

INDEX

<u>GROUP ELIGIBILITY</u>	2
<u>GROUP STRUCTURE</u>	2
<u>GROUP ENROLLMENT REQUIREMENTS</u>	2
<u>EMPLOYER CONTRIBUTION</u>	3
<u>PARTICIPATION</u>	3
<u>MEDICAL UNDERWRITING</u>	4
<u>PRE-EXISTING CONDITIONS</u>	4
<u>CHANGING BENEFITS</u>	5
<u>OPEN ENROLLMENT/ ANNUAL ELECTION PERIOD</u>	5
<u>DUPLICATE COVERAGE</u>	5
<u>PRIOR CARRIER DEDUCTIBLE</u>	5
<u>CARRY-OVER COINSURANCE</u>	5
<u>STRIKES</u>	5
<u>EMPLOYEE/DEPENDENT ELIGIBILITY</u>	6
<u>ACTIVE EMPLOYEE</u>	6
<u>INELIGIBLE EMPLOYEES</u>	7
<u>RETIRED EMPLOYEES</u>	7
<u>LEASED EMPLOYEES/PROFESSIONAL EMPLOYER ORGANIZATIONS(PEO)</u>	8
<u>PREGNANCY ELIGIBILITY</u>	8
<u>APPLICANTS RESIDING OUTSIDE THE U.S.A.</u>	8
<u>INDIVIDUALS FROM FOREIGN COUNTRIES RESIDING IN THE U.S.A.</u>	9
<u>EMPLOYEES ON DISABILITY, WORKERS' COMPENSATION, OR UNPAID LEAVE OF ABSENCE</u>	9
<u>INDIVIDUALS CALLED TO ACTIVE MILITARY DUTY</u>	10
<u>PROBATIONARY PERIOD</u>	11
<u>ENROLLMENT CHANGES FOR EMPLOYEES (ADDITIONS AND DELETIONS)</u>	12
<u>QUALIFYING EVENTS</u>	13
<u>TERMINATION OF EMPLOYEES</u>	14
<u>DEPENDENT ELIGIBILITY AND ENROLLMENT CHANGES</u>	14
<u>ADDING DEPENDENTS</u>	15
<u>COMMON-LAW MARRIAGES AND ROOMMATES</u>	15
<u>DISABLED DEPENDENTS</u>	15
<u>SURVIVING SPOUSES</u>	15
<u>TERMINATION OF DEPENDENTS</u>	16
<u>COBRA</u>	16
<u>CONTINUATION OF COVERAGE (STATE REGULATIONS)</u>	17
<u>CONVERSION TO NON-GROUP COVERAGE</u>	17
<u>FAMILY MEDICAL LEAVE ACT</u>	18
<u>FEDERALLY ELIGIBLE INDIVIDUAL</u>	19
<u>MEDICARE</u>	19
<u>Medicare Working Aged: When is Medicare Primary?</u>	19
<u>Medicare for Disabled Active Individuals: When is Medicare Primary?</u>	20
<u>Medicare and End Stage Renal Disease: When is Medicare Primary?</u>	21

<p>GROUP ELIGIBILITY</p>	<ul style="list-style-type: none"> ▪ Group size and market segments are determined by the number of total <i>enrolled</i> for new groups in the 1-50 market. ▪ For new groups with 51+ and 100+ employees, the group size and market segment is determined by the total active <i>eligibles</i>. ▪ The market segments are groups of 1, 2-4, 5-9, 10-24, 25-50, 51-99, and 100+. ▪ The group must be an entity that has the legal capacity to execute a contract on behalf of its members. ▪ The group must have a physical address (not just a P. O. Box) in a MM licensed state. ▪ The group must be an active business entity that can be supported by tax documentation clearly showing an active ongoing business. An employer-employee relationship must exist in that the individuals comprising the group must be actively employed by the group and receiving a wage or salary. ▪ No more than 25% of the enrollees in the group may be retirees and the group must have a bona fide retirement/pension plan. See “Retired Employees” for criteria retirees must meet to be eligible to enroll. ▪ No more than 25% of the employees in the group may be Medicare primary. ▪ No more than 10% of the enrollees may be COBRA continuants. ▪ The group must have a corporate headquarters or an entity with the ability to enter into a signed contract within a MM licensed state. <p>At least 75% of the enrollees must reside in a MM licensed state. For companies near a state border, at least 75% of enrolled employees must receive their normal health care from health care providers in a MM licensed state.</p>
<p>GROUP STRUCTURE</p>	<ul style="list-style-type: none"> ▪ If the employees from different locations appear on <u>one</u> quarterly wage report form, MM will consider the group to be one company, and will not consider the locations to be separate companies or subsidiaries. ▪ If the employees from different locations appear on different quarterly wage report forms, MM will consider the location to be a distinct company or subsidiary. ▪ Two or more companies will be allowed to combine for insurance purposes when one person or a specific group owns 50% or more of all the companies which desire to be combined. ▪ Segmenting a group into smaller sections and then defining only some of the segments as eligible for coverage is not permitted. ▪ Groups that <u>lease employees</u> from another company may not offer health coverage to the leased employees. The leasing company, however, may offer health coverage to its employees who are leased to other companies. ▪ When a company’s union employees are covered through a separate, union sponsored health plan, MM will allow the non-Union portion of the firm to apply for coverage, with the number of full-time non-union employees defining the number of eligible employees in the group. The group must submit the Union Local Number and identify the union workers.
<p>GROUP ENROLLMENT REQUIREMENTS</p>	<ul style="list-style-type: none"> ▪ The employer must complete and sign the Group Application. ▪ The employer must submit the most recent quarterly wage report filed with the state in which the group is located to substantiate the total number of employees and eligibility of the employees applying for coverage. The salaries and number of weeks worked as stated on the quarterly wage report may not be erased or blacked out. ▪ In situations when an employer is not required to file with quarterly wage report, alternate tax documentation will be required. See the following list: <ul style="list-style-type: none"> Owner of a Sole ProprietorshipSchedule C Partners of Partnership.....Form 1065 with K-1’s Owner of C-Corporation.....Form 1120 Owner of S-Corporation.....Form 1120S with K-1’s Church Group.....*W2 or Payroll Register Non-Profit Group.....*W2 or Payroll Register Agricultural Group.....*W2, Schedule F or Payroll Register Elected Officials...Public Officials Bond (Surety) <p>*When sending W2’s also submit the W3 which list how many W2 employees for the year</p>

EMPLOYER CONTRIBUTION

- At least 25% of the total premium must come from the employer.

PARTICIPATION

- For all lines of business (HP, MRCC, TRCC, and COSE), at least 50% of the TOTAL active eligible employees must enroll for coverage.
- To be eligible for group health benefits with MM, each group must meet the following minimum enrollment requirements:

*Number of *Net Active Eligible Employees:* 1 2 3 4 5 6 7 8 9 10 or more
Minimum Enrollment Requirements: 1 2 3 4 5 5 6 6 7 75%

*To figure the net active eligibles, subtract the full time employees who have spousal coverage or other MM 'group' coverage for which they are the contract holder.

