Insurance Trust

Employer Ease

EMPLOYER'S ADMINISTRATIVE GUIDE

2007

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ADMINISTRATION and CUSTOMER SERVICE

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EMPLOYERS & EMPLOYEES should call Employer Ease if they:

- Have not received their ID Cards within two weeks of effective date.
- Have questions related to administrative procedures.
- Need to report changes in company information (address, phone, etc.).
- Need to report changes in employee information (address, phone, etc.).
- Have claims problems that are not being resolved.
- Need to obtain supplies such as enrollment forms and provider directories.

EMPLOYEES should call their Health Care Provider Member Services if they:

- Want to change their Primary Care Physician (PCP).
- Need to replace a lost or damaged ID Card.
- Have questions about how to use the plan or about benefits, especially when prior authorization is required.
- Have a problem or complaint related to provider services.
- Receive a bill (in error) from their PCP or any other medical facility for services approved by their PCP.
- Are unsure of who their PCP is if it is not printed on their ID Card.

Other requests may require submission of a Change Form. Change Forms should be submitted by the Employer. Please submit forms to Successful Solutions, ***not*** directly to the provider.

IMPORTANT: ***To limit employer liability, employers should NOT contact the Health Care Provider on behalf of the employee.***

IN CASE OF EMERGENCY

If employees or their insured family members need **emergency** care they should:

1) Call their Primary Care Physician (PCP) before seeking emergency care, if at all possible. If they are unable to reach their PCP, they should call their Health Care Provider's Members Services Department.
2) In a severe emergency, employees should go directly to the nearest medical facility. The member's PCP must be contacted within 24 hours of emergency treatment, or as soon as medically possible. A friend or family member may contact the PCP on behalf of the member.

Examples of Medical Emergencies:

Apparent heart attack; cerebral vascular accidents; shortness of breath or difficulty in breathing, sever bleeding; sudden loss of consciousness, convulsions; severe or multiple injuries, including obvious fractures; sudden and severe pain; severe allergic reactions; and apparent poisoning.

Conditions not usually considered Medical Emergencies:

Colds, influenza, ordinary sprains, children's ear infections, nausea, and headaches. In the case of pregnancy, a normal delivery (including Cesarean Section) will not be considered a Medical Emergency unless:

- ♦ The delivery occurs within the Service Area, but us of facilities approved in advance by the PCP could cause a delay dangerous to mother or child; or
- ♦ The delivery occurs outside the Service Area, due to personal emergency or other circumstances beyond the mother's control.

Follow-Up Care:

The PCP should direct any care following a medical emergency. Follow-up care in the emergency room is not a covered service unless authorized by the PCP.

EMPLOYER RESPONSIBILITY

To avoid eligibility problems, all applications and supplemental forms need to be filled out completely, accurately, and submitted to Employer Ease promptly. Missing or inaccurate information and late applications may cause delays in employee eligibility, and health benefits can be lost.

The Employer is responsible for reviewing each application received and verifying that the application is complete before forwarding it to Employer Ease. **Applications cannot be processed without the employee's Social Security Number, Date of Birth and signature.**

The Employer needs to keep at least one Provider Directory available for employees to choose their Provider(s) upon enrollment. This greatly reduces the confusion and delays if employees need services before ID Cards are issued.

The Employer should forward applications to Employer Ease two weeks prior to the effective date to ensure proper processing and that coverage will be in-force on the proper effective date.

The Employer is responsible for reviewing the Eligibility Report/Invoice's received each month from Employer Ease. This report lists all employees for whom application have been received, and who are eligible for benefit coverage for the coming month. This report also itemizes the following;

- The employee's dependent status (employee only, employee & spouse, employee & child(ren) or employee & family).
- The employee's effective date.
- The premium amount due for each employee.
- Payments and adjustments applied since the previous month.

The Employer should notify Employer's Ease immediately of any errors found on the Eligibility Report/Invoice. The Employer is responsible for distributing applications to and collecting them from all eligible employees. **An employee cannot be enrolled for benefits without a completed application.**

Fees

Insurance premiums and remittance forms are due by the 15th day of the month, prior to the next month for which coverage is requested, on an as-billed basis. There will be a $75.00 late fee assessed for payments received after the 15th day of the month in which premiums are due. The payment of the Contributions will continue each month during the term of the Adoption Agreement. Any changes, additions or deletions provided to our administrator will be adjusted on your next monthly billing statement. **Payments not received by the 25th day for the month due, will cause your Plan(s) to be terminated effective to the last day of the prior month.**

An Insufficient Funds Fee of $50.00 will be charged for each returned check. If one check is returned for Insufficient Funds, all further payments must be made by Cashier's Check.

