for participation in the plan.

Example:

- ❖ **New Hire Date – 03/05/05**
Employer established **WAITING PERIOD = 90 days**
Effective Date – 06/05/05

Based on the example above, the new employee would complete their **WAITING PERIOD** and coverage would be effective on 06/05/05.

Your Administrative Supplies will contain the appropriate applications to be completed by your new employee. If you are unsure as to the application to be used, contact our Customer Call Center at (800) 991-2642. **All applications should be sent to 734-853-3276.**

All sections of the application require completion, unless medical coverage is being waived at time of enrollment. If waiving medical coverage, Section 3 Health Information does not need to be completed.

If the employee has other medical/drug or dental coverage, be sure to complete all questions in the waiver section of the application. The employee should apply for life, weekly income and dependent life coverage (if your group has such coverage with American Community).

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If your new employee has a **CERTIFICATE OF CREDITABLE COVERAGE** from prior insurance coverage, you must include a copy. In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your employer's former carrier must provide a **CERTIFICATE OF COVERAGE** letter when an individual's coverage ends. This information will allow us to reduce the pre-existing time limitation on this plan by the correct number of months of **CREDITABLE COVERAGE** as long as there has not been more than a sixty-two (62) day gap in coverage.

The pre-existing condition exclusion period will not be reduced if you do not provide us with a **CERTIFICATE OF CREDITABLE COVERAGE** or other relevant documents satisfactory to American Community. You may contact our Customer Call Center at (800) 991-2642 or e-mail AC-GrpAdminDept@American-Community.com.

For specific benefit information about your plan, see Section 1 – Schedule of Benefits in the **CERTIFICATE**.

Employees who do not enroll within their **ELIGIBILITY PERIOD** or during **SPECIAL ENROLLMENT** will be considered a **LATE ENROLLEE** and will need to apply during the **OPEN ENROLLMENT** period as well as satisfy a pre-existing limit. For specific information about your plan's Open Enrollment, see Section 1 – Schedule of Benefits in the **CERTIFICATE**.

If Dental coverage is a benefit under your plan – dental coverage for your new employee may be subject to waiting periods. Prior coverage may reduce the waiting periods. Proof of similar benefits as well as the start and end dates of coverage will be required. Documentation should be sent at the time of enrollment and is subject to review.

If dental coverage is waived at the time of original enrollment, waiting periods will apply.

Rehires

Employees whose coverage terminated due to lay-off, leave of absence or reduction in hours, are treated differently upon rehire based upon the length of time between the date of termination and rehire. Please refer to the information below based upon your specific situation:

within ninety (90) days
after ninety (90) days

Notify us in writing of the return to work date
Complete a new application. The applicant will be treated as a new employee.

Note: Rehired employees, whose coverage terminated because they quit or were fired, are treated as new employees and must complete an application. They must satisfy the waiting period before they become effective for coverage, even if they return within 90 days.

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Section 1. Employee Information

Open Enrollment

If **OPEN ENROLLMENT** applies to your plan, it will be shown on page 1.1 in your **CERTIFICATE** as the 31 day period when employees or their dependents who had previously waived health coverage during their initial eligibility may apply. They will be considered **LATE ENROLLEES** for the purpose of determining pre-existing condition limitations and coverage applied for during **OPEN ENROLLMENT** will be effective on the policy anniversary date shown on page 1.1 as well as on the face page of the **CERTIFICATE**.

Waiving Coverage

Employees or their dependents can waive coverage when first eligible to participate in the plan. To waive coverage, they should complete the waiver section of the employee application. A spousal signature is required when coverage is waived.

If individuals initially waive medical coverage and wish to apply for coverage at a later date, they will be limited to the **OPEN ENROLLMENT** period shown on your Schedule of Benefits, unless they qualify for **SPECIAL ENROLLMENT**. Coverage applied for during **OPEN ENROLLMENT** will be effective on the policy anniversary date shown on page 1.1 as well as on the face page of the **CERTIFICATE**. Please refer to the sections below for further information.

A. Individuals waiving coverage due to other insurance coverage:

Individuals who waive coverage due to other insurance coverage must complete the waiver section of the application. Individuals, who have completed a valid waiver indicating there is other coverage, may enroll only during **OPEN ENROLLMENT**. However, should other coverage be lost due to one of the qualifying events listed under the **SPECIAL ENROLLMENT** section, the coverage must be applied for within 31 days of the qualifying event.

