Healthy Advantage

Broker Guide

BROKER PRODUCT GUIDE SUMMARY

*Healthy*Advantage is a self-funded medical program providing employers with a cost effective and secure opportunity to save on health care expenses for their employees and dependents.

The program provides benefits of self-funding to small and mid-size groups who are disadvantaged by fully-insured, state and federal regulations and costs (community experience rated, age-banded rate structure, mandated benefits and expenses, etc).

This guide is provided to assist you in developing a comprehensive understanding of HealthyAdvantage. This guide will help you thoroughly gain an understanding of:

- REGULATIONS OF SELF-FUNDING
- FUNDING COMPONENTS
- PLAN FEATURES AND CAPABILITIES
- OBTAINING A HEALTHYADVANTAGE QUOTE

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INSIDE THIS GUIDE

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SELF-FUNDING DIFFERENCE

As the cost of healthcare continues to escalate, more and more employers are looking for alternative solutions. Selffunding offers employers a powerful, practical alternative to traditional insurance.

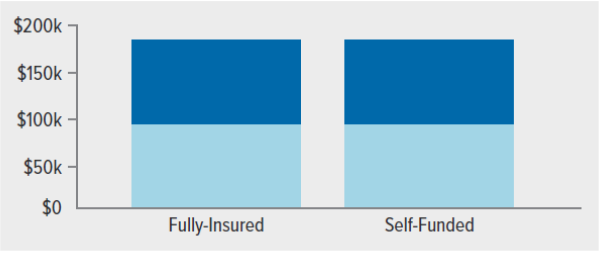
Self-funding allows employers to directly fund their actual claim costs while limiting their risk with the purchase of stop-loss insurance.

With a traditional fully insured plan, the insurance company pays for most medical services and members are responsible to pay small out of pocket expenses in the form of deductibles, copays and coinsurance. The insurance company keeps the unused funds when your claims are lower than expected.

In a self-funded plan, the employer pays for medical services up to a higher predetermined amount, but purchases stop-loss insurance to reimburse the plan if that amount is exceeded.

Stop-loss insurance protects the employer's plan against individual catastrophic claims (specific s top-loss) a nd their total claim expenses (aggregate stop-loss) that exceed their annual predetermined maximum claim liability. SISCO is the Third Party Administrator that processes, manages, and pays claims on behalf of the employer's plan.

It works a lot like fully-insured, with one BIG difference...



Who owns the claims reserve?

SELF-FUNDING REGULATION

*Healthy*Advantage is governed principally by the federal Employee Retirement Income Security Act (ERISA). Federal law permits self-funded groups to reduce the burdens and added costs of state and Federal regulations.

State regulations benefit some fully-insured groups whose health costs are higher than the norm. However, groups with expenses less than the norm must pay substantially higher premiums to subsidize groups with serious health problems. HealthyAdvantage was designed to provide an alternative that helps these employers to capitalize on their good health by self-funding their medical costs.

The most important service you provide to your clients is complete information about their group benefit options. The decision to engage in self-funding should be made only when the employer has a complete understanding of how it works.

When implemented correctly, self-funding can result in significant savings.

It is important to understand the impact serious medical conditions have on the employer group's health care costs.Self-Funding may not be the best option for groups with serious medical conditions.

State Mandated Benefits. Self-funded employer plans are not required to offer coverage's mandated by state law. Federal law mandates such as COBRA, TEFRA and minimum maternity stay do apply. Despite their exemption from state mandated benefit laws, HealthyAdvantage plan designs include many state-mandated benefits for competitive reasons.

Licensing & Registration. We appreciate the opportunity to earn your business. Prior to offering HealthyAdvantage to your clients and prospects you will need to get registered and appointed with us.

Contact your Amwins Connect Sales Representative today for more details.

*HEALTHY*ADVANTAGE PLAN COMPONENTS

With HealthyAdvantage, participating employers pay a monthly bill, similar to a monthly fully-insured premium bill. The monthly billing statement has two key components, claim funding expenses and fixed costs.

Claims Fund

The claims funding amount is determined when Underwriting completes a risk analysis based on the group's demographics, enrollment, and individuals' medical history. Expected claims may be adjusted based on medical underwriting prior to an underwritten rate offer. The monthly claims prefunding are determined by Underwriting and the stop-loss insurance carrier.

The monthly invoice is designed to prefund 1/12th of the maximum expected cost of the health plan. The claims fund contributions are deposited monthly upon receipt of payment.

All unused claim funds are refunded to the employer at the end of the contract term

Third-Party Administration

As a Third Party Administrator (TPA) SISCO provides health benefit administration to ensure an unparalleled level of service including:

1. Claims administration, adjudication & payment
2. Enrollment & billing
3. Customer Service
4. Utilization review, large claim management & cost containment

Provider Networks

Preferred Provider Organization Network (PPO)

*Healthy*Advantage provides access to local and national PPO networks. PPOs have agreed with an insurer or a third-party administrator to provide healthcare services at discounted rates to the insurer's or administrator's clients.