Eligibility of groups of 1(Sole Proprietor)

- **COSE:** A group of 1 is eligible to enroll in this product. However, effective July 1, 2006 any new group that has 2 full time employees; COSE mandates that both be enrolled. The 50% floor rule does not apply to groups of 2 under this product.
- **Georgia:** A group of 1 is not eligible to enroll in this state.
- **Indiana:** A group of 1 is not eligible to enroll in this state. However, if 1of a 2 eligible group has a spousal waiver, 1 can be enrolled; thus meeting the 50% floor.
- **Ohio Health Pool:** A group of 1 is eligible to enroll in this product.
- **Pennsylvania:** A group of 1 is not eligible to enroll in this state.
- **TRCC & MRACC:** A group of 1 is eligible to enroll in this product.
- **West Virginia:** A group of 1 is not eligible to enroll in this state.
- If a husband and wife are both employees of a company, they may choose to enroll under two contracts and will be counted as two for the purpose of determining participation and group size (i.e.; 5-9 versus 10+). If they choose to enroll under one contract, they will count as two for determining participation, but as one for determining 5-9 versus 10+ at renewal (which is determined by number of contracts enrolled).
- Employees who belong to the Amish sect may waive coverage, and such waivers are not included when calculating participation. Such employees must submit a waiver indicating their affiliation with the Amish. If the individual desires MM coverage at a later date, he/she is considered a late entrant and all late entrant regulations apply.
- Union-only pieces of a group are not eligible to apply for MM coverage on their own. Non-union employees may sign a waiver, but both union and non-union employees are counted as eligible employees when determining participation and such a group must meet the participation requirements defined above. MM will, however, extend coverage to the non-union portion of a group when the union portion receives health coverage through a separate, union negotiated contract. In such instances only the non-union portion is reviewed when determining participation and group size. The union local number should be noted on the Group Application form under the other affiliations question, and the employees who are enrolled through the union plan should be noted on the reconciled quarterly wage statement as "union".
- Employees who are retirees of the military or from another company, and who receive health insurance benefits as part of a formal federally qualified retirement program, may waive MM coverage with their current employer, and such waivers are not included when calculating participation. Such employed retirees must submit a waiver stating their situation clearly.
- If the participation of a group falls below the minimum enrollment requirement, such group will have thirty-one (31) days after notice from MM to re-establish minimum enrollment. If minimum enrollment is not re-established within thirty-one (31) days, MM may, with prior notice to the group, cancel coverage.

MEDICAL UNDERWRITING

- When evaluating a group’s medical risk, MM may include medical information obtained from the medical history questionnaire, pre-screens on the group, and/or prior claims history regarding an employee or dependent who is applying for MM coverage or an employee or dependent who is waiving MM coverage. After reviewing the individual applications and Medical History Questionnaires, MM may also request additional information from the group to clarify specific situations.
- Medical History Questionnaires are considered invalid if they are more than ninety (90) days old.
- Prospective groups of 1, 51-99 and 100+ employees may be medically rejected for all lines of business (this includes COSE as of July 1, 2006).
- Prospective groups of 2-50 eligible cannot be medically rejected in accordance to HIPAA.

PRE-EXISTING CONDITIONS

The length and terms of pre-existing conditions limitations vary among the small group products in different states, as well as between HP, GSI (COSE, TRCC, and MRCC) in Ohio.

For all types of business and for all market segments (except for groups of 1) the application of pre-existing conditions to individual subscribers is subject to limitations imposed by HIPAA. HIPAA mandates “pre-existing portability” which requires crediting toward satisfaction of the pre-existing conditions limitations any time a person was covered under a previous carrier.

Previous coverage must have been continuous to a date not more than 63 days (this is for all lines of business except Georgia, they have 90 days) prior to the beginning of the new coverage (exclusive of employer imposed probationary periods prior to the effective date of coverage) to be “creditable coverage”.

Pre-existing will be applied on individuals within new groups, new hires, rehires, newly acquired dependents, and late entrants.

No pre-existing conditions clause may be applied for maternity, nor for any newly acquired dependent child (by birth or adoption), if applications are received within 31 days of the event (if being added to an existing single or two-person contract) or within one year of the event (if being added to an existing family contract)

- **Ohio Health Pool:** applies to all enrollees in new groups and/or new additions to existing group policies. No payment will be made for services related to a pre-existing condition for a period of 9 months for any condition treated or diagnosed within the 6 months immediately prior to the effective date of coverage.
- **GSI:** applies to all enrollees in new groups and/or new additions to existing group policies. No payment will be made for services related to a pre-existing condition for a period of 12 months for any condition treated or diagnosed within the 6 months immediately prior to the effective date of coverage.
- **Indiana:** applies to all enrollees in new groups and/or new additions to existing group policies. No payment will be made for services related to a pre-existing condition for a period of 9 months for any condition treated or diagnosed within the 6 months immediately prior to the effective date of coverage.
- **Georgia:** applies to all enrollees in new groups and/or new additions to existing group policies. No payment will be made for services related to a pre-existing condition for a period of 12 months for any condition treated or diagnosed within the 6 months immediately prior to the effective date of coverage.

	<ul style="list-style-type: none"> ▪ Pennsylvania: applies to all enrollees in new groups and/or new additions to existing group policies. No payment will be made for services related to a pre-existing condition for a period of 12 months for any condition treated or diagnosed within the 3 months immediately prior to the effective date of coverage. ▪ West Virginia: applies to all enrollees in new groups and/or new additions to existing group policies. No payment will be made for services related to a pre-existing condition for a period of 9 months for any condition treated or diagnosed within the 6 months immediately prior to the effective date of coverage. <p>For 51+ groups, pre-existing conditions limitations are at the group’s discretion, but may not include a look-back period in excess of 6 months (per HIPPA).</p>
<p>CHANGING BENEFITS</p>	<ul style="list-style-type: none"> ▪ Benefit changes will be permitted only once per contract year. This change must take place during the anniversary period of your coverage. ▪ Benefit changes to a HSA product is permitted for January effective dates regardless of renewal date.
<p>OPEN ENROLLMENT/ ANNUAL ELECTION PERIOD</p>	<ul style="list-style-type: none"> ▪ Late Entrant’s may apply for coverage during their employer’s annual election period, which coincides with the employer’s renewal. For all lines of business the late entrant will have the month prior to the effective date of the renewal, as well as the month in which the renewal is effective, to enroll. If the application is received outside of the two-month open enrollment period, the application will be returned.
<p>DUPLICATE COVERAGE</p>	<ul style="list-style-type: none"> ▪ It is permissible for an individual to hold coverage as a contract holder while carried as a dependent on a spouse’s coverage. ▪ It may be permissible for an individual to hold two contracts unless this is prohibited by law (i.e., under certain situations COBRA enrollees are not eligible to maintain COBRA coverage if they are enrolled in another group program). <p>This is dependent upon the timing of the COBRA event and date of enrollment in the other group program). Refer specific questions to the Ceridian COBRA Services Hot Line 1-800-488-8757.</p>
<p>PRIOR CARRIER DEDUCTIBLE</p>	<ul style="list-style-type: none"> ▪ MM will honor the carry-over of deductibles met under other programs, whether MM programs or programs of other carriers with presentation of the employee reporting form.
<p>CARRY-OVER COINSURANCE</p>	<ul style="list-style-type: none"> ▪ There is no carry-forward for coinsurance met under another carrier’s or another program’s coverage.
<p>STRIKES</p>	<ul style="list-style-type: none"> ▪ In the event of a strike, MM will continue to provide group benefits for striking workers, as long as the payment of premiums can be assured. If a rate change would normally take effect during the period of time the strike is in process, the rate change will be implemented. Any claims will be charged to the group unless the striking employees end up as conversion subscribers (see last paragraph). ▪ If management agrees to make payment on behalf of striking employees, payment may be made either as a company contribution or as an advance payment to be recovered by payroll deduction after the strike. There will be no refunds for workers who fail to return to work after the strike.