B. Individuals waiving coverage with no other insurance coverage:

Individuals who initially waive coverage without other insurance may enroll only during **OPEN ENROLLMENT** and will be considered late entrants for purposes of determining pre-existing time limitations.

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Section 1. Employee Information

Adding Individual's Coverage at a Later Date

A. Individuals who had prior coverage

Those who completed the waiver section at time of enrollment, may be added only at **OPEN ENROLLMENT** unless a status change occurs as a result of one of the conditions listed in the **SPECIAL ENROLLMENT** section. Proof of prior coverage must be furnished to American Community. The enrollment must be received within 31 days of the qualifying event. Pre-existing condition limitations may apply.

B. Individuals without prior coverage

Medical Coverage may be added during the **OPEN ENROLLMENT** period specified on page 1.1 of your **CERTIFICATE**. Coverage is subject to underwriting and the maximum pre-existing condition limitations for late entrants.

Dental and vision coverage initially waived may be added at a later date. The coverage will be added effective the first of the month following the date of the request provided the request is received by the 5th of the preceding month. Dental is subject to late entrant waiting periods on certain types of procedures.

No dental benefits will be payable for:

- Type 2 services during the first six (6) months of Dental benefits coverage if the Insured Individual's coverage becomes effective more than thirty-one (31) days after the date of the Insured Individual first becomes eligible.
- Type 3 services during the first twelve (12) months of Dental Benefits coverage if the Insured Individual's coverage becomes effective more than thirty-one (31) days after the date the Insured Individual first becomes eligible.
- Type 4 services during the first twelve (12) months of Dental Benefits coverage if the Insured's Individual coverage if the Insured Individual's coverage becomes effective more than thirty-one (31) days after the date the Insured Individual first becomes effective.
- Type 4 services until the Insured Individual has been covered for Dental Benefits under this policy for the Dental Waiting Period shown for Class 4 services in Section 1 – Schedule of Benefits, in the sample **CERTIFICATE**.

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Section 1. Employee Information

Eligible Dependent

For a dependent to be eligible, the following must be met:

1. Must be the employee's spouse, or
2. Must be the employee's natural child, stepchild, adopted, placed for adoption or legal guardian and must be 19 years old or younger. If attending an accredited college or university on a full-time basis, the dependent is eligible until they attain the maximum age shown in the contract. Twelve (12) credit hours is defined as full-time. Verification of eligibility will be requested.

Spouse

Legally married to the employee or legally separated, (but not divorced) from the employee.

Dependent Children

Children of the employee or spouse by birth, legal adoption, placed for adoption, or legal guardianship who are:

1. Under age nineteen (19); AND
2. Unmarried and a dependent for IRS tax purposes; OR
3. Child of an insured employee who is recognized under a medical child support order as having a right to enrollment under a group health benefit plan with respect to such insured employee; or

Over age 19

Children of the employee or spouse by birth, legal adoption or legal guardianship who are:

1. Unmarried and a dependent for IRS income tax purposes; AND
2. Attending an accredited college or university full-time; OR
3. Either mentally or physically disabled prior to age nineteen (19) and is certified disabled by a physician. Verification of continued eligibility due to disability will be requested annually.

If the over-age dependent does not meet the criteria for coverage, the dependent will be automatically terminated at the end of the month in which the dependent reaches age nineteen (19) or on the date which the dependent is no longer eligible for coverage.

You will be required to re-verify eligibility each year beyond age nineteen (19). Sixty (60) days prior to their birthday, a Dependent Eligibility Request form will be mailed out. If it is not returned prior to your dependent's birthday, coverage will end at the end of the month in which the birthday occurs.

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Adding Dependents at the Time of Initial Eligibility

Upon adding an eligible dependent, all sections of the application need to be completed. If the information is missing, it will delay the processing of the application. Refer to **Adding Dependents at a Later Date** if they did not apply when first eligible. If a dependent has a **CERTIFICATE OF CREDITABLE COVERAGE** from a prior carrier, include a copy with the application. This will allow us to apply the correct number of months to reduce the pre-existing time period.

Newborn Children

Newborn children of an Insured Employee or his spouse are automatically covered for the first thirty-one (31) days after birth if American Community is notified during that time period. To continue coverage beyond the thirty-one (31) days, an application for coverage is required. Any additional premium due will be billed on the premium statement following receipt of the application. If the insured is waiving coverage on the child, complete Section B. of the application.