*Healthy*Advantage has access to multiple PPO networks across the country. Contact Amwins Connect Sales Representative to review which network may be right for your client.

*Healthy*Advantage primarily uses the CIGNA PPO Network. NO REFERRALS are necessary. Pre-Certifications may apply to certain procedures.

*HEALTHY*ADVANTAGE PLAN COMPONENTS

Provider Networks (continued)

Pharmacy Benefit Manager (PBM)

*Healthy*Advantage plans offer multiple pharmacy benefit options. The PBM determines the formulary, negotiates prescription prices and processes all in and out-of-network pharmacy claims.

*Referenced Based Pricing (RBP)**

*Healthy*Advantage plans offer a Medicare referenced based pricing model in specific markets. RBP pays providers Medicare's negotiated rate plus an additional percentage.

*RBP is currently being utilized on a case by case basis. Please contact your sales representative for additional details

Stop Loss Insurance

The Stop-Loss Insurance Contract provides insurance to reimburse covered medical costs that exceed predetermined limits. This insurance protects the employer's plan from large claims as well as total claims that exceed their annual maximum costs. The stop-loss policy must satisfy applicable state laws with regard to specific and aggregate limits.
Stop Loss insurance may offer two protections for self-funded plans, specific and aggregate.

Specific Stop-Loss Coverage

In the event a single member experiences large claim amounts, specific stop-loss insurance insures the employer's plan for any claims that exceed the specific deductible level (ex. $20,000). Specific stop-loss regulations vary state to state. The Specific deductible covers every enrolled person in the plan.

Aggregate Stop-Loss Coverage

Aggregate stop-loss insurance insures the plan when the sum of covered claims paid for all covered persons for the year exceeds the predetermined aggregate annual attachment point.

The policy also provides monthly advances if claims exceed the balance in the claims fund through the purchase of aggregate accommodation insurance.

Stop Loss reimburses the plan; it does not pay benefits to employees.

Aggregate Accommodation

Covered claims can exceed the amount the plan has deposited in the claims fund. In this case, due to the aggregate accommodation provision of the stop loss policy, amounts are advanced by the stop loss insurance carrier to cover any deficit.

*HEALTHY*ADVANTAGE PLAN COMPONENTS

Stop Loss Insurance (continued)

The monthly invoice is designed to prefund 1/12th of the maximum expected cost of the health plan. If claims exceed the amount the plan has contributed, the stop-loss insurance reimburses the difference (aggregate accommodation).

If the plan terminates the Stop Loss policy before advances are repaid, the plan will be liable for unpaid amounts.

MINIMUM ATTACHMENT POINT (MAP) *(12X the 1st month's claims fund)*—The predetermined maximum annual amount of claims the group is responsible to pay before the aggregate stop-loss insurance reimburses for the plan year. In the event the claims fund falls below the MAP by the end of the contract period, the group is responsible for the difference IF the claims exceed the predetermined amount funded.

THIS CAN OCCUR WHEN A PLAN HAS A REDUCING AMOUNT OF EMPLOYEE PARTICIPANTS DURING THE COURSE OF ANY PLAN YEAR.

Rate and Deductible Guarantee

Stop loss premium rates and annual employer contributions are guaranteed for one year (unless there are significant changes to the demographics and enrollment of the group during the contract period). Terms and periods appear in the Schedule of Insurance of the Stop Loss policy.

Premium Equivalent

The component parts (claims fund & fixed costs) are combined into a 4-tier fully insured premium equivalent (EE, ES, EC, FAM) for billing, enrollment and COBRA purposes.

Broker Fees

Broker fees are paid monthly upon timely receipt of plan premium. Please refer to Producer Sales Agreement for your agreed upon fees. Standard broker commission is $30 Per Employee Per Month (PEPM) but commissions can be customized. Please refer to the Plan Services Agreement and signed rate sheets for your agreed upon fees.

To ensure timely and accurate payments, please report any change in address, including email address, to SISCO at siscosupporthealthyadvantage@siscobenefits.com

Payments paid to an agency can only be changed to pay another entity by obtaining a written release from the current agency or by obtaining a Broker of Record letter from the group. All changes would be effective the first of the month following 45 days from the receipt of the request.

FEATURES AND CAPABILITIES

Benefit Designs

*Healthy*Advantage offers a wide variety of PPO plan options to fit any group's health plan needs. There are 20 plan designs with deductibles ranging from $250–$7,000.

Thirteen (13) designs use a "traditional" PPO copay plan model where prescriptions, office visits and diagnostic/lab services are subject to co-pays only.

Embedded Designs

*Healthy*Advantage plans use embedded deductibles.*

Embedded deductibles allow a single member of a family to meet the individual deductible even if the coverage is through a family plan. The member doesn't have to meet the full family deductible for after deductible benefits to kick in.

