



GROUP ADMINISTRATIVE GUIDE

FOREWORD

Welcome to Business Health Trust. We are delighted to present our Group Administrative Guide. This guide will assist you in administering your benefit program through the Business Health Trust. It will serve as a valuable reference to you as an employer who participates in Business Health Trust.

Detailed information is included on benefits, eligibility, enrollment, monthly billing statements, and claims submission to assist you in answering your employees' questions.

Upon completion of the Group Master Application and Trust Adoption Agreement for Business Health Trust, you acknowledge and agree to the Terms and Conditions of Participation including following the guidelines established in the Group Administrative Guide, the benefit service contract, insurance policies, and other contracts between Business Health Trust, Endorsed Sponsors and each respective carrier.

Thank you for your participation in Business Health Trust. We look forward to continuing to provide you and your employees with excellent services and benefits under the Business Health Trust.

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Please Note: This Group Administrative Guide is only a summary for informational purposes. It is not a contract. The actual terms conditions and limitations of coverage are set forth in the Group Master Application and Trust Adoption Agreement as well as the applicable Evidence of Coverage, Benefit Booklets, Certificate of Insurance, Service Agreement, or Group Policy.

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INTRODUCTION:

Business Health Trust is a funding mechanism for accessing health and other employee benefits. By taking advantage of the collective purchasing power of the Business Health Trust, your business has access to comprehensive and competitive benefits. A complete range of services are available to your employees.

Business Health Trust is a consolidation of available products put together specifically for the members of Business Health Trust and its endorsed sponsors. Business Health Trust includes employee benefits for medical, dental, vision, life and accidental death & dismemberment, supplemental basic life and accidental death & dismemberment, long-term disability, personal accident insurance, legal, and employee assistance programs for employer groups 2-149 employees.

- Consolidated Administration: one point of contact for billing and eligibility
- Cobra Administration (provided through Benefit Administration Company)
- On-Line Access: 24 hours access to forms, booklets, and summaries on our website www.businesshealthtrust.com
- Premium Only Plans (provided through Benefit Administration Company)
- Worksite Wellness Programs: Through Regence BlueShield & Asuris Northwest Health
 - Care Enhance
 - Special Beginnings
 - Personal Health Coach
 - Case Management

This guide is designed to assist you in the administration of your employee benefits through Business Health Trust. It is also a summary of terms and conditions set forth to participate in the program. It includes brief descriptions of plan administration and is intended to help the member company's administrative representative thru the day-to-day administration of their benefits thru Business Health Trust. It is not a contract, booklet of insurance, summary plan description, or a certificate of coverage.

All attempts have been made to provide accurate information. In all cases the information provided by the insurers or program manager in the benefit booklets, contracts, and certificates of insurance will govern the conditions and limitations of coverage.

Participating Companies:

Regence BlueShield (RBS)
Asuris Northwest Health (ANH)
Group Health Options Inc (GHO)
Washington Dental Service (WDS)
Dental Health Services (DHS)
VSP (Vision Service Plan)
Regence Life & Health (RLH)
Wellspring Family Services EAP (WFS)
21st Century Legal Plan
AIG

MAINTAINING ADMINISTRATIVE RECORDS

Your group is responsible for keeping accurate records of plan beneficiaries relating to eligibility, enrollment, payroll deductions, hours worked, premium payments, and other records necessary to administer the benefit plan. Business Health Trust and its affiliated contractors, have the right at any time during the employer's regular business hours to request, inspect, or audit the employer's records or the records of any third party entity engaged by the employer to administer portions of the employer's business related to the information necessary to administer the benefit plan.

GROUP ENROLLMENT

FOR NEW AND RENEWING BUSINESS

Rates are guaranteed for a 12-month period for individual member groups except in the case of:

- q Government mandated benefit change;
- q New or revised government taxes imposed;
- q An amendment of the benefit plan or contracts;
- q Addition or deletion of a subsidiary, corporate division, or affiliated companies;
- q Any change in employer contribution, employee eligibility, or probationary period;
- q Enrollment change of 10% in any single month or a 25% in any three consecutive months;
- q COBRA enrollment exceeds 10% of the total membership.

