



ASSURANT
Health®

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Employer Guide

for Small Employer Groups



Your Guide to Assurant Health

You chose your health insurance plan to meet current business needs. Just as your business needs change, so may your insurance needs. This guide is designed to help you manage your current plan as well as make changes to accommodate future business needs.

Assurant Health offers a variety of ways to satisfy employer and employee administrative service needs. You choose the most effective means given your situation. You can use this thorough reference or convenient Web-based services, call a knowledgeable customer service representative or contact your agent for assistance.

Employer Guide and State Supplement

This Employer Guide provides general guidelines and important information to effectively administer your plan. The Employer Guide Supplement identifies variations to the general guidelines for your state. Please review this guide and the supplement. Use them as a reference for basic questions regarding your insurance plan. Information contained in this guide is subject to change without notice. Assurant Health's current business procedures and/or the certificate will take precedence over the information in the guide and supplement.

While this guide will answer most questions, you may have additional ones. For assistance, a general contact list is included at the end of this guide.

IMPORTANT NOTES: Assurant Health is the brand name for products underwritten and issued by Time Insurance Company and John Alden Life Insurance Company and is the name used in this guide when referring to either insurance company.

If there is a conflict between this guide or any state supplement and the contract/certificate or any applicable state and/or federal law or regulation, the contract certificate or applicable state/federal law or regulation will take precedence.

Myaccount for Online Convenience

Myaccount is a valuable online resource providing you with the opportunity to make changes to your plan quickly and easily. To gain access to your secure *myaccount*:

- Call 866-ANSWERS (267-9377) between 7:00 a.m. and 6:00 p.m. CST to obtain a PIN (Personal Identification Number).
- Logon to www.answersbyassurant.com.
- Register using your PIN.

You're all set. You can order ID cards, add employees and dependents, update your plan information (such as address changes), and submit employee/dependent termination requests. Update your plan anytime and anywhere you have access to the Internet.

Thank you for selecting an Assurant Health group plan!

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Eligibility Requirements for Employees and Dependents

Employees and dependents must meet certain requirements in order to be eligible for coverage. All eligible enrollees (referred to as additions) are subject to the pre-existing conditions provision, unless otherwise indicated.

Eligible Employees

An eligible employee is any person who performs services on a full-time basis (defined as at least 30 hours per week) and is considered an employee for federal employment tax purposes, at any of the employer's business establishments.

A partner, proprietor or corporate officer of the employer is eligible if he/she performs services for the employer on a full-time basis (defined as at least 30 hours per week), at any of the employer's business establishments.

The term "Employee" does not include: a) retirees or persons who are not expected to perform any duties, responsibilities or services for the employer; b) "part-time" employees; or c) any "seasonal" or "temporary" employees who work only part of the calendar year on the basis of natural or suitable times or circumstances.

NOTE: *Assurant Health's Individual Medical insurance may be a suitable alternative for ineligible employees. Through Assurant Health's List Bill Services, you can provide the convenience of payroll deduction to ineligible employees who purchase individual medical plans. Contact your agent for more information.*

Husband and Wife Employment

Husbands and wives working for the same employer on a full-time basis may elect to enroll EITHER as two employees or as an employee and dependent spouse.

When enrolling as a dependent spouse, only the dependent ancillary products are available to that individual.

Eligible Dependents

Eligible dependents include the insured employee's lawful spouse and their naturally born children, adopted children or children placed for adoption with the insured employee, stepchildren, or children for which the insured employee is a legal guardian.

Eligible dependent children must be unmarried and age 25 or younger.

Coverage under the plan for an unmarried dependent, age 26 or older, may continue until the dependent is no longer a full time student in an accredited institution of postsecondary education.

A dependent on a medically certified leave of absence from a postsecondary institution may continue coverage until the date that is one year following the first date of

the medical leave, or the date coverage would otherwise terminate under the terms of the plan.

Assurant Health reserves the right to request the Qualified Medical Child Support Order (QMCSO) for dependents with court ordered coverage.

A child incapable of self-sustaining employment or engaging in the normal and customary activities of a person of like age because of mental incapacity or physical handicap is eligible if they are chiefly dependent on the insured employee for financial support and claimed as an exemption on the insured employee's most recent federal income tax return. Proof of eligibility must be provided.

Adopted Dependents

An adopted child is eligible as a dependent when the certificate holder has agreed to assume total or partial responsibility of support for a child in anticipation of adoption or legal physical placement of the child in the home. Appropriate documentation must be provided.

Employment Waiting/Affiliation Period

Employees are subject to the specified employment waiting or affiliation period chosen by you. Only one waiting/affiliation period is available for all classes of employees. The group's employment waiting/affiliation period is indicated on the Plan Summary page included in your Employer Kit. All employees must abide by the period chosen. You cannot waive this period for any employee. If you did not select an employment waiting/affiliation period at the time of application, a default period of 30 days is assigned.

You have the option to change your employment waiting/affiliation period once during any 12-month period and the new waiting/affiliation period applies to all employees on a group level. The effective date for the change is the date the request is received by Assurant Health and applies to only those eligible employees hired on or after the effective date of the change.

NOTE: *Assurant Health offers Short Term Medical coverage that can fill the temporary gap in coverage during your employees' waiting/affiliation period. Contact information is listed at the end of this guide.*

Adding Employees/Dependents

An employee or dependent that meets the eligibility requirements can enroll for coverage by submitting an enrollment request. All requests for enrollment are subject to underwriting approval.