*QHDHP 1500/100 USES AN AGGREGATE DEDUCTIBLE IN ORDER TO COMPLY WITH THE IRS QUALIFIED HIGH-DEDUCTIBLE HEALTH PLAN (QHDHP) REQUIREMENTS.

QHDHP-HSA eligible plans

*Healthy*Advantage offers six (6) QHDHPs designed to comply with IRS requirements.

MEC

A MEC plan is an employer-sponsored limited benefit plan that only provides the preventive minimum essential coverage requirements outlined in The Affordable Care Act (ACA). The MEC plan's narrow scope of benefits makes it available at a very low price point.

MEC Advantages:
- Satisfies the employee ACA Individual Mandate
- Satisfies part of the Employer 'Pay or Play' Mandate

FEATURES AND CAPABILITIES

HealthySolutions*

HealthySolutions, one the of HealthyAdvantage plan designs, is a turn-key, population health management plan design. The HealthySolutions incentive capabilities are coupled with a wide range of wellness, preventive & clinical programs. This program can help promote lifelong adoption of choices that can result in healthier, more productive employees. Participants can earn deductible credit by engaging in:

Awareness

Complete the Biometric Screening & Health Risk Assessment. Know your numbers, reach out to a health coach to help you understand your results.

Education

Online Education, Health Challenges and Health Coaching.

Lifestyle

Record food and physical activity, while maintaining health and wellness good practices.

***HealthySolutions is stand-alone and cannot be offered with any other plan design.**

Amwins Connect Administrators Healthy Solutions Flyer

ELIGIBILITY

*Healthy*Advantage is designed for employers that have 5 or more full-time participating employees.

Companies that are affiliated with common ownership and/or eligible to file a combined tax return may be considered one employer.

Seasonal businesses are not eligible. “Seasonal” is defined as operating fewer than six months every calendar year.

Multiple location groups (where some employees live in a state different from where the business is located) are eligible provided the principal business location is a state in which HealthyAdvantage is available.

At the time of application, no more than 20% of the total employees in the business may be on COBRA or state continuation coverage.

Participation Guidelines

*Healthy*Advantage requires:

- 75% of eligible* employees elect to enroll for groups with less than 50 enrolled
- 60% of total eligible* employees elect to enroll for groups with 50+ enrolled

*Part-time, seasonal, or employees failing eligible employee status are not considered eligible when calculating Participation

ELIGIBILITY

Ineligible Industries

*Healthy*Advantage is designed for stable, nonhazardous businesses. Certain industries may not be eligible for coverage. Final decisions on occupational eligibility based on Standard Industrial Classifications (SIC) are determined by Underwriting and stop-loss carrier. Ineligible industries are listed below:

- Amusement Parks
- Auto Repossession
- Bail Bondsmen
- Blast Furnace
- Commercial Fishing
- Fireworks
- Mining, Quarrying & Asbestos
- Professional Athletes
- Refuse & Sanitary Systems
- Wrecking & Demolition Involving Nonmetallic Minerals

Employee Eligibility

Any employee, including a proprietor or partner, who works for the employer at least 30 hours per week on a regular basis is eligible. Employees must be:

- *18 years old*
- *A U.S. citizen or a lawful permanent resident*
- *Must reside in the U.S.*
- *Part of a formal employer-employee relationship that can be confirmed by demonstrating that the employer pays FICA wages and that wages are reported on Federal W-2.*
  - *Straight-commissioned employees under exclusive contract may be eligible but need to be pre-approved by Underwriting*
- *The following are not considered eligible employees under this plan (this list is not inclusive):*
  - *Leased employees*
  - *Temporary employees*
  - *Seasonal employees*
  - *Subcontractors*
  - *Personal employees (i.e., nannies, gardeners)*
  - *Retirees*

Dependent Eligibility

Eligible dependents must be:

- U.S. citizens, or be legal aliens who have a green card and a social security number
- Reside in the U.S.

Eligible dependents include:

Lawful spouse

- If divorced, the former spouse is not eligible for coverage (unless court ordered)
- Common law marriage is a basis for dependent eligibility only if recognized in the state and the burden of proof is on the covered participant.

Unmarried children of the employee who are legally listed as dependents for income tax purposes

- Or for whom a court order requires the employe to provide health insurance.

Dependent children are eligible up to the age of 26

- An adopted child is eligible as a dependent when the self-funded plan participant has agreed to assume total or partial responsibility of support for a child in anticipation of adoption or legal physical placement of the child in the home. Legal documentation would be required to verify eligibility.

The employer may elect to offer coverage to Domestic Partners and their legal dependents in accordance with HealthyAdvantage guidelines. An affidavit and addendum will need to be completed and signed by the employer and plan participant.

QUOTING & SELLING HEALTHYADVANTAGE

This section contains information and answers to frequently asked questions about quoting and submitting new business. It is intended to provide step-by-step advice to make your first and following cases easy to present and sell.