Spouse

Addition of dependent spouse: Coverage for a dependent spouse must be applied for not later than 31 days from the qualifying event. A copy of a marriage certificate must be submitted with the application when applying for a spouse to be added due to a marriage.

Adding Dependents at a Later Date

If eligible dependents have not applied for coverage within thirty-one (31) days of initial eligibility, they will be required to enroll during the **OPEN ENROLLMENT** period specified on 1.1 Schedule of Benefits and will be effective as of the date shown. For the purposes of pre-existing limitations, they will be considered **LATE ENROLLEES**.

Prior **CREDITABLE COVERAGE** will reduce the amount of pre-existing conditions limitations by one (1) month for each month of **CREDITABLE COVERAGE** as long as there has not been more than a sixty-two (62) day gap in coverage.

An Application can be submitted up to 60 days prior to the start of the **OPEN ENROLLMENT** period. **Indiana Only:** Application may be submitted at any time prior to Open Enrollment however; updated medical information may be requested at the time of Open Enrollment.

No dental benefits will be payable for:

- Type 2 services during the first six (6) months of Dental benefits coverage if the Insured Individual's coverage becomes effective more than thirty-one (31) days after the date the Insured Individual first becomes eligible.
- Type 3 services during the first twelve (12) months of Dental Benefits coverage if the Insured Individual's coverage becomes effective more than thirty-one (31) days after the date the Insured Individual first becomes eligible.
- Type 4 services during the first twelve (12) months of Dental Benefits coverage if the Insured Individual's coverage becomes effective more than thirty-one (31) days after the date the Insured Individual first becomes eligible.

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Section 1. Employee Information

- Type 4 services until the Insured Individual has been covered for Dental Benefits under this policy for the Dental Waiting Period shown for Class 4 services in Section 1 – Schedule of Benefits, in the sample **CERTIFICATE**.

Working Spouses

If you have a situation where you employ a husband and wife, 100% participation is required for life, accidental death and dismemberment, and weekly income to meet participation requirements for your group. Other coverage (medical, dental, drug, and vision) can be on either employee's insurance with the other as a dependent.

Special Enrollment

Special Enrollment Period #1

An employee, or dependent of an employee must be eligible for coverage, but not currently enrolled with American Community because of previous coverage under another group health plan, or other health insurance, at the time of the initial enrollment period. This Special Enrollment right is available to current employees and their dependents.

To qualify for the Special Enrollment period, the employee or dependent, must have lost the other group health plan coverage because:

1. Either **COBRA** was exhausted, or non-**COBRA** coverage terminated due to loss of eligibility coverage (including legal separation, divorce, death, termination of employment, or reduction in hours), or
2. Employer contributions for the coverage were terminated, or
3. The lifetime maximum of the other group insurance has been reached, and claims are no longer payable under that coverage, or
4. A claim has been denied under other group health insurance due to the employee or dependent reaching or exceeding the maximum benefit that results in end of coverage.

In addition, the employee or dependent must have:

1. Requested enrollment within thirty-one (31) days after the loss of coverage, AND
2. Signed a form declining coverage upon initial eligibility, AND

Coverage under this Special Enrollment must be effective as of either the date of the event or the first day of the month following enrollment.

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Section 1. Employee Information

Special Enrollment Period #2

This applies to certain dependents of a group health plan participant. Or to an employee or spouse who has satisfied the **WAITING PERIOD** is eligible, but failed to enroll during their initial eligibility. The enrollment period is available for the employee, the employee's spouse, and newly acquired dependents whenever persons become dependents through marriage, birth, or adoption or placement of adoption.

During the Special Enrollment period, the group plan must provide enrollment by the newly acquired dependent, the employee if not already enrolled, and the employee's spouse (who must otherwise be eligible for coverage following a birth or adoption). The Special Enrollment Period must be at least thirty-one (31) days, beginning on the later of the date of the marriage, birth, or adoption or placement for adoption.

The **EFFECTIVE DATE** of coverage in the event of a Special Enrollment attributable to the acquisition of a new dependent may be retroactive.

- **EFFECTIVE DATE** in the event the new dependent is acquired through marriage; For a new dependent acquired by marriage, coverage would be effective no later than the first day of the first month beginning after the date the group plan receives the completed request for the enrollment.
- Effective date in the event the dependent is a newborn or newly adopted child: Coverage would be effective retroactively for a newborn or newly adopted dependent (provided the dependent is enrolled within thirty-one (31) days of birth or placement for adoption.) The **EFFECTIVE DATES** are:
 1. For a birth, the date of birth; and
 2. For an adoption or placement, the date of adoption or placement.