Enrollment requests can be made by using Assurant Health's online resource, *myaccount*, (accessed at www.answersbyassurant.com) or by submitting a fully completed, signed and dated Employee Enrollment Form to the appropriate underwriting office. Customer Service can provide you with the appropriate address to submit enrollment forms.

If your group has Employee Choice, the enrollee must note the medical plan number (listed on your billing statement) for the plan the employee is choosing.

If the enrollee is approved, you are billed from the effective date of coverage on the next available billing statement.

Adding Newborn or Adopted Dependents

Insurance for a newborn or adopted child will become effective on the child's date of birth, adoption or placement if an enrollment request or call to Customer Service is received within 31 days of the birth, adoption or placement. Any later enrollment request will require submission through *myaccount* or submission of a fully completed, signed and dated Employee Enrollment Form and will be considered a Late Entrant. Assurant Health reserves the right to request proof of legal dependence for acquired dependents.

Enrollment Periods

To avoid delays in coverage, employees should enroll on a timely basis. Use *myaccount* at www.answersbyassurant.com for the fastest service.

Timely Enrollment

A timely enrollee is:

1. An employee whose enrollment request is received by Assurant Health no more than 31 days after satisfying the employment waiting/affiliation period.
2. A dependent who enrolls with a timely employee.

Special Enrollment

Special Enrollment refers to a period of time during which eligible employees may apply for coverage for themselves and their eligible dependents without being considered a Late Entrant. A Special Enrollment Period begins when:

1. An employee, spouse or dependent child who waived coverage when previously offered because of other health insurance loses that coverage due to one of the following reasons:
 - a. Legal separation
 - b. Divorce
 - c. Death
 - d. Termination of employment
 - e. Reduction in the number of hours of employment
 - f. Employer contributions toward the other coverage has terminated*(Nonpayment of premiums or termination of coverage for cause do not allow special enrollment.)*
2. An employee, spouse or dependent child who waived coverage when previously offered because of COBRA continuation and that coverage has been exhausted.

3. One of the following life events occur:
 - a. Marriage
 - b. Birth
 - c. Adoption or legal guardianship
 - d. A court orders coverage to be provided for a dependent spouse or child

An enrollment request must be received by Assurant Health no later than 31 days following the loss of other coverage, date of marriage, birth, adoption or legal guardianship or court order.

In addition, an employee or dependent who is eligible, but not enrolled, for coverage under the plan may enroll for coverage if either of the following conditions are met:

1. The employee or dependent is covered under a Medicaid plan or under a state child health plan and coverage of the employee or dependent under that plan is terminated due to loss of eligibility.
2. The employee or dependent becomes eligible for assistance under a Medicaid or state child health plan.

An enrollment request for the employee and dependent must be received by Assurant Health no later than 60 days following the loss of, or eligibility for, Medicaid or a state child health plan. The employee must enroll along with any eligible dependents.

Late Enrollment

Late employees and dependents are those:

1. Whose enrollment request is received by Assurant Health more than 31 days after the end of the employment waiting/affiliation period
2. Who do not meet the qualifications for enrollment under the Timely or Special Enrollment Periods
3. Who request an effective date that is beyond the date for which they are eligible or
4. Whose prior health insurance coverage was lost because of nonpayment of premiums or termination of coverage for cause.

Effective Dates – Additions to Existing Groups

A specific effective date may be requested when adding an employee or dependent, however, an effective date cannot be more than 60 days (90 days for groups with a 90-day or greater employment waiting/affiliation period) after the date of *myaccount* submission or date of signature on the enrollment form.

The assigned effective date for an applicant depends on the date the enrollment request is received in our office and is subject to underwriting approval.

Below are samples of how effective dates are assigned.

Timely Employee and Dependent(s)

1. Enrollments received on or prior to the expiration of the employment waiting/affiliation period will be

effective on the date following the expiration date, or if requested, on the first of the month following the expiration date.

2. Enrollments received no more than 31 days after the expiration of the employment waiting/affiliation period will be effective on the first of the month following the date the enrollment request is received.

For Groups with a Zero-Day Employment Waiting/Affiliation Period

Enrollments received no more than 31 days after the date of hire will be effective on the date of hire, or if requested, the first of the month following the date of hire.

Special Enrollment Employee and/or Dependent(s)

Enrollments received no more than 31 days after the qualifying event will be effective on the date of the qualifying event, or if requested, the first of the month following the qualifying event.

Late Employee and/or Dependent(s)

Enrollments received more than 31 days after any of the following will be effective on the first of the month following the date the enrollment request is received.

- The expiration of the employment waiting/affiliation period
- The beginning of a Special Enrollment Period
- A dependent's date of birth, adoption or placement

Changing an Employee/Dependent Effective Date

If requesting an effective date other than that for which an employee/dependent is eligible, note the following impacts:

- Insured will be considered a Late Entrant.
- Continuity of coverage may be affected.
- Pre-existing period may be lengthened from 12 to 18 months, depending on state requirements.
- Proof of eligible employment date may be required.
- Effective date will be the first of the month following receipt of request.

Delays in Issuance of Coverage

Listed below are common causes for delays in issuance of coverage and the necessary corrective action.

- Employee enrollment request is submitted more than 60 days (90 days for a group with a 90-day or more employment waiting/affiliation period) prior to the eligible effective date.