	<ul style="list-style-type: none"> ▪ If management refuses to make payment on behalf of the striking employees, alternatives for the payment of member's premium should be explored with the Union. ▪ If neither the employer nor the union makes provisions for the payment of the premiums for the continuation of group's coverage, subscribers may be eligible for COBRA or conversion depending on the size of the group. If no agreement can be reached, the terms of the Master Group Contract will prevail.
<p style="text-align: center;">EMPLOYEE DEPENDENT ELIGIBILITY</p>	
<p style="text-align: center;">ACTIVE EMPLOYEE</p>	<ul style="list-style-type: none"> ▪ All employee applications, waivers, and medical history questionnaires must be completed and signed by the employee and spouse if applicable. ▪ To be considered an employee, the individual must receive a wage or salary as regularly reported on state and federal payroll reports. ▪ To be eligible for coverage, employees must work at least 40 weeks per year. ▪ Employees must be actively at work on the effective date of coverage and working the minimum number of hours per week that is established by the employer. Each state has set the minimum or maximum hours for eligibility. ▪ Ohio Health Pool: An employer can choose between 20 – 25 hours as full time. The 25 hour maximum is a state law in Ohio for group's size 2 – 50. A group with 51+ eligible can choose between 20 – 40 hours per week. ▪ COSE/Alliances: An employer can choose between 17.5 – 25 hours as full time. The 25 hour maximum is a state law in Ohio for group's size 2 – 50. A group with 51+ eligible can choose between 17.5 – 40 hours per week. ▪ MRACC & TRCC: An employer can choose between 17.5 – 25 hours as full time. The 25 hour maximum is a state law in Ohio for group's size 2 – 50. A group with 51+ eligible can choose between 17.5 – 40 hours per week. ▪ Indiana: An employer must establish 30 hours as full time. The 30 hour maximum is for group's size 2 – 50. A group with 51+ eligible can choose between 20 – 40 hours per week. ▪ Pennsylvania: An employer can choose between 20 – 40 hours as full time. This is for group's size 2 – 99. ▪ West Virginia: An employer can choose between 20 – 40 hours as full time. This is for group's size 2 – 99. ▪ Georgia: An employer must establish 30 hours as full time. The 30 hour maximum is for group's size 2 – 50. A group with 51+ eligible can choose between 20 – 40 hours per week. ▪ Any individual who is not actively at work due to disability or leave of absence and applying for coverage with the initial group must appear on the prior carrier billing. ▪ Employers, owners and proprietors are eligible if they meet the same work requirements of employees. Trustees, directors, silent partners, associates, stockholders, attorneys, consultants, independent contractors, and relatives do not qualify for enrollment unless they also work the minimum number of hours required for eligibility <u>and</u> receive a wage or salary which can be documented on the group's quarterly wage report. ▪ Individuals who receive compensation reported on a 1099 form rather than a W-2 form are not eligible for coverage with the group. ▪ If the group is a municipal government (a city, town, or township), individuals elected as mayor or members of city council may be eligible in many instances. ▪ If a husband and wife are both employees of a company, they may choose to enroll under two contracts and will be counted as two for the purpose of determining participation and group size (i.e.; 5-9 versus 10+). If they choose to enroll under one contract, they will count as two for determining participation, but as one for determining 5-9 versus 10+ at renewal (which is determined by number of contracts enrolled).

	<ul style="list-style-type: none"> ▪ Employees who belong to the Amish sect may waive coverage, and such waivers are not included when calculating participation. Such employees must submit a waiver indicating their affiliation with the Amish. If the individual desires MM coverage at a later date, he/she is considered a late entrant and all late entrant regulations apply.
<p>INELIGIBLE EMPLOYEES</p>	<p>The following types of employees are not eligible for coverage:</p> <ul style="list-style-type: none"> ▪ Part-time employees; the threshold between part time and full time is set by the employer as long as threshold is in conformance with state legislated requirements. Please refer to ‘Active Employees’ above for specifics by state and product line. ▪ Temporary employees. ▪ Seasonal employees; employees who work less than forty (40) weeks per year are considered seasonal employees and are not eligible for group coverage. To verify whether a person is seasonal or not, the Underwriter needs to review four consecutive quarterly wage reports which show the number of weeks worked in each quarter. ▪ Employees absent from work and off of payroll due to short-term disability, long term disability, out on Workers’ Compensation or on unpaid leave of absence at the time of enrollment. ▪ Employees who are laid off ▪ Independent contractors; compensation is usually reported to the IRS on a 1099 form rather than a W-2 form. Such individuals may apply for MM coverage as their own employer group. Split compensation (1099 and W-2) is permitted as long as a more significant amount is reported through W-2 earnings. ▪ Trustees, directors, silent partners, stockholders, attorneys, consultants, household employees, and relatives who do not perform a function under the direction of the employer. ▪ Employees leased from another company or agency. See ‘Leased Employees’ below for more information. ▪ Former employees not covered under a state or federal continuation of coverage program.
<p>RETIRED EMPLOYEES</p>	<p>As of March 1, 2006 retiree benefits will only be available to new group with 51 or more employees. Existing groups in the 2-50 market segments with effective dates prior to March 1, 2006, will remain eligible for these benefits. This change does not affect COSE and OSMA groups.</p> <p>The following criteria apply to retirees:</p> <ul style="list-style-type: none"> ▪ If the group offers a retirement plan, it must be a non-discriminatory qualified retirement plan which precludes individual selection. ▪ Retiree’s length of service with the firm plus age must equal 60 or more years. ▪ Retirees must have worked the minimum hours established by the group (within regulation by product and state) per week ▪ Retirees must have been enrolled in the group health plan for at least five (5) continuous years prior to retirement. ▪ Retirees must maintain continuous coverage under the group health plan from the date of retirement to present. ▪ At least 25% of the retiree’s premium must be paid by the employer. ▪ Retirees who are also retirees of the military or from another company, and who receive health insurance benefits as part of a formal federally qualified retirement program, may waive MM coverage with their current employer, and such waivers are not included when calculating participation. Such employed retirees must submit a waiver stating their situation clearly. If the individual desires MM coverage at a later date, he/she is considered a late entrant and all late entrant regulations apply. <p>Exception: Due to Title 5 Regulation in Indiana, all government groups in Indiana will be eligible for retiree benefits regardless of group size. This benefit is only available until the retiree becomes eligible for Medicare.</p>

**LEASED
EMPLOYEES
OR
PROFESSIONAL
EMPLOYER
ORGANIZATIONS
(PEO)**

- Groups that lease employees from another company may not offer health coverage to the leased employees, and such leased employees are not counted as eligible or enrolling when calculating participation.
- In the case of employee leasing companies or temporary employment agencies, the employees which are leased or “temped” out to other firms must be counted as part of the eligible population when the leasing company or temporary agency itself applies for MM group coverage. The agency is not permitted to declare the leased/temporary employees as ineligible for coverage.
- When a company hires a Professional Employer Organization (PEO), the PEO becomes the employer and thus monitors the payroll and other services that involve the employees. The hiring company then has to ‘lease’ the employees. Even though these employees solely work for the company that hired the PEO, there is no longer an employer-employee relationship between the company they work for and the employee.
- MM will write business for a PEO location as if it were an employer when the group has less than 51 employees. Standard Underwriting policies and procedures will be used. The primary criteria for writing a distinct location will be their ability to produce a quarterly wage report.

One or a combination of the following may be submitted:

- A reconciled quarterly wage report that is specifically for the prospect group.
- A quarterly wage report that is a combination of all the companies the PEO manages. When this wage report is sent, it must clearly identify the employees for the prospect group. Then, in order for us to verify participation, the group must include a payroll register that list all the employees for this prospect group.
- In lieu of a wage report, MM will accept a payroll journal that lists all the employees for the prospect group. This journal must include the employee’s name, social security number, hours worked, number of weeks worked and wages that show the proper deductions. Also, the journal must be for the most current quarter. A weekly journal will not be accepted.
- Once the group (from a distinct location) has supplied underwriting with the proper tax documentation and meet all underwriting regulations, the group will be approved.
- MM will also consider writing a PEO as an entire organization when the group has 1,000 or more employees. However, the PEO would have to meet standard underwriting regulations. This is due to the special underwriting complexities involved in rating.