Terminating Employees

American Community should be notified prior to the date of termination or within 31 days of the termination. You may submit your request in writing on the Change Form accompanying your monthly statement, by faxing to (734) 591-8033 or e-mail AC-GrpAdminDept@American-Community.com. Be sure to include your group number, certificate number of the employee, the last day worked and the reason for termination.

The notification should always be signed and dated by the authorized contact person you have provided to us to handle your insurance benefit administration.

The termination date given by American Community will be either the last day worked or the end of the month determined according to your certificate. It is based on your selection of the **WAITING PERIOD**.

The **WAITING PERIOD** will determine the termination date. If the Employer chooses a **WAITING PERIOD** that is date of hire or a definite time such as 30 days, 60 days, 90 days etc., the termination date will be the date the Employee's employment with the Employer ends. If it is 1st of the month following any time frame such as 1st of the month following date of hire or 1st of the month following 30 days the termination date of coverage will be the last day of the month.

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Section 1. Employee Information

For specific information about when your employees' coverage will end, refer to the General Information in your sample **CERTIFICATE** for specific information on coverage termination pertaining to your policy.

Credits will be issued on the next **GROUP PREMIUM STATEMENT** after notification. It is important that the information on terminations be submitted monthly as NO credits will be issued beyond three (3) months.

When an employee or dependent is terminated from coverage, American Community, in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will issue a **CERTIFICATE OF CREDITABLE COVERAGE** to provide proof of dates of coverage with American Community. They will be sent to their last known home address. If returned for invalid address, they will be forwarded to the employer for distribution.

As the employer, **you** are responsible for providing information and forms to terminated employees and their dependents on available options to continue their insurance. This would include **COBRA** and **CONVERSIONS** for life and health. Refer to Continuing Coverage in your sample **CERTIFICATE** for more information or to Section 2 of the Group Services Guide.

Terminating Dependents

If an employee wishes to terminate his/her dependents, the waiver section of the application should be completed and the application must be signed by the employee. Be sure to include the date to terminate the dependent.

It is your responsibility to make sure we are notified timely; credit is limited to 3 months if no claims are paid.

Dropping Coverage

If an employee wishes to drop coverage, the waiver section of the application should be completed and returned to Group Services with the employee's signature along with date coverage is to be dropped.

Credits will be issued on the next **GROUP PREMIUM STATEMENT**. Timely notification is important, as no credits will be issued beyond three (3) months.

Name Changes

An employee's name can be changed by notifying Group Services in writing. Include the group number along with the certificate number listed on the employee's ID card or from your premium statement.

Beneficiary Changes

An employee may change their **BENEFICIARY** at any time. Complete, sign and date the beneficiary section of the application -- employee signature and date required -- and return to Group Services.

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Address Changes

An employee or dependent's address can be changed by submitting to Group Services, in writing, by e-mail, or by calling the Customer Service Call Center at (800) 991-2642.

Status Changes

American Community may request proof of employee status changes through submission of payroll records.

Part-time to Full-time

An application must be completed noting the full-time date of hire. Your waiting period will determine the effective date of coverage.

Full-time to Part-time

When an employee is no longer working full-time, they may continue coverage for a certain length of time as described in your sample **CERTIFICATE**, in General Information. Inform American Community in writing when the employee changes to a part-time status. If hours worked indicate the employee would no longer be eligible, the employee will be terminated using the date of the change to part-time.

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Section 2. Your Employees' Continuation Rights

CONVERSIONS

Life and Health

When an employee's coverage ends -- as the employer you are responsible to offer **COBRA** or **CONVERSION** of life and/or health coverages. If an employee wishes to convert his/her in-force **GROUP INSURANCE POLICY** to an individual **CONVERSION** policy, a **CONVERSION** information request form needs to be submitted. This form can be found in the group administrative kit and should be submitted within thirty-one (31) days of termination.

COBRA

Benefits under the Consolidated Omnibus Budget Consolidation Act of 1985 "**COBRA**" are provided by American Community only if:

1. You – the employer – have notified American Community that you are subject to COBRA.
2. American Community has been provided a COBRA verification form for review, including Wage and Tax Information for all of the previous calendar year.
3. Upon return of the verification form and Wage and Tax Information, acknowledgment of your eligibility for COBRA has been provided to you in writing.