Course of Action – A new Employee Enrollment Form should be submitted within the required timeframe.

- Employee Enrollment Forms are not signed or dated.

Course of Action – The Employee Enrollment Form is returned to the employee for completion.

- The signature is altered.

Course of Action – A new Employee Enrollment Form is requested.

- The date is altered.

Course of Action – The Employee Enrollment Form is returned to the employee to initial and confirm the altered date.

- Medical questions are answered “Yes”, but no medical history details are provided.

Course of Action – The employee is contacted for details, or the Employee Enrollment Form may be returned to the employee.

- Medical questions are left blank on the Employee Enrollment Form.

Course of Action – The employee may be contacted for details, or the Employee Enrollment Form is returned to the employee to have the question(s) completed, initialed and dated.

- Waiver of Coverage section is not completed on the Employee Enrollment Form.

Course of Action – The Employee Enrollment Form is returned to the employee for completion of the Waiver of Coverage section.

Pre-Existing Conditions

Pre-existing conditions are those for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the effective date for new group members and late enrollees, or the date of hire for timely enrollees. Pre-existing conditions are not covered for 12 months. Late enrollees are subject to an 18-month pre-existing conditions limitation. This provision applies to medical and prescription drug coverage only.

This limitation does not apply to maternity. Newborn and adopted children are not subject to the Pre-existing Conditions Limitation when the enrollment request is received within 31 days of birth, adoption or placement.

Continuity of Coverage – Medical

The Pre-existing Conditions Limitation is reduced by the amount of time a person was covered under prior creditable coverage, provided there was no more than a 63-day gap between coverages. For timely enrollees and dependents enrolling with them, the group's employment waiting/affiliation period is not counted as part of the gap.

The continuity of coverage provision applies to medical coverage only. For continuity of coverage benefits to be considered, the following information should be submitted with the original enrollment request:

- Completed Prior Insurance Coverage Information section on the Employee Enrollment Form or
- The Certificate of Creditable Coverage letter from the prior carrier.

Creditable Coverage includes the following:

- A group major medical plan
- An individual major medical plan
- Medicare
- Medicaid
- TRICARE or other governmental plan

Cancer-only, hospital-only and other non-major medical limited benefit plans are not prior creditable coverage.

Continuity of Coverage – Dental

The waiting period for timely applicants for certain dental services is waived when the applicant is replacing prior major dental coverage, provided there was no more than a 31-day gap between coverages, exclusive of any employment waiting/affiliation period.

Participation Requirements

Medical

The group must meet, and continue to meet two sets of participation requirements to be eligible. Noncompliance may result in termination of coverage.

1. 50% of all full-time, eligible employees must enroll, regardless of waivers; and
2. In groups of three or fewer eligible employees, all full-time, eligible employees without valid waivers must enroll. In groups of four or more eligible employees, 75% (100% if the employer pays 100% of the employee's premium) of all full-time, eligible employees without valid waivers must enroll.

Valid Waivers

When medical coverage is waived because an employee has existing comprehensive major medical coverage, the waiver is considered to be a valid waiver. Valid waivers are:

- Coverage under a spouse's employer group major medical plan
- Coverage under an individual major medical plan
- Medicare
- Medicaid
- TRICARE
- Coverage under an Indian Health Services Program
- State health benefits risk pool
- COBRA coverage

Participation and Eligibility Review Process

The group must maintain participation requirements throughout the life of the contract. Assurant Health may send renewal questionnaires, call groups or request payrolls records to verify participation and eligibility information at any time. Groups that fail to maintain participation requirements or supply the requested information to verify continued compliance with eligibility and participation requirements may be terminated.

Ancillary Products

Dental Coverage

Dental plans are available to all size groups enrolling for major medical coverage. The dental plan may also be written as a stand-alone product with a minimum of three covered employees. Optional orthodontia is available for groups with at least 10 covered employees.

When dental coverage is purchased with medical, the dental participation requirement is the same as for the medical coverage.

Participation requirements for the stand-alone dental product are:

Groups of four or less – 100% of all full-time, eligible employees must enroll – no waivers are allowed.

Groups of five or more – 75% (100% if the employer pays 100% of the employee's premium) of all full-time, eligible employees without valid waivers must enroll.

The only valid waiver for dental coverage is under a spouse's comprehensive employer dental plan.

Dental offices and dental labs are ineligible for dental coverage.

Life/Accidental Death & Dismemberment (AD&D) Coverage

The life insurance coverage elected is stated on the Plan Summary page included in your Employer Kit.

- Employee Life/AD&D Coverage is available in \$5,000 increments from \$10,000 to \$500,000 (based on plan selection).
- Life/AD&D coverage amounts will be reduced beginning with an employee's 70th birthday and the spouse's 65th birthday (if dependent life was elected).

Employee Coverage Reduction Based on Age

Age	Face Amount
70	to 65% of original coverage
75	to 40%
80	to 25%
85	to 20%
90+	to 10%

To increase life insurance amounts, Assurant Health must receive a new fully completed, signed and dated Employee Enrollment Form.

To add Life/ AD&D coverage to your group plan, a new quote must be signed and submitted, along with a new fully completed, signed and dated Employee Enrollment Form from each employee enrolled for major medical coverage. Eligible employees with a valid major medical coverage waiver may enroll for life coverage alone.

Life insurance coverage is medically underwritten and may be declined.