ENROLLMENT

After the initial group enrollment with the HealthCare Provider, there will be newly hired employees that will become eligible for coverage, as well as changes in the eligibility of enrolled employees and dependents. The most common events to affect group enrollment are:

- Addition of new hires that have served any applicable waiting period.
- Addition of dependents to existent employee coverage.
- Annual Open Enrollment/Plan Renewal.
- Termination of coverage for employees and/or dependent(s).

New Hire Enrollment

After the Employer's initial effective date, employees who are hired or become eligible for benefits have the opportunity to elect coverage under the Employer's Benefit Plan(s).

Employees who are eligible for health benefits **must** complete an enrollment application for each applicable Health Care Provider. Employees need to consider their plan options carefully, and to respond promptly to any request by Employer Ease for more information.

New members will be mailed enrollment material from the Health Care Provider to the address given on the submitted application. These packets generally consist of the ID Card(s), and an Evidence of Coverage/Certificate of Insurance Booklet (which is the official description of the benefit plan), as well as instructions on how to access Provider services.

Dependent Enrollment

New employees, upon initial enrollment, have the option of also enrolling any eligible dependents. Eligible dependents are defined as:

- **Legal Spouse or Domestic Partner:** Employer Ease may request Proof of Marriage or an Affidavit of Domestic Partnership. If this information is requested from the employee, the spouse or domestic partner **WILL NOT** be enrolled until the requested information is received. Note: In order for domestic partners to be covered, the Employer must elect to extend coverage to domestic partners as part of the benefit plan.
- **Children** (employee's legal spouse's adopted, or domestic partners if applicable): Children must be unmarried and entirely dependent upon the employee for financial support. If the child is 19 year of age or older, but under the age limit for the benefit plan (usually 25), the employee must submit Dependent Verification. This verification must be submitted with the initial enrollment application and upon request thereafter.

Parents, siblings or grandchildren **are not** considered eligible dependents unless declared legal wards of the employee (and must meet the standard dependent requirements). Proof of Legal Guardianship will be required.

For employees that are already enrolled in the Employer's plan(s), "newly acquired" dependents may be added when the dependents first become eligible. A Change Form must be completed by the employee, and forwarded via the Employer to Employer Ease within the following time frames:

- **New Spouse:** A Change Form must be **received** by Employer Ease within 30 days following date of marriage.
- **Newborn Child:** A Change Form must be received by Employer Ease within 30 days following date of birth.
- **Adopted Child or Legal Ward:** A Change Form and a copy of the official court paper(s) must be **received** by Employer Ease within 30 days of the date of receiving legal and physical custody of the child.
- **Stepchild:** A Change Form must be **received** by Employer Ease within 30 days following date of marriage to stepchild's parent/legal guardian.

If a Change Form is not received within 30 days of the Event, the dependent(s) will be considered Late Enrollees, and may not be eligible for health coverage. Please refer to the Health Care Provider's Evidence of Coverage Booklet for specific information regarding enrollment of new dependent(s).

Late Enrollment

A Health Care Provider will only allow the enrollment of existing employees and/or dependent(s) outside of the Employer's Open Enrollment period if:

- The employee/dependent(s) declined to initially enroll in the plan due to other health coverage in force, and so stated this other coverage in the Declination of Coverage. **And,**
- The other health coverage was subsequently lost due to circumstance beyond the individual's control (i.e., not a voluntary withdrawal from the plan).

An Enrollment Application or Change Form as applicable, and proof of the loss of the other coverage, (such as a Certificate of Credible Coverage), must be submitted within 30 days of the loss of the other coverage in order to be considered for enrollment into the Employer's plan.

IMPORTANT: If the addition of an employee or dependent is requested more than 30 days after initially eligible, then the addition will be subject to the terms of the benefit plan and the approval of the Health Care Provider. The Health Care Provider will usually require Evidence of Insurability and additional medical information for adding a Late Enrollee and/or dependent(s).

Be advised that the HealthCare Provider may decline to enroll a Late Enrollee until twelve (12) months *after the date of application.* Please refer to the Health Care Provider's Evidence of Coverage for specific information regarding Late Enrollees.

ANNUAL OPEN ENROLLMENT/PLAN RENEWAL

Forty Five days prior to the Employer's Plan Anniversary, Employer Ease will send the Employer the renewal premiums for the current benefit plan(s) and offer to supply open enrollment materials. At this time the Employer will need to meet with Successful Solutions, LLC in order to:

- Change the benefit levels for the current plan (such as adding or removing coverage for domestic partners).
- Add or remove a benefit plan (such as dent or vision).

For most Health Care Providers, employee will also have the opportunity to add without penalty any existing dependent(s) not currently included in their coverage. Successful Solutions, LLC will provide details on the Health Care Provider's open enrollment policy.