To find out if **COBRA** applies to you – contact your legal advisor. To verify your group's status in regard to whether your policy has **COBRA** coverage with American Community, contact Customer Service at (800) 991-2642 or e-mail AC-GrpAdminDept@American-Community.com.

Suggestions for handling **COBRA** beneficiaries:

- As soon as you are notified of a Qualifying Event, refer to the **TERMINATION** date of coverage in your **CERTIFICATE**.
- Your former employee or their qualified dependent should complete Section A. of the current application, checking the box marked **COBRA**.
- It should be sent with premium information by return receipt requested mail to the home address of the **COBRA** beneficiary, or give this information to them directly within fourteen (14) days of the qualifying event. A separate mailing should be sent to the spouse and any dependents of the beneficiary.
- **COBRA** allows the beneficiary sixty (60) days from the date of notification to make their decision on whether or not to continue coverage.
- Forward the application electing **COBRA** to us along with the continuation notification letter and the election form if it is separate from the application. If you notified your terminated employee timely, and they did not return the election form within the sixty (60) days, the terminated employee is not eligible for **COBRA**.

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Section 2. Your Employees' Continuation Rights

- Since there will be no lapse in coverage, the termination date you provide us and the qualifying event date on the application must match.
- A **COBRA** policy with benefits elected for continuation will be issued to the beneficiary and mailed to you for delivery.

Claims may be denied before we receive a **COBRA** application. Denied claims will be reprocessed, however, premium for the month(s) in which they were incurred must first be received.

Family Security

If an employee's insurance ends because he/she dies, the medical insurance benefits of any insured dependents will be continued for six (6) months without payment of premium. This benefit only applies if the employer is not required to:

- Provide continuation of coverage under COBRA, or
- Provide continuation of coverage under a mandated state specific continuation of insurance provision.

Waiver of Premium

Refer to your **CERTIFICATE**, Section 3, to see if this benefit would apply to any of your employees.

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Section 3. Administering Your Plan

Renewal Documents

Small Group (2 – 50 Eligible Employees)

The renewal documents produced include a renewal letter along with an illustration showing the rates currently being billed along with the rates which will be effective with the renewal. A rate table will be provided. You will receive the renewal notification thirty (30) days prior to your policy anniversary date. (60 days if Arizona)

Your renewal documents are an offer to continue your coverage, your normal invoice to remit payment will follow.

Large Group (51+ Eligible Employees)

Renewal letters are sent from the Underwriting Department to your agent approximately 45 days prior to your policy anniversary date. You will also be notified when your agent has been sent your renewal information.

Group Level Changes

Small Groups (2-50 Employees)

For changes in your benefits, including adding or deleting benefits, it is important to verify what is required. Contact your agent, or American Community's Customer Service Department at (800) 991-2642, or e-mail AC-GrpAdminDept@American-Community.com. The following are some general guidelines in regard to making benefit changes.

- Changes involving your medical benefits may only be made during the renewal time period. The renewal time period is defined as sixty (60) days prior and sixty (60) days after the policy anniversary date.
- Underwriting approval may be required depending on the requested benefit change.
- Discontinued benefits may require a one (1) year waiting period before they may be reinstated.
- Benefit additions may only be made one (1) time per year.
- Applications on your current employees, as well as other documentation may be needed in addition to a written request.
- Any credits or debits from prior periods will appear as adjustments on your next premium statement.

Large Groups (51+ Eligible Employees)

All requests for changes for large groups are forwarded to Group Underwriting for approval.

Note for any size group: Any group level changes requested more than five (5) days after the first of the month will be effective on the first of the month following Home Office approval.

Plan changes **do not** take effect until you receive:

1. An acknowledgment letter from American Community stating the approval of your plan change request; AND
2. The effective date the change will take place

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Section 3. Administering Your Plan

Address Changes

If you plan to relocate your business, we need written notification of your address change. Provide the address of the new location along with city, state, zip code and county. County changes could affect rates at your next renewal. Proof of your address change may be required.

If your change is only for billing, inform us in writing “for billing purposes only”.

Requesting Termination

If you are terminating your policy with American Community, written notice must be received within ten (10) days of the date requested for termination. No premium will be refunded on requests that are more than ten (10) days after the requested effective date.

You will be billed and are responsible for any outstanding amounts due as of the date of termination.