Requests to add or increase benefits can be made effective on your group's renewal date or January 1 or 15 (date is dependent on the group's billing cycle).

Life and Accidental Death & Dismemberment (AD&D) coverage is optional. However, when selected by the employer, employees are automatically enrolled for this coverage when they enroll for major medical coverage, unless specified otherwise.

Short Term Disability Coverage

The short term disability coverage elected is indicated on the Plan Summary page included in your Employer Kit. Short Term Disability is only available to employees.

- Benefit amounts may not exceed 66% of the weekly base pay of the employee.
- Maximum benefits are available from \$50 to \$1,000 in \$10 increments.
- Maximum duration is 26 weeks.
- A 7-day waiting period applies for sickness or pregnancy.
- Disability coverage ends on the employee's 65th birthday.

To increase short term disability amounts, Assurant Health must receive a new fully completed, signed and dated Employee Enrollment Form. In addition, the employee's payroll records (minimum of 90 days) must be provided in order to determine the amount of coverage for which the employee is qualified.

Eligible employees must have major medical coverage under our plan in order to enroll for short term disability coverage. To add short term disability coverage to your group plan, the group must have major medical coverage.

Assurant Health must receive a new fully completed, signed and dated Employee Enrollment Form from each employee enrolled for major medical coverage.

Disability coverage is fully underwritten and may be declined.

Requests to add or increase benefits can be made effective on your group's renewal date or January 1 or 15 (date is dependent on the group's billing cycle).

Certain types of businesses are not eligible for this coverage. Please contact your agent for a list of those businesses.

Coverage Changes

Medical and Dental Plan Changes

Changes can be made to plan designs on your group's renewal date or January 1 or 15 (date is dependent on the group's billing cycle). Requests can be submitted 30 days prior to or after the effective date (renewal or January 1 or 15 – date is dependent on the group's billing cycle.) A signed and dated quote is the preferred method for submitting plan changes.

Network changes can be made on your group's renewal date or January 1 or 15 (date is dependent on the group's billing cycle). Such changes can also be made when a new network becomes available or is discontinued in a marketed area.

A group can request to add dental coverage at any time.

All plan changes are subject to underwriting review, approval and possible group rating. When the change involves an increase in benefits, new Enrollment Forms, including current health history, may be required for underwriting review.

NOTE: Any resulting premium adjustments appear on future billing statements.

Maternity Coverage

When elected, maternity coverage must be maintained for a minimum of 12 months.

Employee Choice Program - Medical

Employee Choice allows you to offer multiple plan designs and networks. Network Choice is available to groups with two or more covered employees. Plan Choice is available for groups with three or more covered employees.

An employee can switch to another plan being offered by you on the group's renewal date or January 1 or 15 (date is dependent on the group's billing cycle), unless the switch is due to a physical relocation of an employee.

The employee must identify which medical plan they are choosing. A description of plans and plan numbers appears on your billing statement.

Health Savings Account (HSA)

HSA plans for small employer groups are available with qualified HSA deductibles and coinsurance out-of-pocket maximums. Annually the Department of Labor reviews the qualified HSA plan deductibles and out-of-pocket maximums based on the Consumer Price Index (CPI) and may make cost-of-living adjustments (COLA). As a result, all insurance companies selling HSA plans are required to re-evaluate their HSA deductibles and out-of-pocket maximums to ensure these are within the qualified range. If an adjustment is required, your plan deductible and coinsurance out-of-pocket will be increased to meet the new qualified range. You will be notified if such a change is made.

Administrator Changes

The Group Administrator is the liaison between your company and Assurant Health. Your designated representative should notify Assurant Health of any coverage changes. Please be sure to notify Assurant Health if you make a change in your Group Administrator.

Ownership Changes

If your business undergoes a change in ownership, merger or acquisition, a new Employer Participation Agreement/ Application must be completed and submitted for review. Additional requirements may apply.

Group and Member Address Changes

Notify Assurant Health of any changes. The fastest and most convenient way is through the Internet at www.answersbyassurant.com and accessing *myaccount*. To ensure that billing statements and/or correspondence are sent to the correct location, please communicate any address changes in advance. If you, the employer, change your telephone number, please notify Assurant Health of this change as well.

Beneficiary Changes

A Beneficiary Change Form must be completed for beneficiary changes and beneficiary address changes. Witness signature is needed for beneficiary changes. The witness cannot be the beneficiary. Please contact Customer Service for the necessary form.

Changes are effective upon receipt of the change request in Assurant Health's office.

NOTE: *If naming a minor as a beneficiary, some states may require that guardianship be established in order for benefit payout.*

Termination of Coverage

Termination may refer to termination of an employee's and/or dependent's coverage, your entire group's coverage or a specific type of coverage. Follow the guidelines that apply to your situation.

Coverage Terminations

Group/Employee/Dependent coverage may be terminated for the following reasons (please review the certificate for further termination provisions):

- Premium payment is not received by Assurant Health on the date it is due or by the end of the grace period.
- There is evidence of fraud or misrepresentation.
- There is noncompliance with plan provisions, including your group failing to meet participation requirements.
- The business ceases to operate or loses its identity by means of liquidation, merger or otherwise.
- The business moves to a state in which Assurant Health no longer writes business.
- An employee or dependent loses eligibility according to the certificate requirements.
- For a dependent, the date an employee's coverage ends or the employee's family coverage ends.
- A dependent reaches the maximum age allowed.
- The group Master Policy terminates.
- You requested termination for your group, an employee, or dependent, provided such request is received by Assurant Health within 31 days of the requested termination date.