Quoting with your Broker Representative Team

Send a complete census template with group demographics to your Amwins Connect sales representative.

What's in the Initial Quote?

The initial quote is illustrative* and is based on the demographics of the employees (age, gender, dependents, etc.) and employer (industry, zip code) ONLY and does not take into account any medical underwriting factors.

The file will contain:

- Cover Page
- Information on self-funding, HealthyAdvantage & HealthySolutions
- Assumptions page (contract terms, client demographics, effective date, participation guidelines, etc.)
- Benefit & Rate Comparison for all 20 HealthyAdvantage plans
- Conditions & Underwriting Terms

***It is important to note that final rates are based on final enrollment and final medical underwriting for all plan participants.**

QUOTING & SELLING HEALTHYADVANTAGE

Field Underwriting & Sales Support

It is the intention of HealthyAdvantage to provide a complete risk analysis in an effort to ensure your clients are empowered to make the best healthcare purchasing decision.

If you are unsure whether a group will qualify, our broker representatives can prescreen particular conditions or answer questions for you. We are committed to helping you become familiar with our underwriting criteria and process.

Self-funding may permit more liberal risk acceptance or a lesser rating than would occur in fully-insured products. Therefore, it may be prudent to ask questions of our team even where experience suggests an unfavorable answer.

Field Underwriting Questions:

- **Are you aware of any serious medical conditions within your employee population? If yes, what?***
- **If applicable, is an HRA claim report available?**
- **HIPAA permits the collection of Personal Health Information (PHI) for the purposes of underwriting a health benefit program. For more information on employee and employer rights under HIPAA and the treatment of PHI visit www.hhs.gov/hipaa**

Serious Condition List

*Healthy*Advantage may not be a viable option if any of the conditions below are present in a group:

- Alzheimer's Disease
- Alcoholism, Drug Addiction, Alcohol Abuse or Substance Abuse
- Aneurysm
- Brain Tumor or Abscess
- Cancer—Malignant
- Cardiomyopathy (Enlargement or Congestive Heart
- Disease)
- Crohn's Disease
- Cerebral Palsy
- Chronic Renal Failure
- Congenital Heart Defects
- Cystic Fibrosis
- Emphysema (COPD)
- Gastric Bypass/Balloon
- Hemophilia
- Hepatitis C
- Hemochromatosis (Iron Storage Disease)
- HIV+, AIDS, ARC
- Huntington's Chorea
- Leukemia or Hodgkin's disease
- Liver Cirrhosis or Hepatic Failure
- Lou Gehrig's Disease, ALS
- Lupus Discoid or Systemic
- Meningitis, Encephalitis
- Multiple Sclerosis
- Muscular Dystrophy
- Organ or Bone Marrow Transplants
- Parkinson's Disease
- Paralysis
- Prosthetic Heart Valve
- Pending or recommended surgery (any)
- Pregnancy
- Spina Bifida
- Stroke (CVA) (TIA)
- Suicide Attempt

This list is not all inclusive and does not indicate an automatic declination. The severity of a condition, the size of the group and the other medical conditions present inany group will contribute to underwritten pricing.

UNDERWRITING

Contact your Amwins Connect Sales Representative to initiate the underwriting process.

There are 3 methods to go through the underwriting process:

1. Group Level Underwriting – Employer provides member level census and a disclosure statement about the health of the group in order for underwriters to provide a risk profile.

2. Personal Health Questionnaires (PHQs): Employees complete & provide detailed health questionnaires to underwriting in order to provide a more detailed risk profile

3. Experience Underwriting: Employer with more than 50 eligible employees provides detailed claims experience & high-claimant information to underwriting in order to provide a detailed risk profile.

UNDERWRITING

Group Level Underwriting

Contact your Amwins Connect sales representative for information.

Personal Health Questionnaire (PHQ) Underwriting

Available via FormFire and other third party sites.

Eligible* employees (including those in their waiting period are required to complete a PHQ or waiver. A unique link and letter is provided to the employer and broker for distribution to employees. If questions arise during underwriting, a telephone call may be requested with the employee.

It is important that all medical history and pertinent information regarding the employee, spouse and dependents be fully disclosed on the PHQ. Failure to do so may result in an increase in Stop Loss premium rates retroactively to the effective date of the group's coverage OR cause claims to be denied.

Telephone verification may be conducted at the underwriter's discretion, calls entail a short interview with the employee conducted by an underwriter. The focus is to clarify information provided on the PHQ.

It is important that all medical history and pertinent information regarding the employee, spouse and dependents be fully disclosed on the PHQ. Failure to do so may result in an increase in Stop Loss premium rates retroactively to the effective date of the group's coverage OR cause claims to be denied.

UNDERWRITING

Experience Underwriting

Coordinate with Amwins Connect sales representative to discuss the requirements for this form of underwriting. Underwriting may take 10 business days to return a proposal.