Note: MM reserves the right to decline coverage to a PEO or any distinct location should the group’s experience warrant.

**PREGNANCY
ELIGIBILITY**

- Pregnancies of women applying for coverage (as part of initial group enrollment, as new hires, or as late entrants) either as contract holders or dependents, will be reviewed according to the date of conception and the expected date of delivery and will be treated the same as any other health condition.

**APPLICANTS
RESIDING
OUTSIDE THE
U.S.A.**

- Underwriting will request verification that a true employer-employee relationship exists between the group and the particular applicant. Assuming such a relationship exists, Underwriting will attempt to ascertain whether a national health insurance program exists in the particular country, and whether MM should extend coverage to the subscriber depending upon the subscriber’s eligibility for the foreign country’s national coverage. Usually such eligibility depends on whether the individual pays into that country’s Social Security system. As rules change from country to country, each case must be considered individually by Underwriting.

**INDIVIDUALS
FROM FOREIGN
COUNTRIES
RESIDING IN THE
U.S.A.**

- Assuming the individual meets normal employee eligibility criteria, MM will extend group coverage to such individuals and their dependents regardless of whether or not such individuals are currently covered by or eligible for the national health insurance program of their native country. These individuals should appear on a quarterly wage report form.
- As a point of information, residents from other countries may or may not be able to maintain their coverage through that country’s national health insurance program when they take up residence in the U.S.A. In other instances, they can keep such coverage only for a limited period of time. For example, Canadian citizens who move to the U.S.A. can maintain their coverage through the Canadian system for one year.
- The following are several questions to ask when looking to enroll an individual from a foreign country:
 - Does the individual have a green card? This would be a person who came to the United States on an Immigrant Visa. A Green Card will allow a person to live and work permanently in the US.
 - An Immigrant Visa is given either when a person is sponsored by an employer, related to a US citizen or related to a permanent resident.
 - Does the individual have a Working Visa? Non-Immigrant Visas are for people who do not intend to stay permanently in the US. The most common types are H-1 (professional worker) and L-1 (manager to open a US office). These individuals are eligible for healthcare as long as they appear on the wage report.
- If an individual comes to the US with a Visitor’s Visa or a Student’s Visa, he/she is not eligible to work in the US. The individual would have to apply for a Working Visa.

**EMPLOYEES ON
DISABILITY,
WORKERS’
COMPENSATION,
OR UNPAID LEAVE
OF ABSENCE**

When an employee is on short term disability income, (either via the use of accrued “sick days” or via a formal short term disability insurance policy), on long term disability income, on leave through Workers’ Compensation, or on leave of absence, his/her eligibility for continued group health coverage depends largely on the employer’s internal policies for these issues.

- **Short Term Disability Income:** When an employee goes on sick leave, and is receiving compensation through a short term disability policy or through accrued “sick days”, a formal employer-employee relationship still exists, and the employee is still eligible for group health coverage.

If short term disability benefits have been exhausted, and it is determined that the employee is physically unable to return to work and no long term disability program exists within the group, the subscriber would be eligible for Conversion (non-group), Continuation of Coverage (if applicable), or COBRA (if the group has 20 or more employees). In such cases the Conversion, Continuation or COBRA benefit period begins on the day group health coverage ceases.

If short term disability benefits have been exhausted, and the employee, though physically able, decides not to return to work, if applicable the COBRA notification period and the COBRA coverage period begin on the day group health benefits cease as a result of the employee’s resignation.

- **Workers’ Compensation:** Follows the same procedure as outlined immediately above under “Short Term Disability”.

	<ul style="list-style-type: none"> ▪ <u>Long Term Disability Income:</u> Some groups offer long term disability coverage; within this subset of employers, some continue to offer group health coverage on the same terms as offered to active employees, and some discontinue group health coverage. If an employer chooses to offer company-sponsored health coverage, they must maintain the same employer contribution level as for active employees and the employee must receive compensation through a long term disability policy. MM will affirm that an employer-employee relationship still exists and will view the long term disability recipient as eligible for group health benefits. COBRA does not come into play, as no qualifying event resulting in a loss of benefits has occurred. If an employer ceases to offer company-sponsored health coverage when the individual moves to long term disability, the employee is eligible for Conversion (non-group), Continuation of Coverage (if applicable), or COBRA (if the group has 20 or more employees). ▪ <u>Unpaid Leave of Absence:</u> If an employer’s policy is to grant unpaid leaves of absence while maintaining company-sponsored health coverage (with employer contribution), MM will honor the individual’s eligibility for coverage for unpaid leaves of absence for a period of time not to exceed the Continuation of Coverage laws as governed by each state. (See ‘Continuation of Coverage’ for details). If an employer’s policy is to grant unpaid leaves of absence but also to withdraw company-sponsored health coverage, the individual is eligible for Continuation of Coverage (if applicable) or COBRA (if the group has 20 or more employees). When the individual returns to work, he/she would be treated as a rehire. (See “Rehires” for further information).
<p style="text-align: center;">INDIVIDUALS CALLED TO ACTIVE MILITARY DUTY</p>	<ul style="list-style-type: none"> ▪ Employees called to duty remain on the employer’s policy for the first 30 days. ▪ They are eligible for coverage under the military at 31 or more days of service. ▪ They may choose to remain on the employer’s policy at their own expense +2% (similar to COBRA, but paid to the employer). ▪ They may enroll in the military coverage and retain their coverage under their employer. ▪ When an individual returns from military service, return to work, and resume coverage under their employer’s program, there will be no waiting period and no new pre-existing conditions imposed. <p>For those employees choosing to enroll under the military coverage after their first 30 days of duty, the following procedures will ensure a smooth transition:</p> <ul style="list-style-type: none"> ▪ <u>Regular Insured Business:</u> The employer should note on their monthly invoice “called to active duty” and the date called to duty next to the name of any person who has been called to active duty ▪ <u>Alternative Funded Groups:</u> The employer should fax information on any employees called to active duty directly to the Membership Department at (419) 473-6493. Please include the Name, Social Security Number and the date called to active duty in your letter. ▪ <u>Groups of One and Non-Group:</u> If the contract holder in a group of one or a non-group contract holder is called to active duty, the Ohio regulations concerning continuation of coverage does not apply. In the case of a group of one, the business would not be an ongoing concern in the absence of the only employee. <p><u>Internal Procedure:</u></p> <ul style="list-style-type: none"> ▪ MMO’s Membership department will cancel the contract, but will note “reservist” in the “clock number” field. (Note: Dependents will follow the reservist to coverage provided by the military.)

- When an individual returns to actively at work status for the employer, the employer should note on their monthly invoice that the person has returned (for regular business) or fax a letter directly to the Membership Department (for alternately funded groups and to GSI for chamber business). The employer should list the person’s name, Social security number and effective date of his/her return to work Based on this, MMO will re-activate the contract, and assign a new group number (for groups of one and non-group only).
- It will not be necessary to complete a new application, unless the person or one or more dependents was not enrolled on the group’s contract at the time they were called to duty.

Military Reserves: The Legal Department has received several inquiries from the Sales and Customer Relations Department regarding procedures and requirement for providing health insurance to reservists and their families when the reservist is called to active duty.

Under certain circumstances, military reservists are entitled to the same benefits as active duty members of the military. If the reservist is called up to duty for 31 days or more, he and his family are entitled to enroll in the Military Health Care System. There is a new system that replaced CHAMPUS called TriCare. TriCare is a managed care plan that is organized on a regional basis. There are three TriCare plans: Prime, Standard and Extra. Eligibility for enrollment in the type of plan can depend on the length of the reservist’s orders.