All coverage termination requests must be submitted within 31 days of the termination of the group, employee, or dependent. Also, provide the reason for employee and dependent terminations, including last date of eligibility, waiver information, etc.

Employee/Dependent Termination Notification

There are several ways to notify Assurant Health of an employee's/dependent's coverage termination. Notification must occur within 31 days of loss of eligibility.

- Use the online resource, *myaccount*, at www.answersbyassurant.com.
- Contact Customer Service.
- Use the back of your premium statement to request termination.
- Send a separate notice (refer to Contact Information Section).

CAUTION: *Verify you are terminating the correct employee. An employee whose coverage has been mistakenly terminated as a result of a request will need to reapply for coverage and may be considered a Late Entrant.*

Include the employee's/dependent's name, certificate number, and termination date.

Once the termination request is processed, any credit due will appear as an adjustment on your next billing statement.

Review your next billing statement to ensure the employee/dependent was removed from your plan.

Be sure to collect and destroy the insurance Identification (ID) cards of all terminated employees.

Group Termination Requests

To terminate your group's plan, notify Customer Service or submit your request in writing. Requests should be received by the billing due date.

The earliest date for group termination is the paid-to date of the group. Group termination dates coincide with group billing and paid-to dates.

Lapsed Coverage

- If premiums are not received by Assurant Health within 31 days of the due date, coverage for all employees terminates as of the premium paid-to date.
- Unless required by state mandate, Assurant Health does not notify employees that coverage is terminated. It is your responsibility to advise your employees of your group's coverage termination.
- Checks are automatically deposited and cashed by Assurant Health's bank, regardless of the status of your plan. Cashing of a premium check on a terminated plan does not guarantee approval for reinstatement.

Continuation of Coverage

IMPORTANT: *A request for continued coverage must be submitted within the required time period listed below.*

There are several alternatives for continuing coverage after the termination of an employee's or dependent's coverage. The options available are determined by federal and state laws and product options.

Information specific to your state's requirements is contained in the Certificate of Group Insurance.

Once a continuation option is elected, the start date of the continuation will coincide with the qualifying event date.

Following are brief descriptions of options that may be available to employees/dependents.

COBRA Guidelines

A federal law, referred to as COBRA (Consolidated Omnibus Budget Reconciliation Act) requires employers, who customarily employ 20 or more full or part-time

employees at least 50% of its typical business days during the previous calendar year, to offer continuation of the group's plan to qualified individuals who may lose coverage for one of several reasons.

The term "qualified individual" means any person who, on the day before a qualifying event for that employee, is a beneficiary under the group plan (e.g. spouse or dependent child of a covered employee).

You are obligated to notify qualified individuals of their COBRA rights when a qualifying event occurs. That notice must be provided to the qualified individual within 14 days of the qualifying event. Notice of such qualifying event must also be provided to Assurant Health within 31 days.

Employees have 31 days to elect COBRA coverage from the date coverage terminates OR the date notice is given to you of the qualifying event, whichever is later.

Assurant Health requires that a signed and dated statement/Application for Continued Health Insurance be received within 31 days of the qualifying individual's election for COBRA continuation coverage.

Additional information and the Application for Continued Health Insurance can be found in your Employer Kit. Please refer to these documents for information regarding this option to continue coverage.

Life insurance is not available under COBRA.

Your billing statement will indicate when an individual is covered under COBRA.

State Continuation (if listed in the Certificate of Group Insurance)

Many states have their own continuation laws. Employees should review their Certificate of Group Insurance for State Continuation information. Since state laws tend to change more often than federal laws, please contact Customer Service for current information.

How to Obtain State Continuation Coverage

Confirm the timeframe in which continuation must be requested. The timeframe is indicated in the Certificate of Group Insurance.

Submit the request in writing or by telephone.

Premium for employees/dependents on continuation is to be remitted by the employer with your group's premium. You must collect the premium from the employees/dependents. This applies unless otherwise required by state law.

Your billing statement will indicate when an individual is covered under State Continuation.

Early End to COBRA or State Continuation

Such coverage will end on:

- The date the plan terminates.
- The date that you, the participating employer, terminate coverage.
- The last day of a period for which a required premium contribution was paid, if the next required premium is not paid.
- The date a covered person becomes insured under another group health insurance plan that does not exclude or limit coverage for any pre-existing condition.
- The date the insurance would otherwise terminate, as described in the Termination provisions of the Certificate of Group Insurance.
- The date a covered person becomes entitled to Medicare coverage.
- The first day of the premium month following 30 days after the date a final determination is made by the Social Security Administration that a covered person is no longer disabled (but only if the covered person recovers from the disability after the original 18-month continuation period and prior to the end of the 29-month continuation period).
- The date a covered person has continued insurance for the maximum continuation period allowed by COBRA.
- The date you cease to provide any group health insurance plan to employees.
- The date on which coverage is terminated for cause. Termination for cause will end the coverage of a qualified individual in the same manner that the coverage ends for employees who have not undergone a qualifying event, and the member would not be eligible to enroll for COBRA.

A member on COBRA or state continuation who is rehired on a full time basis is considered a new employee and must re-enroll for coverage following the group's chosen waiting/affiliation period.