Underwritten Proposal

After the group has completed their underwriting requirements, Amwins will submit to the carrier for underwriting review.

Group & PHQ underwriting can take 3-5 days upon receiving a complete submission. Experience underwriting can take a few additional days.

What's in the Underwritten Proposal?

The Underwritten Proposal contains the following:

- Cover Page
- Information on self-funding and the HealthyAdvantage product
- The Assumptions page (quote demographics contract provisions, i.e. specific deductible, SIC, effective date, etc.)
- Benefit and Rate Comparison for all 20 plans
- Contingencies

Declining Groups

If underwriting determines the group may not be a good candidate for self-funding, a decline to quote (DTQ) letter will be provided. Groups should never cancel other health coverage until accepted by HealthyAdvantage.

ENROLLMENT

When the group wishes to move forward after seeing the Underwritten Proposal they should work with their broker to complete the New Business Checklist and online enrollment.

Participation Guidelines

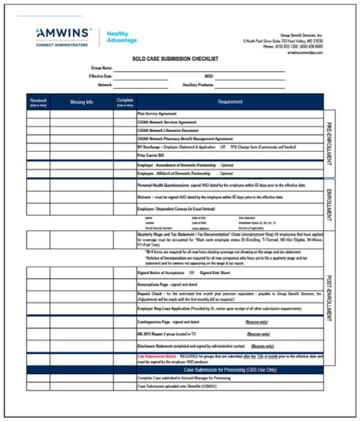
HealthyAdvantage requires:

- 75% of eligible* employees elect to enroll for groups with less than 50 enrolled
- 60% of total eligible* employees elect to enroll for groups with 50+ enrolled

*Part-time, seasonal, or employees failing eligible employee status are not considered eligible when calculating Participation.

New Business Checklist

The New Business Checklist is a compilation of everything needed to set up, implement and bind coverage. The checklist can be found in the Forms & Benefits Section of the Amwins Connect website.



AMWINS CONNECT ADMINISTRATORS | Healthy Advantage

Group Benefit Services, Inc.
6 North Park Drive Suite 310 Hunt Valley, MD 21030
Phone: (410) 832.1300 (800) 638.6085
amwinsconnecttpa.com

SOLD CASE SUBMISSION CHECKLIST

Group Name:
Effective Date: MGU:
Network: Ancillary Products:

Received (Date & Initial)	Missing Info	Complete (Date & Initial)	Requirement	
			Plan Service Agreement	PRE-ENROLLMENT
			CIGNA Network Services Agreement	
			CIGNA Network Lifesource Document	
			CIGNA Network Pharmacy Benefit Management Agreement	
			NY Surcharge – *Employer Statement & Application* OR *TPA Change form (if previously self funded)*	
			Prior Carrier Bill	
			Employer - Amendment of Domestic Partnership - Optional	
			Employee - Affidavit of Domestic Partnership - Optional	
			Personal Health Questionnaires: signed AND dated by the employee within 60 days prior to the effective date.	ENROLLMENT
			Waivers – must be signed AND dated by the employee within 60 days prior to the effective date.	
			Employee / Dependent Census (in Excel format): Name, Date of Hire, Plan Selection, Gender, Date of Birth, Enrollment Status (E, ES, EC, F), Social Security Number, Home Address, Division (if applicable)	
			Quarterly Wage and Tax Statement / Tax Documentation* (State Unemployment filing) All employees that have applied for coverage must be accounted for. *Mark each employee status (E=Enrolling, T=Termed, NE=Not Eligible, W=Waive, PT=Part Time) *W-4 forms are required for all new hires electing coverage not showing on the wage and tax statement. *Articles of Incorporation are required for all new companies who have yet to file a quarterly wage and tax statement and for owners not appearing on the wage & tax report.	POST-ENROLLMENT
			Signed Notice of Acceptance OR Signed Rate Sheet	
			Assumptions Page - signed and dated	
			Deposit Check - for the estimated first month plan premium equivalent - payable to Group Benefit Services, Inc. *(Adjustments will be made with the first monthly bill as required.)*	
			Employer Stop Loss Application (Provided by SL carrier upon receipt of all other submission requirements)	
			Contingencies Page - signed and dated (Beacon only)	
			HB 2015 Report if group located in TX (Beacon only)	
			Disclosure Statement completed and signed by administrative contact (Beacon only)	
			Late Submission Notice - REQUIRED for groups that are submitted after the 12th of month prior to the effective date and must be signed by the employer AND producer.	
			Case Submission for Processing (GBS Use Only)	
			Complete Case submitted to Account Manager for Processing	
			Case Submission uploaded onto Sharefile (USMGU)	

Waivers

The following are considered valid waivers and are not counted against calculating participation:

- Employees with OTHER GROUP COVERAGE (spousal, parental, retirement, etc.)
- Employees with MEDICAID, MEDICARE, VETERAN AFFAIRS

Pre-Enrollment Paperwork

Open Enrollment & Plan Selection

- Plan elections, payroll deductions and a waiting period are selected and completed on the Plan Service Agreement (PSA).
- All agents/agencies should be licensed with the stop loss carrier prior to case submission

The employer may select up to three plans. *Healthy*Solutions is stand-alone and cannot be offered with any other plan design.