Termination of Health/Prescription Drug

When you terminate the coverage for the last employee with medical benefits on your plan, this will terminate the medical coverage to your employees. Prescription drug is a benefit that requires active medical coverage and will terminate along with the medical coverage. You will be notified of the termination date. To re-activate medical/prescription drug benefits, underwriting will be required.

Name Change

If your company name changes, notify Group Services in writing. This can be faxed to Group Services at (734) 591-8033 or by e-mail to Ac-GrpAdminDept@American-Community.com.

Change in Ownership

If the company experiences a change in ownership, notify American Community in writing and complete an “Assignment of Policy Rights and Liabilities” form by yourself and the new owners. This form is available by contacting Group Services at (800) 991-2642 or e-mail AC-GrpAdminDept@American-Community.com.

Eligibility

Participation

Participation requirements vary based on group size. We may audit participation on your group. You will be notified should you be selected for a participation audit.

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Section 3. Administering Your Plan

For Life, AD&D and Weekly Income, 100% of full-time employees, eligible employees must apply.

Group Size
2-5 Employees

Requirement
100% of the eligible employees (employees waiving due to spousal coverage are not included as eligible for this participation requirement).

6 or more employees

75% of employees (employees waiving due to spousal coverage are not included as eligible for this participation requirement).

Note: Missouri mandates that for group sizes of 11-25 employees, employees and dependents waiving due to having any type of other coverage are not counted for this participation requirement.

Minimum Group Size

At renewal, should your group fall below the minimum of two (2) employees, with health, or if the participation requirements are not met, the group plan will be terminated.

Employer Contribution

The minimum employer premium contribution requirements are as follows:

2-50 Employees

25% of the total cost of the insurance for the employee and dependents, or
50% of the total cost of insurance for the employee only

51 or more employees

50% of the total cost of insurance

Wage and Tax

American Community reserves the right to request Wage and Tax Forms or payroll records to verify eligibility requirements.

Failure to provide wage and tax forms may result in termination of the policy.

Special Information for Health Savings Accounts (HSA) Groups

Qualified High Deductible Plans

New Employees

A Health Savings Account application will need to be completed along with the Employee application. Both forms are required.

Billing

You may have two statements each month, your premium statement for health coverage and a contribution reminder for your Health Savings Account.

Medical Claims should be mailed to:

Claims should be mailed according to the instructions on the back of the ID card.

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Section 4. Your Monthly Premium Statement

Premium Payment

You will receive a **GROUP PREMIUM STATEMENT** approximately two (2) weeks prior to the premium **DUE DATE**. The **DUE DATE** is printed on the upper right hand corner of the **GROUP PREMIUM STATEMENT**.

Premiums are due on or before the **DUE DATE**. To ensure continuous coverage, it is advisable to remit your premium payment immediately upon receipt of your **GROUP PREMIUM STATEMENT**. Prompt receipt of premium assures uninterrupted service for your employees in order to pay claims and verify benefits with providers. Failure to remit by the due date may result in denied claims along with notification to your employees of the reason for denial.

Be sure to review each **GROUP PREMIUM STATEMENT** for accuracy. Each of your eligible employees should be listed.

We require that you pay the AMOUNT DUE as stated on the summary page of the **GROUP PREMIUM STATEMENT**. Adjustments for additions, changes and terminations sent within five (5) days of the statement date will appear on your next statement.

A premium reminder notice will be sent to you around the 20th of the current month if payment has not been received. Calls may be made to our Customer Call Center (800) 991-2642 or e-mail AC-GrpAdminDept@American-Community.com to verify if payment has been received or to check on any amounts due.

If payment is not received by the end of the **GRACE PERIOD**, insurance will be terminated for non-payment of premium and a letter sent to you with a copy to your agent.

Reminder – Your monthly payments must be drawn on the business account of the group. Agent/Agency checks, personal checks and money orders are not accepted. They will be returned to you and this delay could result in claims not being paid for your employees.

Reinstatement

Timely payment of your monthly premium is essential for the continuance of your employees' insurance benefits. If your coverage has lapsed, requests for reinstatement must be in writing and received within thirty (30) days of the date of your termination letter. Your request is subject to review. Include in your request:

1. The circumstances resulting in your lapse in coverage. Note any employee who may not have been working as of the termination date.
2. Do not submit premium until American Community notifies you of an approval for reinstatement. If approved, you will be notified of the amount due.
3. Requests can be mailed to the address on your bill or faxed to (734) 853-3236. Be sure to include your group number on your request.