NOTE: *Assurant Health's Short Term Medical or Individual Medical plans may be more affordable alternatives to COBRA. You or your employee may contact your agent, or Assurant Health at the number shown at the end of this guide, for additional information. (Short Term Medical and Individual Medical Plans are not guaranteed issue and pre-existing conditions are not covered.)*

To preserve your rights to guaranteed health insurance and coverage for pre-existing conditions, you may need to purchase up to 18 months of COBRA. You may forego these rights when you purchase a Short Term Medical plan or choose to go without insurance.

Layoff

A laid off employee is not eligible for coverage. Laid off employees may request continued coverage, as outlined in their Certificate of Group Insurance.

If an employee returns to work, a new enrollment request must be submitted, as the employee would be considered a new hire and must satisfy the chosen employment waiting/affiliation period.

Leave of Absence

If the employee is no longer currently performing services on a full-time basis, the employee may be eligible to continue coverage for a period of 3 months, provided that you, the participating employer, still consider the person to be an employee and continue to pay your portion of their health insurance premium. You must notify Assurant Health within 31 days, if the employee is requesting a leave of absence.

Continuation options outlined in the Continuation of Coverage section apply. Please refer to the Certificate of Group Insurance for availability of this benefit.

Some employees may be eligible to continue coverage under the Federal Family and Medical Leave Act. Please consult an attorney to determine the applicability of this act to you, as the employer.

Leave of Absence Coverage Continuation

Coverage may continue until the earliest of:

- 3 months on continuation
- The date you cease to make premium payments
- The date you no longer consider the person an employee and terminate his/her coverage
- The date you cease to provide any health insurance plan to employees.

Reinstatement After a Leave of Absence

- If an employee returns prior to the end of the 3-month leave of absence, notification must be sent to Assurant Health so the employee's coverage is not terminated.
- If notification is not received resulting in the employee's termination, a new enrollment request must be submitted. Please refer to the guidelines described in the Adding Employees/Dependents section.

Military Leave

Notify Assurant Health in writing, within 31 days of a covered person being placed on active duty.

There are several coverage alternatives for employees who serve in the military during their employment. In most situations, your employee will have government-sponsored health coverage while actively serving. Due to military coverage, his/her benefits with Assurant Health may be terminated for the duration of duty

unless otherwise requested. The employee and his/her dependents have the right to 18 months of extended health care coverage subject to receipt of payment for the entire cost of the coverage.

Return from Active Duty

To reinstate coverage upon return from active duty:

- Submit a copy of the employee's discharge papers.
- Send a letter stating full-time employment has resumed.
- Submit a fully completed Employee Enrollment Form.

NOTE: *To ensure guaranteed acceptance, the above information must be received by Assurant Health within 31 days of the resumed employment date. Underwriting guidelines for a Late Entrant will apply if the request is received after 31 days from the resumed employment date.*

Billing

Premium Payments

Use the coupon at the top of your billing statement when submitting payments. Write your group number on the memo section of your check. Please keep the remaining pages of the billing statement for your records.

Your premium payments go directly to the bank, so do not include other documents or requests with your payment. Please refer to the addresses listed in the back of this guide for sending other documents.

Employer Responsibility for Premium Payments

- The employer must pay at least 50% of the employees' portion of the premium.
- The employer determines whether employees are responsible for paying all or part of their dependents' premium.
- The employer must submit premium payment for the group. Individual checks from employees are not accepted.

General Billing Information

- You are billed approximately 15 days prior to the bill due date.
- If your payment is not received, past due amounts display on your next billing statement. A message appears on the billing statement indicating the date payment must be received in order to keep coverage in force. This will be your only notice of overdue premium.
- Some states require that we notify employees when premiums are received late or when coverage has lapsed. This legislation is designed to ensure that employees are aware of the status of their coverage. This is one reason why timely payment is important.

- If you cannot locate or have not received your billing statement, please contact Customer Service for assistance.
- Premiums must be submitted to the address listed on the billing statement. Agents are not authorized to collect premium payments.

REMINDER: *If premium is received later than the 31st day after the due date, coverage terminates. If this happens, Assurant Health will send you a termination notice. In some cases, your employees will also receive a letter notifying them of the termination of coverage (based upon state mandates). Please refer to the Lapsed Coverage section of this guide.*

Adjustments

Adjustments on your billing statement will reflect changes in the make-up of your group plan. Please do not submit premium for such changes until it is reflected on your billing statement. If you are adding new members or changing your coverage, you will be billed or receive credit for changes on the next statement generated after the changes are processed.

Checks Returned Unpaid

Assurant Health will notify you by mail if your premium check is returned unpaid.

You will be given 14 days from the date of the letter to submit a replacement payment. The replacement payment must be in the form of a certified check, cashiers check or money order.

Premium and Rate Adjustments

First-year Premium

When you purchased your plan, you provided a census of your group. The initial rate assigned is based on the age of your employees at the time the coverage is issued, the types of coverages selected and the location of your business. The initial rate is guaranteed for 12 months, provided there are no changes.

More than likely, within the first 12-month period, there will be adjustments to your actual monthly premium. These adjustments can reflect changes in the age of employees, coverage changes or changes in the location of your business.

The premium rate charged depends primarily on the specific benefits elected, the characteristics of the group and applicable state insurance regulations. These may include:

- Age and gender of employees and their spouses
- The number of children
- Eligibility of members for Medicare coverage
- Medical history of members
- Geographic location of business
- Group size
- Employer's nature of business
- Mandated state benefits
- Network selection.