Reservists are also entitled under state and federal law to continue their civilian employer group health coverage. If the reservist is called up for 31 days or less, the employer must allow the reservist to stay on the plan and can only require that the reservist pay the normal employee contribution. During this 31-day period, the reservist is not entitled to military health coverage. If the reservist is called up for 31 days or more, he has the right to continue his civilian health coverage on a basis similar to COBRA. The coverage may be continued for 18 months and the civilian employer can charge the reservist up to 102% of the premium. Note that it is the duty of the employer to notify the reservist of his right to continue coverage while on active duty. The reservist must pay the employer for the coverage, not Medical Mutual directly.

The 18 months of continuation coverage may be extended to 36 months in the event of the death of the reservist or divorce of the reservist’s spouse. A child who reaches a limiting age may also extend the continuation coverage for up to 36 months. If the reservist has coverage under both his civilian employer and the Military Health Care System, the civilian coverage will always be the primary coverage.

PROBATIONARY PERIOD

Probationary periods normally last 0-90 days. Some types of industries with high turnover rates may use probationary periods up to 180 days. As part of small group reform regulations, however, the length of the probationary period may be restricted by law and by state.

- **Georgia:** Groups of 2-50, 51-99 and 100+ active eligible employees may impose a probationary periods of no longer than 180 days (thus probationary periods of “1st of the month following 180 days” are not permitted).
- **Indiana:** Groups of 2-50, 51-99 and 100+ active eligible employees may impose a probationary periods of no longer than 180 days (thus probationary periods of “1st of the month following 180 days” are not permitted).
- **Ohio:** Groups in the 1-50 rating class are prohibited from having probationary periods of longer than 90 days (thus probationary periods of “1st of the month following 90 days” are not permitted). Groups in the 51-99 and 100+ market segments may set probationary periods up to 180 days (6 months).
- **Pennsylvania:** Groups of 2-50, 51-99 and 100+ active eligible employees may impose a probationary periods of no longer than 180 days (thus probationary periods of “1st of the month following 180 days” are not permitted)

**ENROLLMENT
CHANGES FOR
EMPLOYEES
(ADDITIONS AND
DELETIONS)**

- **West Virginia:** Groups of 2-50, 51-99 and 100+ active eligible employees may impose a probationary periods of no longer than 180 days (thus probationary periods of “1st of the month following 180 days” are not permitted).

Probationary periods may not be waived for specific employees. The group may change probationary periods for all employees, but the change must be for a future effective date. A group may set up separate sections for specific classes of employees in order to assign each of the sections a different probationary period.

- **New Hires:** When an individual is hired into a group, there is an enrollment period during which the new hire may obtain health coverage for him/her and any eligible dependents. This enrollment period is 31 days long and begins on the day the probationary period ends. If there is no probationary period, the 31-day period begins on the actual date of hire. This is for Health Pool and all GSI products.

All new hires are required to fulfill the pre-existing condition requirement unless the individual meets part or all of the creditable coverage criteria outlined in the HIPAA regulations. New hires are required to complete an individual application.

If the employee application is received within the appropriate time, the effective date of coverage will be either the date the probationary period ends, or, if there is no probationary period, the hire date itself.

Any new hire whose application is not received within 31 days of eligibility will be considered a late entrant (unless the individual experiences a “qualifying event”). Such late entrants are subject to all late entrant regulations. See “Late Entrants” for further information.

- **Rehires or Recalls from Layoffs:** A group may select a different rehire probationary period from it’s new hire policy, but all other new hire policies and procedures apply. Rehires or employees returning to work from a layoff must submit the individual application to MM either:

- Within 31 days from the end of the Rehire probationary period, if the group has a distinct Rehire probationary period, or
- Within 31 days from the end of the New Hire probationary period, if the group does not have a distinct Rehire probationary period but does have a New Hire probationary period, or
- Within 31 days from the date of return to work, if the group does not have a New Hire nor a Rehire probationary period.
- Such rehires who fail to submit an application to MM according to the above criteria are considered late entrants, and all late entrant underwriting regulations and procedures are applicable. (See “Late Entrants” for further information.)

Rehires, or employees returning to work from a layoff, and who did not have coverage through the group prior to separation from the group occurring less than one year earlier, are considered late entrants, and all late entrant underwriting regulations and procedures are applicable.

- **Part Time (Temporary) to Full Time:** If an employee moves from part time to full time status or from temporary to full time status, he/she must fulfill the requirements stipulated for new hires. For specific information regarding new hires, see “New Hires” above.
- **Late Entrants:** All late entrants are required to fulfill the pre-existing condition requirement unless the individual meets part or all of the creditable coverage criteria outlined in the HIPAA regulations. Late entrants must complete an individual application and MHQ (long form for groups within the 1-19 market segment and short form for groups within the 20+ market segment).

If a late entrant enrolls during open enrollment (at renewal), they cannot be declined according to HIPAA regulations, however, this information may be used to evaluate rate adequacy of the group.

Late entrants include the following:

- Employees and/or their dependents who waive health coverage when first becoming eligible.
- New hires and newly eligible dependents for whom MM fails to receive an application within 31 days from the date of eligibility.

Enrollment Policy: All late entrants may apply for coverage during their employer’s annual election period, which coincides with the employer’s renewal. The late entrant will have the month prior to the effective date of the renewal, as well as the month in which the renewal is effective, to enroll. This policy is for all lines of business. If the application is received outside of the two month open enrollment period, that application will be returned.

QUALIFYING EVENTS

The following summary list the various types of qualifying events an employee or dependent may experience, and the documentation that helps to verify the event and dates.

<u>Qualifying Event</u>	<u>Time Limit</u>	<u>Documentation</u>
Newborn or Newly Adopted Children added to an existing contract.	31 days single 1 Year family	NONE
Adding a child to an existing contract for whom the applicant has just become the legal guardian.	31 days single 1 Year family	Legal Guardianship Papers*
Adding a child to an existing contract whom the applicant has been ordered by the court to cover.	31 days single 1 Year family	Court Order*
Spouses and other dependents added within 31 days of marriage.	31 Days	NONE
Loss of coverage through parent due to a dependent child ceasing to be an eligible dependent as defined in the plan, either through age or marriage.	31 Days	Marriage certificate or benefit booklet and birth certificate*
Loss of coverage due to termination of the Spouse’s employment or applicant’s alternate employment is terminated.	31 Days	A letter from the former employer on company stationary which verifies employee’s termination. The letter must include date of termination and must be signed by an authorized representative of the former employer.*
Loss of coverage due to spouse’s reduction of hours from full time to part time status or applicant’s alternate employment hours is reduced.	31 Days	A letter from the employer on company stationary which verifies employee’s reduction in hours. The letter must include the date the reduction in hours is effective and must be signed by an authorized representative of the employer.*
Loss of coverage due to spouse’s employer or applicant’s alternate employer canceling entire group health plan, or plan cancelled by carrier, and spouse or applicant remains employed.	31 Days	A letter from the employer which verifies the termination of employer’s group health plan. The letter must include the date the group health plan benefits will end and must be signed by an authorized representative of the employer.
Spouse taking a leave of absence	31 Days	A letter from the employer which verifies the spouse’s leave of absence. The letter must include the date of the group health plan benefits will end and must be signed by an authorized representative of the employer.
Spouse’s disability benefits ceasing	31 Days	A letter from the employer which verifies the spouse’s exhaustion of disability benefits. The letter must include the date the group health plan benefits will end and must be signed by an authorized representative of the employer.*
Divorce or Legal Separation	31 Days	Divorce decree or legal separation agreement which states the date of the divorce or the date the separation began.*
Death of spouse	31 Days	Death certificate.*

TERMINATION OF EMPLOYEES

The employee's coverage under all benefit programs will automatically terminate when:

- The policy terminates or coverage for the entire group ends.
- The employee ceases to be eligible for coverage under the term and conditions of the policy.
- Premium payments for the employee's coverage are discontinued
- An employee's coverage will also be terminated if the employee is found to be ineligible for coverage. The eligibility for non-group conversion will be determined by Underwriting Compliance or Financial Investigations as appropriate.