You may contact our Customer Call Center at (800) 991-2642 or e-mail AC-GrpAdminDept@American-Community.com if you have any questions or to request an update on the status of your reinstatement request.

Group Services Guide

Section 4. Your Monthly Premium Statement

Premium Change Form

The **GROUP PREMIUM STATEMENT** is accompanied each month with a Premium Change Form. Use this form to report any changes or corrections regarding an employee status.

If there are changes, this form must be signed and dated by the employer or authorized contact person and returned with your next premium payment or you may fax it to (734) 591-8033. Be sure to keep a copy for your records.

If you have more than one group number with American Community and receive more than one **GROUP PREMIUM STATEMENT** each month, be sure to indicate how the money is to be allocated on your check stub or other document sent in with your payment if submitting one payment for both groups. This will allow us to correctly allocate the funds to the appropriate statement.

Group Services Guide

Section 5. Your Documents: POLICY and ID Cards

ID Cards

Medical Cards

American Community will send identification cards and **CERTIFICATES** for new employees/dependents enrolled for health and/or dental benefits to your billing address. Dependents who are eighteen (18) years or older will receive an identification card with their name on it.

Prescription Drug Cards

Prescription drug cards will be mailed directly to you from **Caremark**. Refer to the schedule page of your **CERTIFICATE** for information regarding the plan you have chosen or the benefit information received with your prescription drug card. Call Customer Service Call Center at American Community (800) 991-2642 or e-mail if you need replacements or need additional cards.

Dental Cards

You will receive an ID card for dental if you do not have health coverage.

Lost Cards

If an employee loses a medical ID card, contact American Community at (800) 991-2642 and we will reorder cards. They should be mailed to you within a week to distribute to your employee.

Dependents Living Elsewhere

If an employee has a need for additional cards for dependents that do not live at his address, contact American Community at (800) 991-2642 and we will order these additional cards. The cards will be mailed to you. The employee can forward them on to his/her dependents.

Provider Information

Medical

Physicians can be located by contacting the PPO network listed on their cards or accessing our website at www.american-community.com, then click on "networks & directories". You can also contact the network using the Network Customer Service number on the back of the card.

Prescription Drug Coverage

Refer to the Prescription Drug Manual in your Group Services Kit. Employees should refer to the prescription drug information sent with their identification card.

Vision Service Plan – Vision Coverage

Your vision coverage is provided through Vision Service Plan (VSP). Included in the Group Services Kit are VSP brochures and a listing of participating providers. You may also go to the website for the most updated list of providers at www.vsp.com or if you would like to contact Vision Service Plan's Customer Service, they can be reached at (800) 877-7915.

Note: For your vision benefits: Ophthalmology providers listed in the PPO directory may not be participating VSP providers. When making your appointment verify they are VSP providers otherwise benefits may not be covered.

Group Services Guide

Section 5. Your Documents: POLICY and ID Cards

Certificates

CERTIFICATES for employees enrolling as of your **EFFECTIVE DATE** were included with the Group Services Kit.

Additional Supplies

The Group Services Kit contains the supplies necessary to administer your group insurance plan. It includes most of the forms mentioned in this Guide, with the exception of the Appendix forms, and the Change Form which is sent along with your monthly **GROUP PREMIUM STATEMENT**.

When you need additional supplies, complete the Group Supplies Requisition Form and send by mail or fax to Group Services at (734) 591-8033.

- Be sure to include your group number on the form.
- Allow two (2) weeks for delivery
- A new supply request form will be included with your order.

Group Services Guide

Section 6. Filing a Claim

Type of Claim

Filing Procedures

**Life/Accidental Death &
Dismemberment/Dependent Life**

To obtain a claim form and instructions, contact American Community Claims Customer Service at (800) 991-2642.

Health

Comprehensive Major Medical Coverage

Claims should be mailed according to the instructions on the back of the ID card. If an employee has already paid the provider, the employee should send us an itemized bill marked "paid" to American Community within ninety (90) days of the date of the expense.

PPO Coverage

PPO claims should be submitted directly to the PPO Network by the provider.

Disability Income

The disability claim form, Initial Claim Form – Accident and Sickness, should be completed by the employee, employer and doctor. Refer to the waiting period for disability shown on the schedule page of your **CERTIFICATE** for when the form should be mailed to American Community.