NOTE: Sharp Health Plan has a "Focal Point Renewal", which means they renew all of their Employer Ease business at the same time, usually each September. This may result in the first policy year of a new Employer being less than twelve months.

TERMINATIONS

All employees and dependents that become ineligible for group coverage will be removed from the group plan and offered COBRA continuation coverage. Employees and/or dependents electing COBRA will be required to **re-enroll** in the plan by submitting a COBRA enrollment application when responding to their election notice. See "The COBRA Process" for more information about COBRA Continuation of Coverage.

Termination of Employee Coverage

To notify Employer Ease of a terminated employee, simply enter the Termination Code and the last day worked in the space provided for the employee on the Invoice.

Insurance coverage for a terminated employee will end on the last day of the last month the employee worked. When coverage ends for a terminated employee, the coverage also ends for any enrolled dependents.

Termination of Dependent Coverage

If an employee requests to drop his/her dependent(s) from the insurance, coverage for the dependent(s) will cease on the last day of the benefit month in which Employer Ease receives the

Change Form, unless a different date is requested on the form. A Change Form will also need to be submitted in each of the following situations:

- In the event of divorce, annulment, or dissolution of marriage or domestic partnership.
- A dependent child gets married, or otherwise ceases to be a dependent.

Termination of Over-Age Dependent Coverage

A covered employee's dependent(s) may become ineligible for coverage even if the employee's coverage continues. When a child turns 19, the child may continue to be covered provided he/she is entirely financially dependent upon the employee; is unmarried; and/or is a full-time student. However, if Student or Dependent Verification is not provided upon request, the dependent's coverage will end at age 19 or on the last day of the month in which the dependent is considered no longer a full-time student.

Coverage for dependents who reach the maximum age (usually 25) will automatically cease on the last day of the birth month. COBRA coverage is available to dependents terminated for becoming over-aged.

The Employer's Eligibility Report will be adjusted to reflect any changes in dependent status for employees whose dependents are terminated for being over-age. Please refer to the Health Care Provider's Evidence of Coverage for specific information regarding over-age limits and Student Verification Requirements.

THE COBRA PROCESS

COBRA is a Federal program and Cal-COBRA is a State Program that allows employees terminated from the group health plan to self-pay in order to continue coverage under the same plan. To assist our clients in complying with COBRA regulations, Employer Ease has contracted with **Igoe & Company** to administer the COBRA Notification and Election process.

When employees are terminated from the insurance, they and any enrolled dependent(s) will be sent a COBRA Election Notification, advising them of their rights under COBRA law. The Notification also gives complete instructions on how to elect COBRA coverage, and specifies the deadlines involved.

Because of the limited election period, it is important that the Employer notify Employer Ease of any change in an employee's address during the course of the Program, and especially upon termination. **Igoe & Company, Employer Ease and Successful Solutions, LLC *are not responsible for delayed, lost or misdirected mail.***

COBRA enrollees are allowed to continue the benefits plan(s) they had, and cover any dependents enrolled, at the time their insurance was terminated. During the Employer's Open Enrollment Period, COBRA enrollees will be allowed to add any applicable benefits offered by the Employer as well as add any dependents not previously covered.

Because COBRA enrollees must be treated the same as regular employees, Employer Ease will inform COBRA enrollees of their benefit options during the Employer's Open Enrollment Period.

The Employer is not responsible for any COBRA payments. **Igoe & Company** will bill and collect premium directly from COBRA enrollees.

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FREQUENTLY ASKED QUESTIONS

Who is Employer Ease?

Employer Ease is the Trust Administrator who handles the day-to-day responsibilities of collecting and forwarding premiums to Sharp Health Care. Employer Ease establishes eligibility, processes additions and deletions to the plan, and helps Successful Solutions, LLC negotiate rates and benefit plan changes.

When are an employee's dependent(s) eligible for benefits?

Eligible dependents may be added at the employee's initial enrollment, when newly acquired (birth, adoption, or marriage), or during the Employer's Open Enrollment Period.*

What is (Annual) Open Enrollment?

For most Health Care Providers, Open Enrollment is a period during which employees and their dependents who declined to participate in the program at the initial group enrollment (or when they first became eligible) are again given the option to enroll.

This is also the time for the Employer to review the benefit plan(s) and request any changes, such as addition of dental coverage or a PPO option. Employers need to contact the broker regarding any desired changes to their benefit plan so that they may negotiate rates with the Health Care Provider. IMPORTANT: Not all Providers offer an Open Enrollment Period. The Group Plan Administrator will be notified of any restrictions that may apply. The current Anniversary Date is September 1st each year.

When is (Annual) Open Enrollment?