Rating Method

There are two methods of rating used to calculate premiums. Depending on the number of employees with medical certificates in your group and the medical plan chosen, either age rating or composite rating is used to calculate your group's medical premium. Both methods produce the same total medical premium for your group.

Age rating produces a premium for each employee that is based on age and gender (where allowed). Ages are generally grouped in five-year age brackets, but this may vary by state. Rate adjustments due to reaching a new age bracket are made on the first day of the billing month following the change in age, unless your state requires this to be done at renewal.

Composite rating provides the same premium to all employees and spouses, based on the age and gender of all employees and spouses in your group (where allowed).

Ages are generally grouped in five-year brackets, but this may vary by state. Rate adjustments due to reaching a new age bracket are included when group premium is re-averaged. Re-averaging is calculated at renewal or when you request a group level plan change.

Medicare Eligibility/TEFRA

The federal agency administering the Medicare program has introduced mandatory requirements for administrators of group health insurance plans. Consequently, Assurant Health needs employers, who are covered by one of our plans, to provide Social Security numbers for all employees, spouses, and their dependents covered by their plan from Assurant Health.

This information is being requested to comply with the governmental requirements set forth in the Medicare, Medicaid and SCHIP Extension Act of 2007. The information will be reported to the Centers for Medicare and Medicaid Services (CMS). We realize this is sensitive information and have appropriate safeguards in place to protect it. For additional information on the mandatory reporting requirements, you can visit the CMS website at <http://www.cms.hhs.gov>.

The Tax Equity and Financial Responsibility Act, or TEFRA, affects the way in which Assurant Health pays benefits for employees or insured spouses and dependent children who may be eligible for Medicare.

For groups of 19 or fewer full and part-time employees, the medical rates for a member who reaches the age of Medicare eligibility will decrease, and Assurant Health will pay benefits secondary to Medicare. This means Medicare processes the expenses first. This change is effective the first of the month in which the member reaches age 65. If a 65-year-old employee has a covered dependent under age 65, Assurant Health continues to pay primary benefits for the dependent, subject to TEFRA guidelines.

Groups with 20 or more full and part-time employees fall under the federal legislation referred to as TEFRA. TEFRA determines premium and reimbursement guidelines. Under TEFRA rules, Assurant Health represents the primary insurer and Medicare is secondary. Please notify Assurant Health immediately of any changes in group size that would impact the rules used when administering benefits, as governed by TEFRA.

To ensure that you are properly billed when eligible for TEFRA, please notify Assurant Health when your group size changes.

Premiums are not reduced when Medicare is primary due to dialysis or disability.

Renewal Premium Changes

Rating procedures are designed to treat groups consistently and to comply with state requirements. Notification of any renewal rate change is sent in advance of the change in accordance with your state's requirements.

The rate charged to your group depends primarily on:

- The specific benefit plan you elected
- The network selected
- The case characteristics of your group (*Please refer to the First-year Premium section.*)
- Applicable state insurance regulations

Claims Information and Filing Instructions

Details regarding filing for claim reimbursements and receiving benefits are provided in the Certificate of Group Insurance. The following information is dependent on the type of coverage your group has chosen.

Before employees use their coverage, encourage them to read their Certificate. Employees may contact Customer Service for assistance. Although we do not guarantee benefits over the phone, we can help employees understand the benefit process. Also, understanding the financial impact prior to incurring expenses has a major effect on the level of employee satisfaction.

A review of the Certificate will outline:

- If a planned treatment or service is a covered expense.
- If prior authorization for a specific service is required.
- If your group plan has a network provision. If so, employees should check to see that the providers being considered are in the network. For assistance finding a network, the employees should call the Participating Provider Network at the number and/or Web site shown on the employee's ID card. Because network affiliation can change, your employees should also confirm network membership when seeking care from a provider.

When employees use network providers, they receive the maximum benefits available with their plan.

Medical Claims

The information on where to submit a claim can be found on the employee's ID card. Claim forms completed by an insured are not necessary. To process a claim, an itemized statement from a provider is needed.

The statement must provide the following information: group and certificate number or employee's social security number, date of service, type of service (using CPT codes), diagnosis, billed amount, and complete provider information. Balance due statements are not accepted in lieu of an itemized bill.

Assurant Health encourages timely filing of claims. Claims received more than 12 months from the date of service are not covered.

For the following types of situations, the insured member should complete and submit the Claim Information Report that is included in the Employer Kit you received when coverage was issued:

- Accidents/Injuries (of all natures)
- Other insurance coverage when a lawsuit may be involved.

Assurant Health may send notices to the insured requesting additional information in order to process a submitted claim.

Prescription Drug Expenses

The prescription ID card is combined with the medical ID card, but displayed in a separate section of the card.

So employees receive available prescription discounts, encourage them to always use a pharmacy associated with the network indicated on their ID card.

For any prescription drug purchases outside the network, employees should send their receipts to the address provided on their ID card.

EXCEPTION: *Most injectable drugs are covered under the major medical plan. Employees should contact Customer Service for information, as some may require pre-certification.*

Dental Claims

If your group has elected dental coverage, a separate ID card is issued for dental coverage.

The information on where to submit a claim can be found on the employee's dental ID card. Claim forms completed by an insured are not necessary.