Groups must not have any other medical or prescription plans, other than that provided through the Business Health Trust. A group may select medical coverage provided by Regence BlueShield/Asuris Northwest Health or Group Health Options Inc.

MEDICAL

Pre-existing waiting period: Waiver of the 3-month pre-existing condition clause (waiting period) applies to all enrollees with comparable prior coverage. The waiting period will be credited month for month as long as there is no more than a 63-day break in coverage.

The insurers reserve the right to adjust rates for potentially new member groups if any information differs from the original quote and/or to decline the group if it does not subsequently meet underwriting guidelines.

LONG-TERM DISABILITY

There is also a pre-existing exclusion for LTD coverage. The pre-existing condition limitation can be 12/6/24 for groups with less than 25 employees and 3/6/12 for groups with greater than 25 employees. Exclusion period is either 24 or 12 months from employee's effective date. If treatment free for six consecutive months during the exclusion period, pre-existing provision is waived. Pre-existing is anything treated for in the look-back period prior to effective date. Please refer to group certificate for complete details.

RENEWAL PROCESS

All renewal information is sent to the credentialed producer. BHT does not send any renewal rates or other renewal information to the group. The producer is responsible for contacting the group regarding the new rates and any benefit changes.

A renewal workbook is sent to the producer 45-60 days prior to the renewal date. BHT will send the packets as soon as the information is available to us. It is always our goal to send them at least 45 days prior.

The packet includes a letter explaining any benefit and administrative changes to the plans, the renewal rates for all plans and benefits. A Group Master Application is required for all renewing groups. This is regardless of any plan or benefit changes. Open enrollment is the month before the renewal date (i.e. the open enrollment for January would be the month of December). Renewals must be returned to the Program Manager (Wells Fargo Insurance Services USA) no later than 15-days before the renewal date.

EMPLOYEE ENROLLMENT

EMPLOYEE ENROLLMENT

In order to participate in Business Health Trust the employer must agree to define the enrollment requirements on their annual Group Master Application and then apply these requirements in a non-discriminatory fashion for all employees in determining their eligibility, enrollment, waiting period, and contribution. These requirements can be changed at renewal. These may not be changed during the year without a formal request submitted to the administrator and written approval from the Trust. If your group, as a result of an acquisition, merger, or other circumstances, wish to add a new group or expand the group of eligible employees to the plan, please contact your producer.

ELIGIBLE EMPLOYEE

Active, full-time employees of the group who satisfy the weekly hours requirement and have satisfied the appropriate probationary period (as set forth in the group's annual Group Master Application) are eligible for coverage under this plan. Temporary, Seasonal, Contract, or Employees paid via 1099 are not eligible.

ELIGIBLE DEPENDENT

Eligible dependents include:

- The subscriber's lawful spouse.
- The domestic partner of the subscriber. If all requirements are met, as stated in the signed Affidavit of Qualifying Domestic Partnership, all plan provisions stated as applicable to a spouse will also be applicable to a domestic partner. For the purpose of this plan, the use of the term "marriage" will also be applicable to a domestic partnership.
- If applicable, the employer's contribution that is attributable to the coverage for the domestic partner or domestic partner's child will be taxable income to the employee. Similarly, if an employee is contributing some or all of the contribution for coverage of a non-dependent domestic partner or domestic partner's child, that portion of the employee's contribution may not be contributed as a pre-tax salary reduction through an Internal Revenue Code section 125-cafeteria plan. Whether a domestic partner or domestic partner's child is a tax dependent of an employee is a legal tax question. BHT, its' Program Manager (Wells Fargo Insurance Services USA) and its Billing Administrator (Benefit Administration Company, LLC) cannot provide legal or tax advice. If the employer covers domestic partners as dependents, the employer should consult legal counsel for advice on the taxability of the contributions for domestic partner or domestic partner's child coverage.
- A natural child, an adopted child, a child legally placed with the subscriber for adoption including a child for whom the subscriber has assumed a total or partial legal obligation for support in anticipation of adoption, a stepchild, or a child for whom the subscriber is the legal guardian (the subscriber will need to provide a court order showing legal guardianship), and dependent on the subscriber, spouse, or non-covered legal parent for total or partial support. In addition, a child of the subscriber will be eligible for coverage under this plan when required by a court