The Employer's Open Enrollment Period is usually two months prior to the Plan Anniversary Date, and occurs annually after the Employer's Initial Effective Date. All changes made during Open Enrollment become effective on the anniversary date. Check with the Group Plan Administrator for the exact period and for any benefit change(s) that may apply.

Who is the Group Plan Administrator?

The Group Plan Administrator is the Employer's internal contact person for Employer Ease Administration.

Who/What is a Health Care Provider (HCP)?

The Health Care Provider is the insurance carrier providing your coverage. An Employer may have more than one Health Care Provider (i.e. Kaiser for medical and MetLife for dental).

What if Provider services are needed before an ID Card is received?

For HMO members, employees should present a copy of their enrollment application to the Primary Care Physician (PCP) selected on their application. The physician's office will contact the Health Care Provider's Member Services Department, who will verity coverage.

IMPORTANT: If, in the period before the ID Card(s) arrive, HMO members visit a Provider different from the one selected on their application, any claims for services will be denied. If HMO employees do not select a Provider when enrolling, they may have great difficulty accessing services before their ID Card arrives. This is the main reason why HMO employees need to select a Primary Care Physician when enrolling.

What if a prescription is needed before an ID Card is received?

Members should first make sure that the pharmacy they wish to use accepts their Health Care Provider's plan. Employees not in the system as newly eligible members will need to pay the full amount of the prescription, and retain the receipt(s). Once their ID Card is received, employees will need to contact the Health Care Provider's Member Service Department for the reimbursement procedure (usually as simple as returning to the pharmacy with their ID Card).

What is the benefit plan?

The benefit plan is the level of coverage and the range of benefits that the Employer selects upon joining the program (such as amount of co-payment, whether there will be chiropractic coverage, etc.). Benefit summaries are available for the selected benefit plan(s) upon request.

Can each family member select a different plan?

NO. All family members must select the same benefit plan.

Can the benefit plan be changed?

Yes, but only the Employer can change the benefit plan(s) and only during the Annual Open Enrollment Period for the company.

What is a Co-Payment?

The co-payment is the set dollar amount an HMO member must pay at the time of service (i.e., $10 for doctor visit, $5 for generic prescriptions).*

What/Who is a Primary Care Physician (PCP)?

The PCP coordinates all health care and medical services including basic care, preventive services referrals to specialists, and hospitalization arrangements. A PCP can be a general practitioner, internist, OB/GYN, or pediatrician. Every HMO applicant is expected to select a PCP for self and each enrolled dependent.*

Can each family member select a different Primary Car Physician?

Yes. Each enrolled family member may choose a different PCP to suit his or her needs.

Can a Primary Care Physician be changed?

Yes. Employees should contact the Health Care Provider's Member Services Department to change their PCP. Usually, if the member requests a PCP change before the 15th of the month, the change will take effect the 1st. of the following month (some restrictions may apply).*

If hospitalization is necessary, what hospital should be used?

Your Primary Care Physician works with specific hospitals. Employees needing hospitalization should check their ID card, the Provider Directory, or ask their PCP. Affiliated hospitals are listed in the Provider Directory, and should be noted at the time of choosing a PCP.

What if a specialist is needed?

For HMO members, the PCP, in consultation with a panel of doctors, will determine the proper treatment and make referrals to specialists when necessary.

What about self-referrals?

The Health Care Provider may not allow for self–referrals. Details on this benefit, if available, would be in the evidence of Coverage issued to each member by the Health Care Provider.*

What if health services are needed while away from home?

If employees are away from home and cannot visit their Primary Care Physician, coverage will be granted for emergency treatment that is medically necessary. Members should contact their PCP first to confirm coverage for the services needed. If the PCP cannot be reached, that member must contact the Health Care Provider's Member Services Department.*

What if there is an emergency?

In the event of an emergency, HMO members should contact the PCP first, if possible. Depending upon the nature of the emergency, the PCP will either: help over the phone; make and appointment to come in as soon as possible; or make a referral to an Emergency Room or Urgent Care Facility.

If the emergency is life threatening (such as a hear attack) or serious (such as a broker leg), the member should go directly to the nearest medical facility. However, the PCP must be contacted as soon as possible. If the PCP cannot be reached, the member must contact the Health Care Provider's Member Services Department. See also the section entitled "In Case of Emergency".*

What if an employee receives a bill for services?

Although members should not receive bills for medical care provided or approved by their Primary Care Provider, bills may be sent in error. Members should contact the Health Care Provider's Member Services Department for assistance. The Member Services phone number is located on the back of the Medical ID card. *

***This FAQ section is only a general summary of benefits. Please refer to the Evidence of Coverage issued by the Health Care Provider for specific benefit and coverage information.**