ENROLLMENT

Deductible Credit

Deductible credit is ONLY available to groups that elect a calendar year deductible. Carry-over is not available for groups with a January effective date.

Post-Enrollment Paperwork

Additional paperwork will be required upon completing the enrollment. These documents are contingent upon the final enrollment. **Final underwritten rates are based on final enrollment.**

Implementation

Upon receiving all completed items on the New Business Checklist and the employer closing the open enrollment, our team will review all of the documents to make sure everything is accurate and accounted for.

Once all documents are complete, accurate, and accounted for, the group is released to the Account Installation and Management teams. At that point they provide a final quality assurance audit and get the group ready for implementation. **The implementation of the group takes up to 30 business days from the time that the account manager receives all of the paperwork.**

If the submission is past the **12th of the month prior to the effective month**, the group and consultant are required to sign a late submission letter.

This informs the group that they will not have ID cards and the group will not be set up in the network and pharmacy systems by the proposed effective date. We will also give the group an instruction letter for their employees to review if they have to see a medical provider or fill a prescription prior to receiving ID cards.

ID cards arrive approximately 21 days after the complete case is submitted.

ENROLLMENT

Issuing Coverage

When a group is accepted to participate in HealthyAdvantage, SISCO will establish the employer's plan and forward employer and employee plan documents to your client which will include the following:

- New Client Welcome Kit
- HealthyAdvantage Employer's Administration Guide
- Stop Loss Insurance Policy/Excess Loss Policy
- Summary Plan Descriptions (SPD's) for distribution to each employee
- Employee ID cards

Rates

Rates determined at issue may change due to employee census change within 30 days of the effective date. We reserve the right to change pricing should the business move to another location, state or make changes to the benefit plan. Coverage is renewed on an annual basis.

Plan Effective Date

Effective dates shall begin on the 1st of the month.

Waiting Periods

Waiting periods for employees available are:

- 1st of the month following 30 days of employment
- 1st of the month following 60 days of employment

Only one waiting period may be chosen for all classes of employees. Waiting periods can only be changed at time of renewal. Employers may waive the waiting period during the group's annual open enrollment. Other, alternate and pro-rated waiting periods are not available.

ENROLLMENT

Adding a Newly Eligible Employee:

- New employees must fully complete, sign and date the PHQ or Waiver within 31 days of their effective date (open enrollment or qualifying event).
- Employees that submit a PHQ more than 31 days after their effective date must:
  - Provide proof of an ACA eligible qualifying event; OR
  - Wait until the Employer's next Open Enrollment Period.

Adding a Spouse:

- Employees may add a spouse by submitting:
  - A PHQ with sponsored information indicating a change in coverage; AND
  - Provide proof of an ACA qualifying event
- The effective date of coverage for the spouse will be the first of the month following the ACA qualifying event.

Adding a Dependent (Newborns, Adopted Children, or Children under Legal Guardianship):

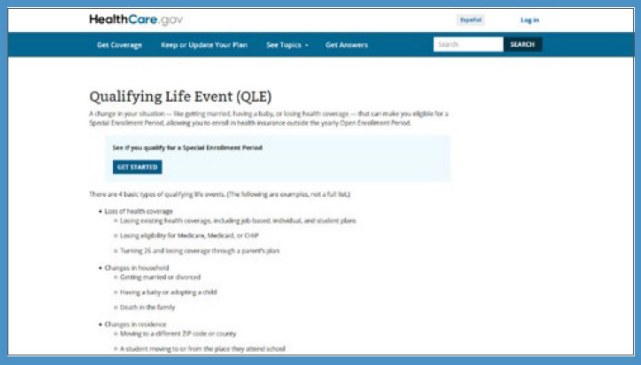
- Employees may add a newborn or adoptee by submitting:
  - A PHQ with newborn/adoptee information indicating a change in coverage; AND
  - Proof of legal dependency or birth certificate.
- The effective date is the child's date of birth or the date of legal dependency.

ENROLLMENT

If enrollment notification is not received within 31 days of an ACA qualifying event, the member cannot be enrolled until the employer's next open enrollment period.

ACA Qualifying Events:

- Loss of other coverage
- Changes in household (married, divorced, birth, death, etc.)
- Changes in residence



Other specifics available at:

www.healthcare.gov/glossary/qualifying-life-event

FINANCIAL AND BILLING

Monthly Payment by the Employer

The Employer Benefit Plan is invoiced for the Fixed Costs and 1/12th of the pre-funded claims fund.

The bill is due on the first day of each coverage month and the group must pay the amount billed. Enrollment adjustments will be reflected on the next applicable invoice.

