



Use this variation in conjunction with the Assurant Health Agent's Guide and Product Brochures. This document contains state specific coverage information that is materially different from the Time Insurance Company generic contract language.

Agent's Guide

Carve-Out Groups

The state of Ohio prohibits carving out any class of employee from coverage in the small group market.

Contribution Requirements

The employer must contribute a minimum of 50% toward the cost of the employees' medical coverage in order to be eligible for group health insurance coverage, and must continue to meet this requirement throughout the life of the contract.

Creditable Coverage

Creditable coverage is applicable to medical benefits only and includes benefits provided under one of the following:

1. A group health plan or other health insurance coverage.
2. Medicare.
3. Medicaid.
4. TRICARE or a health plan under the Peace Corps.
5. A medical care program of the Indian Health Service or other tribal organization.
6. A state health benefits risk pool.
7. A public health plan as established and maintained by a state, the United States government, a foreign country, or any political subdivision of a state, the United States government, or foreign country that provides health coverage to individuals who are enrolled in the plan.
8. The Federal Employees Health Benefits Program.
9. Title XXI of the Social Security Act such as State Children's Health Insurance Program.

Effective Dates of Coverage

Effective dates for timely enrollees cannot exceed a 90-day waiting/affiliation period. Timely enrollees on groups choosing a 90-day waiting/affiliation period will become effective on at least their 90th day of employment. If the 90th day falls on the 29th, 30th or 31st of the month, the assigned effective date will be the 28th of the month.

Eligible Dependents

- A lawful spouse.
- Unmarried dependent children through age 18.
- Unmarried dependent children through age 23, if a full-time student.

Dependent children who are not subject to a Qualified Medical Child Support Order (QMCSO) and who do not reside with the certificate holder (the non-custodial parent) are eligible to enroll for coverage provided the certificate holder assumes total or partial responsibility of support for the dependent child.

The eligibility requirements in the state of Ohio do not require that a dependent be a U.S. resident to be eligible for coverage, nor does the dependent child need to reside in the service area if the certificate holder is the non-custodial parent of the dependent child.

Please review the Certificate of Insurance for dependent eligibility requirements.

Eligible Employee

An eligible employee is any person who performs services on a full-time basis (defined as at least 25 hours per week) and is considered an employee for federal employment tax purposes, at any of the employer's business establishments within the United States.

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 25 hours per week), at any of the employer's business establishments within the United States.

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.

Life Insurance

Life insurance coverage is an optional benefit to all groups. The first \$15,000 of life coverage is available on a guaranteed basis. Requests for additional amounts are medically underwritten.

Misrepresentation

If a misrepresentation is discovered, we will only take action if it is an intentional misrepresentation of a material fact or fraud.

Participation Requirements

The following requirements must be met for the group to be eligible for coverage and must continue to be met to keep the group's plan in force. Failure to comply can result in termination of coverage.

- For firms with fewer than four eligible employees, all eligible employees without valid waivers must enroll.
- For firms with four eligible employees, a minimum of 75% of all eligible employees without valid waivers must enroll.
- For firms with five or more eligible employees, a minimum of 50% of the total number of eligible employees (not subtracting valid waivers) must enroll **and** 75% of all eligible employees without valid waivers must enroll.

Valid Waivers

The following are considered valid waivers:

1. Medicare/Medicaid.
2. Coverage under spouse's employer group health plan.
3. TRICARE.
4. Coverage under an Indian health services program.
5. State health benefits risk pool.
6. COBRA.

Participation/Eligibility Documentation

At the time of initial group enrollment a State Quarterly Unemployment Withholding Form (or other federal business tax returns) may be required. We do request a copy of the most current State Quarterly Unemployment Withholding Form (or other federal business tax returns) during the Participation and Eligibility Review process. In both instances, substantially similar documentation will be accepted in lieu of the State Quarterly Unemployment Withholding Form or other federal business tax returns.

Rating and Renewability Provisions

Please refer to the Rating and Renewal provisions notice for detailed information.