In reviewing such an individual's eligibility for non-group conversion, Admin Central uses the following guidelines:

- If the subscriber appears to have been an eligible enrollee in a group plan and is still within the time frame allowed to choose conversion, conversion will be offered.
- If the subscriber is still enrolled, but has been found to have lost his/her eligibility more than 31 days ago, the group must prove that he/she had been an eligible enrollee prior to the end of their eligibility.
- Underwriting may request that the group provide written documentation of eligibility on a case by case basis depending upon the circumstances of the case and reliability of information gained from other sources.
- When performing this review, Underwriting must determine whether the group appears to be in compliance with underwriting regulations. If the group appears to have low participation, another carrier, or any other unusual circumstances, Admin Central will consult with Underwriting Compliance, Financial Investigations, and/or Legal to determine whether conversion is to be approved or denied.
- If the individual was cancelled more than 31 days prior to the review, he/she is not eligible for conversion.

DEPENDENT ELIGIBILITY AND ENROLLMENT CHANGES

Eligible dependents include an employee's spouse acquired by ceremonial marriage. The eligibility of a spouse acquired through common-law marriages is governed by the laws of the specific state governing common-law marriage. In addition, MM does require documentation of the common-law marriage to be provided to MM before such dependents are enrolled. (Please see "Common-Law Marriages and Roommates" for further information).

Eligible dependents also include certain categories of children (see list immediately following) up to the limiting age of the contract. Because of the possible variations in income tax filing, MM no longer requires the child to appear on the contract holder's IRS return.

- Natural children of the certificate holder; Even if the child does not reside with the certificate holder, the child may be a dependent on the policy if the child's birth certificate identifies the certificate holder as the natural parent.
- Adopted children, or children placed in the employee's home for purposes of adoption.
- Children for whom the certificate holder or spouse is either legal guardian or been ordered by a court to provide health coverage.
- Stepchildren may be listed on the certificate holder's policy. Normally stepchildren should reside with the certificate holder, though they would still be eligible for coverage if the natural parent was bound by court order to provide health coverage to the certificate holder's stepchildren.
- Foster children placed in the employee's home for a temporary period of time (to be distinguished from children placed in the home for purposes of adoption) are **not** eligible for coverage. The health coverage of foster children is the responsibility of the appropriate social service agency.
- Grandchildren are **not** eligible dependents, unless the grandparent is the Legal Guardian (court documentation required).

	<ul style="list-style-type: none"> For dependent students age 19-25, some parents give up claiming their student children as dependents (even if they are providing the majority of the student’s support), so as to facilitate the student’s eligibility for loans/grants. In these situations MM will still consider the student children to be eligible dependents for the purposes of group health insurance coverage.
<p style="text-align: center;">ADDING DEPENDENTS</p>	<ul style="list-style-type: none"> The effective date of coverage when adding dependents will be the date of the event, unless otherwise defined by the Plan or Underwriting Regulations. Dependents for which these materials are not submitted within the 31 day period are considered late dependents and subject to the late entrants guidelines (see the “Late Entrant Section” under Employee Changes for further information). If the addition of a newborn or newly adopted child causes a contract change and a rate change, a 31-day enrollment period applies. In instances where no rate change occurs, the application to add a newborn or newly adopted child must be received within 1 year. Under HIPAA rules, the birth of a child automatically provides a new eligibility period for the employee (even if the employee previously waived coverage) and for all dependents (even if they have previously waived coverage). The application and Medical History Questionnaire (if required) must be submitted within 31 days of the birth of the child. <p>For information regarding late dependents, see the “late entrants” policy on page 12.</p>
<p style="text-align: center;">COMMON-LAW MARRIAGES AND ROOMMATES</p>	<p>If two persons are merely living together and have not entered into a ceremonial marriage (or common-law marriage, if recognized by the state in which the employee resides) the roommate is not permitted to be enrolled as a dependent on the contract.</p> <p>Common law marriages are permitted in a minority of states. The information following identify common law guidelines per state:</p> <ul style="list-style-type: none"> Georgia: Only for common law marriages formed before January 1, 1997. Indiana: Common law marriages are not permitted. Ohio: Only for common law marriages formed before October 10, 1991. Pennsylvania: Only for common law marriages formed before January 1, 2005. West Virginia: Common law marriages are not permitted.
<p style="text-align: center;">DISABLED DEPENDENTS</p>	<ul style="list-style-type: none"> Disabled dependents are eligible for group coverage if they are: (1) unmarried or married to the certificate holder; (2) under the limiting age; (3) primarily dependent on the contract holder for support; (4) covered by the prior carrier (if applicable). Eligibility will continue past the age limit for eligible dependents, if they are the unmarried children of the certificate holder, are unable to support themselves due to physical handicap or mental retardation, and are primarily dependent on the contract holder for support. In addition, this incapacity must have started before the age limit was reached and must be medically certified by a physician. MM may require further proof of the continuance of such incapacity and dependency annually.
<p style="text-align: center;">SURVIVING SPOUSES</p>	<ul style="list-style-type: none"> Surviving spouses are <u>not eligible</u> for group coverage. Surviving spouses may be eligible for continuation of group health coverage through COBRA or through the specific state’s continuation of coverage provision if the state has enacted such a provision. (Please see “Continuation of Coverage” for specific state regulations). Surviving spouses are normally eligible for conversion to non-group coverage provided that their application and premium are received within 31 days of losing eligibility under the group’s contract.

TERMINATION OF DEPENDENTS

Dependent coverage under all programs will automatically terminate when:

- The policy terminates or coverage for the entire group ends;
- The dependent ceases to be eligible as a dependent;
- The employee ceases to be eligible for coverage;
- Premium payments for the employee or dependent coverage are discontinued.

The date of termination will be the date of ineligibility, providing the Plan is notified within 31 days from the date of ineligibility.

A dependent's coverage will also be terminated if the dependent is found to be ineligible for coverage. The effective date of the termination will be determined by Admin Central or Underwriting Compliance. The eligibility for non-group coverage will also be determined by Admin Central with assistance from Underwriting Compliance or Financial Investigations as appropriate.

In reviewing such an individual's eligibility for non-group conversion, the following guidelines apply:

- If the dependent appears to have been an eligible enrollee in a group plan and is still within the time frame allowed to choose conversion, conversion will be offered.
- If the dependent is still enrolled, but has been found to have lost his/her eligibility more than 31 days ago, the group must prove that he/she had been an eligible dependent prior to the end of their eligibility. Membership may request that the group provide written documentation of eligibility on a case by case basis depending upon the circumstances of the case and reliability of information gained from other sources.

COBRA

COBRA continuation of coverage for qualified beneficiaries is required by law for groups of more than 20 employees (part time and full time) which are not governmental or religious entities. Because of the administrative expense involved and because of the financial risk posed, MM will not administer COBRA for groups having less than 20 total employees, nor will groups be permitted to continue ineligible subscribers or dependents on their group contract.