To process a claim, an itemized statement from a provider is needed. These statements must provide the following information: group and certificate number or employee's social security number, date of service, type of service (using ADA codes), tooth numbers (if applicable), billed amount, and complete provider information. Periodontal expenses must include charting and classification. Balance due statements are not accepted in lieu of an itemized bill.

Assurant Health encourages timely filing of claims. Claims received more than 12 months from the date of service are not covered.

If services are expected to reach \$300 or more, an estimate of benefits should be requested by the dentist before receiving service. For pre-estimates, x-rays may be necessary for some procedures. Prior to submitting the pre-estimate, have the dentist contact Assurant Health at the phone number on the dental ID card for any requirements.

Assurant Health may send notices to the insured requesting additional information in order to process a submitted claim.

Disability Claims

This only applies if your plan includes Short Term Disability Insurance coverage.

If it appears a disability may extend beyond seven (7) days, a covered employee must contact Customer Service immediately. Instructions and necessary forms are sent to the requester.

Life Claims

This only applies if your plan includes Life Insurance coverage.

Please immediately notify Customer Service of any claim for life insurance benefits. Instructions and the necessary forms are sent to the designated beneficiary.

Grievance Process

Details regarding ERISA (Employee Retirement Income Security Act) are provided in the Certificate. In compliance with ERISA guidelines, Assurant Health has a grievance procedure. Some states offer one level of grievance, while others offer two levels. If an employee believes his/her case is not being administered according to the terms of the contract, he/she has the right to request a review of his/her case.

All appeals must be in writing. For states with two levels, the initial grievance will be reviewed and researched. The pertinent information for the grievance is gathered by a correspondent and referred to other administrative departments if necessary during the review process.

Upon completion of the review, the party filing the grievance and/or the insured is notified of the outcome in writing. For upheld grievances, the written notification will be a letter. Depending on the level of grievance and state mandates, the written notification for overturned grievances may be an updated Explanation of Benefits (EOB) or, in some cases, a letter and an updated EOB.

If the insured is still in disagreement with Assurant Health's determination in a state with two levels of grievance, he/she may submit, in writing, a second level grievance explaining why he/she disagrees with the determination along with any supporting information and documentation. Upon receipt, a second review is conducted. All available information, including Assurant Health's files and additional information from the insured, are reviewed.

Upon completion of the review, the party filing the grievance and/or the insured is notified of the outcome in writing.

Contact Information

Internet

www.answersbyassurant.com

Myaccount is a valuable online resource to meet your service needs anytime you have access to the Internet. To access *myaccount* you must first obtain a PIN (Personal Identification Number). Call 866-ANSWERS (267-9377) between 7:00 a.m. and 6:00 p.m. CST to obtain your PIN number.

Then go to www.answersbyassurant.com and register. Registration is quick, easy and free. You can order ID cards, add employees and dependents, update your plan information (such as address changes), and submit employee/dependent termination requests.

Telephone

Customer Service Department – 800-328-4316

An automated system is available 24/7 to provide callers with answers to some common questions regarding claim status, identification of benefits and premium paid-to dates. If you need assistance, Customer Service is available to handle your questions or concerns. Please have your group number available when you call. Due to confidentiality and protection of our customers, we do require specific information be verified prior to releasing information.

Writing/Fax

Administration Requests

- Coverage terminations (*Group, Employee, Dependent, Benefits*)
- Changes to Member Information (*Social Security Number, Name, Address, etc.*)
- Plan changes
- Address changes
- COBRA/State Continuation
- Premium inquiries

Mailing Address: P.O. Box 3227 Milwaukee, WI 53201-3227 Fax: 763-577-4594

Premium Payments

See your Billing Statement.

Medical Claims/Benefits

Refer to the information on your medical ID card.

Dental Claims/Benefits

Refer to the information on your dental ID card.

Customer Service Department

Mailing Address:
P.O. Box 9398, Minneapolis, MN 55440-9398 or
9955 59th Ave N Plymouth, MN 55442
Fax: 763-577-4575

For information on Short Term Medical and Student Select products, call 800-800-5453 or write to Assurant Health at P.O. Box 3175, Milwaukee, WI 53201-3175.



ASSURANT
Health®

About Assurant Health

Assurant Health has been in business since 1892 and is the brand name for products underwritten and issued by Time Insurance Company, John Alden Life Insurance Company and Union Security Insurance Company. Together, these three underwriting companies provide health insurance coverage for almost one million people nationwide. Each underwriting company is financially responsible for its own insurance products. Primary products include individual medical, small group, short-term and student health insurance products, as well as non-insurance products and consumer-choice products such as Health Savings Accounts and Health Reimbursement Arrangements. With almost 3,000 employees, Assurant Health is headquartered in Milwaukee, Wisconsin, with operations offices in Minnesota, Idaho and Florida, as well as sales offices across the country. The Assurant Health Web site is www.assuranthealth.com.

Assurant Health is part of Assurant, a premier provider of specialized insurance products and related services in North America and selected international markets. Its four key businesses – Assurant Employee Benefits, Assurant Health, Assurant Solutions and Assurant Specialty Property – have partnered with clients who are leaders in their industries and have built leadership positions in a number of specialty insurance market segments worldwide.

Assurant, a Fortune 500 company and a member of the S&P 500, is traded on the New York Stock Exchange under the symbol AIZ. Assurant has more than \$24 billion in assets and \$8 billion in annual revenue. Assurant has approximately 15,000 employees worldwide and is headquartered in New York's financial district. The Assurant Web site is www.assurant.com.

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

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