Waiting/Affiliation Periods

Waiting/Affiliation periods of 0, 30, 60 or 90 days are available.

Product

Continuation for non-COBRA Groups

Eligible persons

Employees and dependents whose coverage would terminate due to involuntary termination of employment are considered eligible if the employee is entitled to unemployment compensation.

Eligible persons can continue coverage provided that:

1. Such persons were insured under the group policy or any group policy providing similar benefits that was replaced for the prior three month period.
2. Such persons are not covered or eligible for coverage under Medicare.
3. Such persons are not covered by any other group insurance carrier or employer self-insured group medical plan under which the person was not covered immediately prior to termination of employment.
4. Such person is not eligible for COBRA.

A reservist called or ordered to active duty has up to an 18-month period of continuation.

However, coverage may be extended up to a 36-month period if one of the following events occurred in the 18-month period:

- a. The death of the reservist.
- b. The divorce or separation of a reservist from the reservist's spouse.
- c. The cessation of dependency of a child pursuant to the terms of the policy.

Notification

The eligible person must notify the employer of the desire to continue coverage in writing within 31 days. The first required premium must accompany this notice. Thereafter, the premium must be forwarded to the employer in advance of each premium due date in accordance with the employer's instructions.

Duration

Continued coverage will be provided until the earliest of:

1. The date any premium is due and not received.
2. The date such person becomes covered or eligible for coverage under Medicare.
3. The date such person becomes covered or eligible for coverage under any other group insurance plan or employer self-insured group medical plan under which the person was not covered immediately prior to termination of employment.
4. The date the spouse or child ceases to be a dependent.
5. The date the group policy terminates.
6. Six months.

Medical Services

Child Health Supervision Services

Benefits include periodic review of a child's physical and emotional status performed by a physician or by a health care professional under the direction of a physician. On plans with wellness dollar limits, benefits are limited to \$500 for a covered child to age one, and to \$300 thereafter. On plans without wellness dollar

limits, covered services at a non-network provider are limited to \$500 for a covered child to age one and to \$150 for a covered child from age one to age nine per calendar year. Services provided to a child from birth to age one include benefits for the hearing screening required under the statewide hearing, screening, tracking and early intervention program established by the department of health. The benefits for the hearing screening must not exceed \$75.

Routine Mammogram Coverage

If a physician has determined that a covered female age 40 through 49 has risk factors for breast cancer, the normal mammogram schedule increases to one mammogram per calendar year instead of one every two years.

Substance Abuse

Benefits for covered charges for treatment of substance abuse are limited as follows:

- a. The rate of payment is 50%.
- b. The rate of payment does not increase to 100% regardless of the out-of-pocket limits.
- c. The amount of covered charges for which we do not pay benefits because of the rate of payment cannot be used to satisfy any copayment, out-of-pocket limits or deductible.
- d. For inpatient treatment, the maximum benefit is \$1,000 for each covered person per calendar year.
- e. For outpatient treatment, the maximum benefit is \$50 per visit, up to \$550 for each covered person per calendar year.

Treatment for alcohol abuse is not covered under this provision. Covered charges subject to the above limitations include consultation, diagnostic services, neuropsychological services including psychotherapy, counseling and neuropsychological evaluations and other treatment furnished by a hospital, psychiatric or substance abuse facility, residential or non-residential treatment facility, free-standing laboratory, pharmacy, physician or nurse practitioner.

Alcohol Abuse Treatment

Benefits for covered charges for outpatient, inpatient and intermediate primary care for treatment of alcohol abuse is limited to \$550 for each covered person per calendar year subject to the deductible and a 50% rate of payment. Covered charges include consultation, diagnostic services, neuropsychological services including psychotherapy, counseling and neuropsychological evaluations and other treatment furnished by a hospital, psychiatric hospital, psychiatric or substance abuse facility, residential or non-residential treatment facility, free-standing laboratory, pharmacy, physician or nurse practitioner.

Mental Illness or Nervous Disorders

The \$5,000 maximum for combined inpatient and outpatient treatment does not apply.