In determining whether an employer employs fewer than 20 employees, the following rules apply:

- An employer is considered as having normally employed fewer than 20 employees, if and only if, it had fewer than 20 employees on at least 50% of its working days during the preceding calendar year.
- In determining the number of employees, an employer is to treat as employees all full time and part time employees and all employees within the meaning of IRC 401(c)(1). For example, partners in a law firm are treated as employees for this purpose.
- COBRA regulations require the employer to offer COBRA extension of benefits for 18, 29 or 36 months from a qualifying event. MM will not permit an individual to remain on COBRA extension of benefits beyond the 18, 29 or 36 month period. MM will not permit COBRA benefits for enrollees of groups under size 20 or for groups exempted by law from COBRA responsibilities, even though the group may desire to extend such benefits.
- If an individual entitled to COBRA continuation coverage is disabled (as determined under the Social Security Act) and satisfies the applicable notice requirements, the plan must provide COBRA continuation coverage for 29 months, rather than 18 months. As of 7/1/97, HIPAA mandates that the disability extension will also apply if an individual becomes disabled at any time during the first 60 days of COBRA continuation coverage.

	<ul style="list-style-type: none"> ▪ HIPAA also makes it clear that, if an individual entitled to the disability extension has non-disabled family members who are entitled to COBRA continuation coverage, those non-disabled family members are also entitled to the 29 month disability extension. ▪ If a qualified COBRA eligible elects, during the election period, to waive coverage, then later elects, during the same election period, to revoke the waiver and continue coverage, the coverage does not have to be provided retroactively. However, if a gap in coverage occurs, a pre-existing conditions waiting period may be required. ▪ If a person is covered by COBRA under the group’s policy and becomes employed by another group, the person may continue COBRA coverage under the old group until his/her period of benefits (18, 29 or 36 months) expires or until the person is actively covered under the new health plan, whichever comes first. ▪ If the individual must meet pre-existing conditions limitation under the new health plan, he/she is permitted to continue COBRA coverage until the period of benefits (18, 29 or 36 months) expires or until the individual fulfills the pre-existing requirements limitation of the new health plan, whichever comes first. ▪ The group should always be referred to their own legal counsel for COBRA determination and advice in specific cases, and/or should be referred to Ceridian COBRA Services at 1-800-488-8757. ▪ At the time of COBRA election, the continuant is eligible to choose from any of the coverage’s offered by the group at that time. MM will not open special Traditional sections for COBRA Continuant. COBRA Continuant do have rights of product election during the group’s Annual Election Period if an Annual Election Period is offered, and may transfer to a different Product Option offered by the group during that election period.
<p>CONTINUATION OF COVERAGE (STATE REGULATIONS)</p>	<p>This section includes information regarding continuation of coverage by state. This is offered to individuals who have terminated employment with a group and the group is <i>not</i> COBRA eligible.</p> <p>Criteria:</p> <ul style="list-style-type: none"> ▪ The person was employed and covered by the group’s policy for at least three months immediately prior to leaving the group. ▪ The person is eligible for Unemployment Compensation. ▪ The person is not eligible for Medicare or for other insurance. ▪ The employee is responsible for paying the premium for continuation coverage to the employer. <p>The following is a list of continuation benefits by state:</p> <ul style="list-style-type: none"> ▪ <u>Georgia:</u> The extension of benefits is for three (3) months. ▪ <u>Indiana:</u> The extension of benefits is for twelve (12) months ▪ <u>Ohio:</u> The extension of benefits is for six (6) months. ▪ <u>Pennsylvania:</u> There is no extension of benefits for this state. ▪ <u>West Virginia:</u> The extension of benefits is for eighteen (18) months. This only applies to employees that are <i>involuntarily</i> laid off from work.
<p>CONVERSION TO NON-GROUP COVERAGE</p>	<ul style="list-style-type: none"> ▪ Upon termination of employment, the person can convert to benefits available under the non-group program. The benefits and the rates will be changed to non-group conversion rates and benefits.

The subscriber must file a request for conversion in writing within 31 days of termination. Application materials and premium for eligible subscribers must be returned within 14 days after the conversion materials are sent out.

Conversion is allowed in the following situations:

- Individuals who have been covered under the group's policy with MM who terminate from the group.
- Individuals who reach either the end of their COBRA coverage period or the end of their six month continuation of coverage (for cost plus groups only). For fully insured groups an individual does not have to keep COBRA for the entire time of eligibility; thus eligible for conversion.
- Employees who move from full time to part time status.
- Dependent children who marry.
- Dependent children who are students and then lose their student status.
- Spouse or dependent of a COBRA recipient upon death, divorce, or legal separation during the COBRA period (may also choose to continue COBRA).
- Surviving spouses and dependents upon death of the group certificate holder. (May also be COBRA eligible).
- Dependent who reaches the limiting age.
- Spouse and/or dependents after divorce or legal separation from certificate holder.

Conversion is ***NOT*** allowed in the following situations:

- The group has cancelled MM.
- The group has not paid their premium or has been cancelled for non-payment.
- The group has been terminated for non-compliance with MM underwriting regulations.
- Employees who are not covered under the policy (such as new hires who have not fulfilled the probationary period).
- Persons who have been removed from the group's coverage because they were not eligible to be enrolled in the group's program.

Conversion to a non-group product will no longer be offered to ASC & Alternate Funded Groups unless otherwise noted in the Master Group Contract, Summary Plan Description, or other documentation within the group file. This change in policy is effective with all new ASC prospects received on or after 9/1/01 and for all 12/1/01 renewing ASC groups.

As the Underwriter prepares each renewal, search of the group file should be made to determine if the group has specifically requested a conversion privilege. If so, contact your Director or Manager to see if the group should be given a conversion option on an exception basis. If the exception request is approved, notify Underwriting Compliance of your renewing groups with a conversion option. Underwriting Compliance will advise Membership of this request. Groups opting for the conversion option will be charged according to a fee schedule being developed by Actuarial.

For new group ASC prospects, the conversion option should be noted as yes or no on the PAP and Account Worksheet level. CMS will have a new field called "NG CONV" at the section level to indicate if the group has a conversion option or not. The PAP and account worksheets have been updated to accommodate this information. Again if the ASC prospect wants to offer conversion, a rate should be charged according to the conversion fee schedule being developed by Actuarial.

ASC conversions are required to exhaust COBRA benefits prior to non-group conversion.

**FAMILY MEDICAL
LEAVE ACT**

- The Family Medical Leave Act is federal legislation which requires employers of 50 or more employees to offer unpaid leave to employees and to extend health care benefits at the same level as regular employees in the case of certain defined medical or family situations.