Dental

Refer to the back of the dental card for submission of dental claims

Any type of claim

Please be sure to include your Group number as well as well as your certificate ID on all claims forms and correspondence.

Questions regarding your claims

Contact our Group Claims Customer Service Department at (800) 991-2642.

Fraud

Insurance fraud is costing over \$100 billion per year. We at American Community ask your help in watching for fraudulent claims submitted for services not rendered, billings for services not received and waiver of co-payments by providers. Should you find you have been billed incorrectly for services or for services that did not take place, you may be eligible for a refund providing we obtain reimbursement. Refer to the tab in your employee certificate, "Error Refund Program" to obtain further information.

These fraudulent costs directly affect premium you pay.

If you or your employees suspect a provider of fraudulent activities as described above, or have another situation you feel may qualify as fraud, please call us at (800) 991-2642.

Group Services Guide

Section 7. Federal Disclosures

U. S. Federal Disclosure Form 5500 Series

You may be required to file the appropriate IRS tax form from the 5500 series including a Schedule A-insurance information, to document the amount of premium paid.

Compliance with this requirement is the employer's responsibility. Upon your request, American Community will assist you by supplying the necessary insurance information on Schedule A. Once our portion of the schedule is completed it will be sent to you. Complete your portion and file it with the IRS along with the 5500 form appropriate for your group's size (i.e. number of employees).

Depending on your group size (100 employees or less) you may be requested to pay a \$100.00 annual fee at the time the service is provided/requested.

American Community cannot act in the capacity of legal counsel involving interpretation of the law. You should contact your attorney or the Customer Service Call Center (800) 991-2642.

Death Claims

Upon request, American Community issues Form 712 indicating benefits paid out. If this form is necessary, contact our Customer Service Call Center (800) 991-2642.

Group Services Guide

Section 8. Glossary of Terms

BENEFICIARY	The person (s) or entity designated by an insured to receive Life, Accidental Death and/or Health Savings Account proceeds upon the insured's death.
CERTIFICATE	A document delivered to each insured, which summarizes the benefits and principal provisions of the GROUP INSURANCE POLICY .
CERTIFICATE OF CREDITABLE COVERAGE	Form issued upon employee's termination of employment or termination of medical coverage to provide proof of coverage. This form details coverages as well as the effective and termination dates
COBRA	<u>Consolidated Omnibus Budget Reconciliation Act.</u> Federal legislation requiring employers with twenty (20) or more employees to offer continuation of coverage to employees and/or dependents who lose coverage as a result of certain events. Refer to your legal advisor.
CONVERSION	The privilege given to the insured to change his/her group life and/or medical care coverages to a form of individual insurance without medical examination. The conditions under which conversion can be made are defined in the Group Insurance CERTIFICATE .
CREDITABLE COVERAGE	Means continuous coverage under a previous health benefit plan. An Individual's coverage under most forms of health insurance is considered creditable coverage as long as there has not been a break in coverage longer than sixty-two (62) days.
DUE DATE	The date on which your insurance premium is due.
EFFECTIVE DATE	The date on which insurance becomes effective.
ELIGIBILITY PERIOD	The time period which an individual has to apply for coverage without penalty. For new dependents or special enrollments, this is within thirty-one (31) days from the date of the event (date of marriage, date of birth, date of loss of coverage).

Group Services Guide

Section 8. Glossary of Terms

GRACE PERIOD	The period of time you have to pay any premium due to prevent the policy from ending. This is thirty-one (31) days from the DUE DATE listed on the premium statement.
GROUP INSURANCE POLICY	The legal document that sets forth the contract of insurance.
GROUP PREMIUM STATEMENT	The monthly statement detailing each employee who is Covered under the plan along with appropriate charges for insured's coverages. Any adjustments from prior periods will included on a separate page of the statements.
HIPAA	<u>Health Insurance Portability and Accountability Act of 1996</u> . Federal legislation applying to group health plans establishing new requirements relating to pre-existing condition exclusions; discrimination based on health status and access coverage.
LATE ENROLLEES	An employee who does not apply for insurance within the ELIGIBILITY PERIOD . (See OPEN ENROLLMENT)
OPEN ENROLLMENT	The 31 day time period that begins 90 days prior to the policy anniversary date. Employees or their dependents who originally waived or did not apply for coverage when first eligible, may enroll, or change benefits.
WAITING PERIOD	Employer imposed length of time an employee must continuously work for the employer before he/she is eligible for insurance.