There is a 31-day grace period for late payment of the premium. *Payment must be received within 31 days or Stop Loss coverage and participation in HealthyAdvantage will be terminated or suspended.*

Claim Prefunding

Employers participating in HealthyAdvantage agree to pay a monthly claim amount to prefund anticipated claim costs for the plan. The amount is based on the maximum claim exposure of the plan. The expected claims are determined upon completion of underwriting and/or renewal.

Plan Claims Fund Accounting

Monthly payments allocated to prefund claims are deposited into a bank account established to pay claims. The account is maintained and reconciled by SISCO.

SISCO is authorized to substantiate, adjudicate and pay claims, pay stop loss premiums, administrative fees, risk management fees and consultant compensation from the plan's payment.

Claim funds not used for claim payment accumulate in the account. Upon completion of the contract run out period, any funds not used will be refunded to the employer.

Advance Funding Provision: Aggregate Accommodation

Monthly advance funding is automatically provided. Advance funding provides reimbursement to the Plan's claim fund account for claims payable from the policy when the employer's prefunded claim account balance is insufficient.

Advances are only available if the plan's stop loss premiums and monthly claim prefunding contributions are paid-to-date.

FINANCIAL AND BILLING

Claim and Plan Services

Employee Claim Submission

A claim form is required for claims submitted by employees in the event services are rendered without an ID card or Out-of-Network. Submit claims forms to SISCO for payment.

Medical bills must be received no later than 180 days after an expense was incurred in order to be eligible for consideration and payment by the plan.

Pre-Certification

If an inpatient hospital stay or surgery is planned the participant needs to follow the instructions for precertification or preauthorization which are included in his or her summary plan description*. Penalties may be incurred if a precertification is not obtained

**Summary Plan Descriptions may vary per Stop-Loss carrier.*

Plan Claim Payment

As the primary risk bearer, the plan becomes responsible for all claim decisions. Plans utilize claim adjudication services from SISCO, as the third party administrator (TPA) and elect to legally delegate claim authority for applicable claim decisions to SISCO.

SISCO adjudicates all claims under a stated amount in cases where the claim determination is clear under the Summary Plan Description (SPD) and stop loss contract.

Claim Payment Clarification

In rare cases where the terms of coverage do not produce a clear claim determination, SISCO coordinates with the plan executive for final claim payment determination.

The plan executive's decision may set precedent on how future like claims are paid. It is necessary for the plan to obtain the stop loss insurance company's approval to determine whether the claim (or one similar) would be payable under the stop loss insurance.

Should a plan elect to override the denial of a claim payment, the dollar amount paid may be considered income to the participant. In such cases, the employer may be required to add this amount as "bonus" wages on the employee's W-2.

Neither Amwins Connect Administrators nor SISCO are Certified Public Accountant (CPA). In such cases a certified tax professional should be consulted.

FINANCIAL AND BILLING

Stop Loss Claims

SISCO is responsible for submitting claims to and paying claims on behalf of the stop loss insurance. SISCO tracks claim payments to determine when aggregate or specific limits are reached and a stop loss claim needs to be filed.

SISCO is responsible for filing stop loss claims on the plan's behalf. When stop loss claims are paid, they are credited directly to the plan's account so claims against the plan can be paid promptly.

Health Plan Management Reports

Clients and brokers have access to monthly reports that illustrate claims activity and financial summary. The Aggregate report will reflect their maximum claim fund liability vs. their actual claim payment expenses.

Plan Coverage Changes

Plan changes may only be made at the group's renewal date.

Plan changes must be submitted **12th of the month prior to the renewal effective month** to provide sufficient time to make system changes, issue new member ID cards and Schedule of Benefit certificates to the employees.

COBRA Continuation Services

HealthyAdvantage plans comply with the COBRA Continuation mandate for COBRA eligible employers. www.dol.gov/general/topic/health-plans/cobra

At the initial implementation and at each subsequent renewal, employers are required to inform SISCO whether they are subject to the COBRA regulations.

SISCO COBRA Administrative Services are included in the TPA fee.

COBRA participants are billed the full premium equivalent and the additional 2% administrative charge allowed by law.

RENEWALS

Renewal Rates

Renewal Rates are determined based on claims data, new enrollees, and any changes made to the group or benefits. Rates determined at renewal may change due to employee census change within 30 days of the effective.

Costs Subject to Change Annually

Required claim prefunding is adjusted at the start of the new plan year based on changes in anticipated claim costs for the coming year. This claim fund is unique to the new plan year. Any left-over claim funds from the prior year will be refunded to client and not rolled over to the next year.

TPA Administration Fees

The fee charged by SISCO for claim administration, medical management services, customer service and other services may be adjusted annually.

Stop-Loss Premiums

The Stop-Loss Insurance carrier may adjust charges for stop loss premiums annually. Any changes to the above costs will be reflected on the first monthly invoice of the subsequent contract period.