	<ul style="list-style-type: none"> ▪ The Family Medical Leave Act can create difficult administrative situations, especially when juxtaposed to COBRA requirements. ▪ Please refer questions in this area to your Human Resource Department or to your Legal Department.
<p style="text-align: center;">FEDERALLY ELIGIBLE INDIVIDUAL</p>	<p>January of each year, carriers that are in the business of issuing non-group and non-employer related health benefit plans must accept a limited number of Federally Eligible Individuals for open enrollment coverage as defined within this section.</p> <p>Federally eligible individuals must meet the following criteria:</p> <ul style="list-style-type: none"> ▪ The individual must have at least 18 months of creditable coverage without a significant break (defined as 63 days under HIPAA regulations) in coverage. ▪ The individual's most recent coverage must have been under a group health plan. ▪ The individual cannot currently be eligible for Medicare or Medicaid or covered under any other health insurance. ▪ The individual has both elected and exhausted any continuation coverage available under COBRA or a similar state program. ▪ The individual must be a resident of a state where MM is licensed to do business. <p>Contact Membership for additional information regarding this program</p>
<p style="text-align: center;">MEDICARE</p>	<p><i>Medicare Working Aged: When is Medicare Primary?</i></p> <p><u><i>For Employers with 20 or More Employees</i></u></p> <p>MM is primary and Medicare is secondary for all individuals (and their dependents) who are age 65 or older and who are still actively employed by an employer who employs 20 or more employees. Such active employees must be issued regular group contracts. Such employees do reserve the right to elect Medicare as their primary plan, but are then prohibited from accepting a Medicare supplement policy from their employer. (Such employees are permitted to purchase non-group Medicare supplement policies).</p> <p>Occasionally a group will discover that it has not been in compliance with this law, and will request MM to issue MM-primary contracts to individuals for whom MM should have been primary in the past. Due to expensive retroactive benefit changes and re-adjudication of claims, MM will make such changes for <u>future</u> effective dates only.</p> <p><u><i>For Employers with Fewer than 20 Employees</i></u></p> <p>Medicare is primary and MM is secondary for all individuals (and their dependents) who are age 65 or older and who are still actively employed by an employer who employs fewer than 20 employees. Such active employees are eligible only for Medifil or Medicare supplement contracts; their dependents are issued either Medifil or non-Medifil contracts, depending on their Medicare status (see chart below). Actively employed individuals over age 65 may not remain enrolled in the group with regular group benefits in this type of group.</p> <p>In determining whether an employer employs fewer than 20 employees, the following rules apply:</p> <ul style="list-style-type: none"> ▪ An employer is considered as having normally employed fewer than 20 employees, if and only if, it had fewer than 20 employees on at least 50% of its working days during the <u>preceding calendar year</u>. ▪ In determining the number of employees, an employer is to treat as employees all full time and part time employees and all employees within the meaning of IRC 401(c)(1). For example, partners in a law firm are treated as employees for this purpose.

Every employee, retiree or dependent that is entitled to Medicare must be enrolled in Medicare Parts A and B to be eligible for MM Medifil coverage.

A chart is provided below to clarify possible contract combinations.

For Employers with 20 or More Employees:

Eligible participants, who are actively at work and their dependents, must elect a single or family contract in which MM is primary, regardless of whether the participant is eligible by law for Medicare on the basis of age.

<i>20 or More Employees</i>	Spouse; -65	Spouse; +65
Certificate Holder; -65, actively at work	Family Contract	Family Contract
Certificate Holder; -65, retired	Family Contract	Certificate Holder: Single Spouse: Medifil
Certificate Holder; +65, actively at work	Family Contract	Family Contract
Certificate Holder; +65, retired	Certificate Holder: Medifil Spouse: Single	Certificate Holder: Medifil Spouse: Medifil

For Employers with Fewer than 20 Employees:

MM requires eligible participants and/or their dependents, who are eligible by law for Medicare on the basis of age, to select a Medifil contract, in which MM is the secondary payer. Such individuals are not permitted to select a regular group contract in which MM is primary. Such persons must be enrolled in Medicare Parts A and B to obtain MM Medifil coverage.

<i>Under 20 Employees</i>	Spouse; -65	Spouse; +65
Certificate Holder; -65, actively at work	Family Contract	Certificate Holder: Single Spouse: Medifil
Certificate Holder; -65, retired	Family Contract	Certificate Holder: Single Spouse: Medifil
Certificate Holder; +65, actively at work	Certificate Holder: Medifil Spouse: Single	Certificate Holder: Medifil Spouse: Medifil
Certificate Holder; +65, retired	Certificate Holder: Medifil Spouse: Single	Certificate Holder: Medifil Spouse: Medifil

Medicare for Disabled Active Individuals: When is Medicare Primary?

MM is primary and Medicare is secondary for individuals entitled to Medicare on the basis of disability, and who are covered through their own or through a family member's group health plan, if the group employs at least 100 full or part time employees. (Such a health plan is known as a "Large Group Health Plan", or "LGHP".)

In determining whether an employer employs at least 100 full and part time employees, the following rules apply:

- An employer is considered as having normally employed at least 100 employees, if and only if, it had 100 or more employees on at least 50% of its working days during the previous calendar year.
- In determining the number of employees, an employer is to treat as employees all full time and part time employees and all employees within the meaning of IRC 401(c)(1). For example, partners in a law firm are treated as employees for this purpose.
- Medicare is also secondary for certain people under age 65 who are entitled to Medicare on the basis of disability (but not including those with permanent kidney failure,) and who have LGHP coverage.

- A LGHP must not treat any of these people differently because they are disabled and are entitled to Medicare on the basis of disability. The term employee here includes both those who are actively working despite their disability (such as disabled Medicare beneficiaries engaged in a trial work period) and those who are not actively working, but whom the employer treats as employees. Medicare determines whether an individual is considered to be an employee.
- Disabled persons also have the option of accepting or rejecting LGHP coverage. If they reject the plan, Medicare becomes their primary payer, and the employer may not provide or subsidize supplemental coverage, except for items and services not covered by Medicare.

Medicare and End Stage Renal Disease: When is Medicare Primary?

Unlike Medicare on the basis of age or disability, the regulations below regarding the primary/secondary payer status of “Medicare on the Basis of End Stage Renal Disease” are not affected by the number of employees employed by the company offering group health insurance coverage.

When ESRD Medicare Protection Begins:

When an individual becomes entitled to Medicare because of permanent kidney failure, Medicare protection starts the fourth month of dialysis treatments. For example, if the individual began receiving dialysis treatments in July, the Medicare coverage would start on October 1.

There are ways in which the Medicare protection can begin earlier; see below.

- Medicare coverage can begin in the first month of dialysis if:
 - The individual participates in a home dialysis training program in a Medicare-approved training facility to learn how to administer dialysis at home; and
 - The individual starts the training before the fourth month of dialysis; and
 - The individual expects to administer the home dialysis treatments thereafter.
- Medicare coverage can begin the month the individual is admitted to an approved hospital for a kidney transplant or procedures preliminary to a transplant if the transplant takes place in that month or within the two following months. If the transplant is delayed more than two months after the individual is admitted to the hospital for the transplant or procedures preliminary to the transplant, Medicare will begin two months before the month of the transplant.

When ESRD Medicare Protection Ends:

If the individual is entitled to Medicare only because of permanent kidney failure, Medicare protection will end 12 months after the month the individual no longer requires maintenance dialysis treatments or 36 months after the month of a kidney transplant. But, if the transplant fails during or after the 36-month period and the individual again resumes maintenance dialysis or receives another transplant, Medicare coverage will continue or be reinstated immediately without any waiting period.

Medicare Part B can stop at any time if the individual fails to pay premiums or if the individual decides to cancel it. This could affect your payment from Medicare because Part A and Part B are needed.

ESRD Medicare Payment for Beneficiaries Covered by Employer Group Health Plans

Some ESRD Medicare beneficiaries are also covered by an employer group health plan.

For these Medicare beneficiaries the employer plan is often the primary plan--that is, the employer plan pays first on the Medicare beneficiary's health insurance claims. Unlike Medicare on the basis of Age or Disability, these regulations for Medicare due to End Stage Renal Disease apply regardless of the number of employees employed by the employer.

If the individual becomes eligible for Medicare only because of permanent kidney failure and is covered by an employer group health plan, Medicare will be the secondary payer during an initial period of 30 months. This 30-month period in which Medicare pays secondary begins the first month the individual is eligible for Medicare. It is called the coordination period.

Employer plans pay first for kidney treatment and other health services furnished during the 30-month period. However, if the employer plan does not pay in full, Medicare may make secondary payments to supplement the amount paid by the employer plan. At the end of the 30-month period, Medicare becomes the primary payer. If the individual is covered by an employer group health plan during the 30-month period, the individual should inform his/her provider of medical services so that the services can be billed correctly.

If the individual has more than one period of Medicare entitlement based on kidney disease, there is a separate coordination period for each period of Medicare entitlement.