order. A child must be under age 25 to be eligible for coverage under this plan. Legal documentation may be required.

- q Children who are incapacitated due to developmental disability or physical handicap and chiefly dependent upon the subscriber, spouse, or non-covered legal parent for support and maintenance are also eligible for benefits, provided the dependent child was covered on the day before the 25th birthday and the incapacity occurred prior to the 25th birthday. Benefits will be provided for the duration of the incapacity unless coverage terminates. Proof of the incapacity and dependency will be required within 31 days after the child's 25th birthday, and not more frequently than one time per year after the child's 27th birthday. If the incapacitated child's coverage ends for any reason after the 25th birthday, the child will not be eligible for coverage under this Dependent Eligibility provision.

MEDICARE SECONDARY PAYER

The Program is subject to the Medicare secondary payer rules for the working aged, even for those employers who had fewer than 20 employees in the prior calendar year. The employer must offer its employees, who are age 65 and older (and their spouses and dependents of any age) the same coverage the employer offers to its employees who are under the age of 65. The employer cannot offer any financial incentive or encouragement for the participant to reject the employer's plan and select Medicare as their primary coverage.

If a participant is on COBRA and is entitled to Medicare based on age or disability, Medicare is primary for any period in which the participant continues with their COBRA coverage.

ENROLLMENT APPLICATION

To become covered under this plan, an employee must first complete an application for themselves and each family member they wish to cover. For employees, coverage begins on the first day of the next month after the application has been accepted by the Administrator and they have completed any probationary period required. For dependents that are eligible and are included on the subscriber's application, coverage begins on the subscriber's effective date.

- q If they or their dependent is not enrolled for coverage when initially eligible, coverage will not be available until the next open enrollment period, except when required by court order or special enrollment provisions. If they declined enrollment in writing, for themselves or their dependents, due to other health coverage, they and any eligible dependents may apply for coverage under this plan, or any other plan offered by the group, prior to the next anniversary date if the Administrator receives their application for coverage within 30 days of exhaustion of COBRA continuation coverage, loss of eligibility for the prior health coverage, or loss of an employer's contribution to the rate for the prior health coverage.

For Regence Life & Health, Evidence of Insurability is required for late enrollees. They would be made effective the first of the month following date of approval from Regence Life & Health.

Coverage will begin on the first day of the month after the Administrator has accepted the application. If an employee acquires a dependent through adoption, placement for adoption, birth of a child, or marriage, they and their dependents may apply for coverage either under this plan or any other plan

offered by the group, prior to the next anniversary date. The Administrator must receive their application within 31 days of marriage, or within 60 days of birth, placement for adoption, or date of assumption of total or partial legal obligation for support of a child in anticipation of adoption. Coverage will begin retroactive to either the date of birth of a natural newborn, the date of placement of an adoptive child, the date of assumption of total or partial legal obligation for support of a child in anticipation of adoption, or in the case of marriage, on the first day of the month after the Administrator has accepted the application. Please submit a new Employee Enrollment & Change Form if there is any change in the family's eligibility.