PHQ's

If PHQs are used to underwrite the case then PHQs will be collected for new enrollees throughout the year and at renewal. Renewal rates are contingent upon the receipt of complete and underwritten PHQs. Underwriting reserves the right to collect additional member information in advance of renewal for PHQs collected during the plan year.

RENEWALS

Renewal Contract Terms

Plans may receive an offer for a subsequent plan period following the first year of coverage. Rates for this plan period reflect claims experience and changes in health status among participating members of the plan, changes in coverage, and changes to the enrollment.

Renewal Checklist

The Renewal Checklist is a compilation of everything needed to continue, implement and bind renewal coverage.

Non-Renewal

If the group no longer meets the participation/eligibility requirements or is considered a poor risk they will be provided 60 days written notice of non-renewal.

Plan Termination

An employer's participation in HealthyAdvantage can be terminated upon notice for any of the following reasons:

- Any portion of the billed monthly cost is not received in accordance with Financial and Billing guidelines
- The group fails to maintain minimum enrollment and participation
- There is evidence of fraud or misrepresentation.
- There is non-compliance with plan or Stop Loss policy provisions.
- The business is no longer engaged in the same business that it was on the effective date
- All Stop Loss coverage in the state in which the group is located is terminated.
- The business moves to a state where HealthyAdvantage is not offered.
- The group submits a voluntary written request for termination

Refer to the Stop Loss policy for termination provisions specific to Stop-Loss coverage.

RENEWALS

Early Termination Provision

In the event the group terminates their plan during the plan year (i.e., nonpayment or per request) all benefits end the last day of the month for which payment has been received.

Early termination requests are processed first of the month following 30 days of receipt.

Should the group terminate the plan early, coverage ends the date of termination and no claims prior to or after termination will be paid by SISCO or covered by the stop loss insurance contract. Any claims incurred but not paid by the termination date will be the financial responsibility of the employer. HealthyAdvantage utilizes a 12-month contract, designed to be entered into for the entire year.

Reinstatement Provision

In the event of termination, the plan may request reinstatement within 5 days following the date of termination. Reinstatement is at the sole discretion of SISCO and the Stop Loss Insurance Carrier.
Consideration will include prior premium and claim history.

If reinstatement is approved, coverage will be reinstated retroactive to the termination date contingent upon receipt of all outstanding premiums, including the current month plus $500 Plan reinstatement fee.

Broker of Record (BOR) Changes

BOR change must be requested in writing on the groups' letterhead and signed by an officer or owner of the company.

- Letters cannot be dated more than 60 days prior to the receipt date.
- BOR changes are effective the first of the month following 30 days from the receipt of the group's request.
- BORs must be registered, appointed and approved by SISCO.
    - The BOR change effective date can be delayed until such appointment is complete.

RENEWALS

Compliance

SISCO is required to provide the necessary plan documentation to the client and broker in compliance with ACA, ERISA, COBRA, HIPAA and other applicable legislation; as it applies to the role of a TPA. It is the responsibility of the client and broker to maintain a compliant employee benefit offering. SISCO does provide relevant market updates and informational broker and client communication.

Patient Centered Outcomes Research Institute (PCORI)

Self-Funded Plans are exempt from a large portion on State premium taxes and certain ACA fees. Fully-Insured and Self-Funded Plans pay a Patient Centered Outcomes Research Institute fee (PCORI fee).

The client is responsible to pay the applicable PCORI fees. SISCO provides notification and guidance on the amount and payment procedures.

SISCO is not a Certified Public Accountant (CPA). In such cases a certified tax professional should be consulted.

CUSTOMER SERVICE CONTACTS

SISCO Enrollment & Billing Department

Enrollment: enrollment@siscobenefits.com
Billing: billing@siscobenefits.com
Phone: 800.457.4726
Monday-Thursday 7:30am-7pm CST
Friday 7:30am-5pm CST

Enrollment & Billing Department assists with:

- Adding/terminating employees or dependents to the plan
- Address changes
- Additional Member Identification Cards
- Summary Plan Descriptions
- Checking on the status of a reinstatement request
- Providing assistance with monthly billing questions

Claim & Customer Service Department

Phone: 800.457.4726
Monday-Thursday 7:30am-7pm CST
Friday 7:30am-5pm CST
Fax: 563-587-5953
Email: siscosupporthealthyadvantage@siscobenefits.com

Claim & Customer Service Dept. assists with:

- Benefit questions
- Learning how to file a claim
- Claim status
- Finding a Doctor

Claims Address:

SISCO
P.O. Box 389
Dubuque, IA 52004-0389

Amwins Connect Forms & Benefits Library

Access can be found at amwinsconnect.com. If you do not have access to this Library please contact your Amwins sales representative.

Forms & Benefits Library:

- Physician Network Documents
- Benefit Summaries
- Brochures & Sell Sheets
- Sold Case Submission Forms

Healthy
Advantage

amwinsconnect.com