SPECIAL ENROLLMENT RIGHTS

If a participant declines enrollment for themselves or their dependents (including spouse) because of other health insurance coverage, they may in the future be able to enroll in this plan, provided that they request enrollment within 30 days after the other coverage ends. In addition, if they have a new dependent as a result of marriage, birth, adoption, or placement for adoption, they may be able to enroll themselves or their dependents, provided that they request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption

- In order to have Special Enrollment Rights:
 - Participant or dependent must have previously declined coverage in writing.
 - Participants must notify administration within 30 days of event and submit Enrollment/Change form.
 - Participant must have a qualified event such as:
 - § Loss of coverage
 - Effective 1st of the month following application
 - § Marriage
 - Effective 1st of the month following application
 - § Birth
 - Effective on the date of birth
 - § Death
 - Effective on the date of death
 - § Divorce
 - Effective 1st of the month following application
 - § Adoption
 - Effective on the date of adoption, or the date in which the child(ren) are placed with the employee for adoption.
 - Participant can then enroll themselves (if not previously enrolled), and their dependents in available coverage.

COVERAGE TERMINATION

- Coverage will end without notice, on the last day of the month for which premiums have been paid and in which ONE (1) of the following events occur (for Life and LTD coverage: coverage ends the day employment ends):
 - For the employee and dependents when ANY of the following occur
 - § the contract between the Trust and the insurance carrier is terminated
 - § the next monthly premium is not paid when due or within the grace period

- § the employee dies or is otherwise no longer eligible as an employee (for example, the employee's employment terminates)
 - § the participating employer ceases to meet the Program's continued participation requirements
 - § the participating employer notifies the Program that it no longer wishes to participate in the Program. Such notice must be received prior to the next premium due date, otherwise the participating employer will be charged for an additional month's premium
- q Basic Life insurance, Voluntary Life insurance and Long Term Disability coverage ends on the day employment ends. Basic Life and Voluntary Life coverage continues 31 days past the date of employment termination (through the conversion privilege). If the insured person dies during the 31 day conversion period, the life benefit will be paid under the policy. The proceeds payable will be the maximum amount available for conversion, whether or not application for conversion was made.
 - q Employees who are rehired within 90 days of termination will not have to re-satisfy their probationary benefits period.
 - q For a spouse/dependents:
 - o when his or her marriage to the employee is annulled
 - o when he or she becomes legally separated or divorced from the employee.
 - o For a domestic partner when his or her domestic partnership relationship with the subscriber is ended. (See Appendix).
 - o For a child when he or she no longer meets the requirements for dependent coverage.

It is the responsibility of the employee to notify the participating employer when an enrolled dependent is no longer eligible to be covered as a dependent under the Program. The participating employer must then notify the billing administrator, BAC, within 30 days of the date the participating employer was notified of such event. Retroactive adds and deletes are only available for 30-days plus the current month.

When an individual's coverage terminates, the employer (or its designated representative) must distribute HIPAA certificates of creditable coverage. If the insurance carrier sends the certificate, the employer is still responsible to ensure that the certificates satisfy HIPAA's requirements. If the plan is subject to COBRA, very specific notice obligations apply to the employee or affected qualified beneficiary if coverage is lost due to divorce, legal separation or a child's losing dependent status (see the following sections). In addition, if the plan is not subject to COBRA (generally the employer had less than 20 employees in the preceding calendar year), the employer must be aware of the continuation of Group Health Options Inc coverage rights that are available to terminated employees. These rights are described in the next section.

For complete details about coverage termination, please refer to the appropriate benefit booklet

BENEFIT EXTENSION

The employer must inform participants that there is a benefit extension for medical, dental, and vision plans for up to 6-months for participating employees. This is available to groups who are not subject to COBRA (typically defined as having less than 20 employees in the prior calendar year). The employee must submit an Enrollment/Change form and elect the benefit extension. The premium may be charged to the employee on a self-payment basis. The premiums for employees on benefit extension will be reflected on the monthly group invoice and group must pay the premium via company check. Personal Checks or payments directly from the participant will not be accepted. This coverage cannot extend beyond 6-months.

LEAVE OF ABSENCE

Coverage for an employee and enrolled dependent(s) may be continued for up to 90 days when the employer grants the employee a leave of absence and full premium rates continue to be paid. The 90-day leave of absence period counts toward the maximum Non-COBRA continuation of coverage and the maximum COBRA continuation period, except as prohibited under the FMLA (Family and Medical Leave Act of 1993). For LTD Coverage, Leave of Absence ends as of the end of the next month.

LIFE INSURANCE CONVERSION

The group life insurance conversion privilege is explained in the Regence Life & Health or Summary Plan Description that has been distributed to employers. Employers have an obligation to make employees aware of the life insurance conversion privilege at the time of termination. Employees have 31 days from the date of termination to apply with Regence Life & Health for an individual life insurance policy without submitting evidence of insurability.

ADMINISTRATIVE REVIEW

The program has established procedures for employers, members, and their dependent(s) to request a review of non-claim decisions affecting their coverage. If the request for review involves eligibility, enrollment, disenrollment, waiting periods, late payment, reinstatement of delinquent employers, and similar issues concerning the day-to-day administration of the Trust, the affected employer or their agent/producer should contact BAC. Requests may not be directly submitted by employees or dependents. Requests for review must be in writing and must be submitted to BAC within 180 days of the event.

Upon the receipt of a request for review, a review committee will consider the matter and notify the employer and agent/producer in writing of its decision.

ENROLL A NEW EMPLOYEE

Use the BHT Employee Enrollment/Change form. A copy of the form can be found in our form library, which can be located at www.businesshealthtrust.com. Alternatively, contact customer service at Benefit Administration Company to have a copy of the form sent to you.

Coverage Enrollment Rules		
Medical	Regence BlueShield	EE can waive
	Asuris Northwest Health	EE can waive
	Group Health Options Inc	EE can waive
Dental	Dental Health Service	EE can waive
	WDS - 100% Employer Paid	If coverage 100% ER paid then ALL employees must be enrolled.
	WDS - 75-99% Employer Paid	If coverage less than 100% ER paid then EE must complete form to waive.
Basic Life and AD&D	Regence Life & Health	If the group offers it, ALL employees must be enrolled
LTD	Regence Life & Health	If the group offers it, ALL employees must enroll - Small groups may have to complete and qualify thru EOI
Vision	VSP	If the group offers it, ALL employees must be enrolled
EAP	Wellspring Family Services	If the group offers it, ALL employees must be enrolled.
Supplemental Life and AD&D	Regence Life & Health	Voluntary
Dependent Life	Regence Life & Health	Voluntary
Personal Accident (PAI)	AIG	Voluntary
Legal Plan	21 st Century Legal	Voluntary
Groups must satisfy carrier minimum participation rules.		

FILLING OUT THE FORM

Make sure you complete the form accurately and legibly. Enrollments with errors, ambiguities, and/or illegible information will take longer to process and are more likely to cause errors in the future. Forms with any missing information, such as birth date, date of hire, enrollment reason, will not be processed. You must print clearly or type the form.

Write the company name in the "Employer Name" box.

In the "Hire/Event Date" box, write the date of the employee's hire or other qualifying event. If the qualifying event is not a new hire, note what the qualifying event is. If the employee is transitioning from part time to full time employment, note both dates. Additionally, write the number of hours the EE works each week.

EFFECTIVE DATE

Consult your Group Master Application for the length of your probationary period. Most probationary periods are 0, 30, 60, or 90 days long. The period begins on the employee's date of hire. Their effective date is the first day of the month following or coinciding with the end of the probationary period. For example, if an employee was hired on January 1, 2009 and the group had a 30-day probationary period, the effective date would be February 1. If the same employee were hired January 8, 2009, the probationary period would end February 6 and the employee's effective date would be March 1. If an employee's probationary period ends on the 1st of the month, that will be the effective date.

- Check the "Hire/Rehire" box in the "Reason for Enrollment" section.
- Enter the employee's name, date of birth, gender, Social Security Number, and mailing address in the "Employee information" section.
- Check the boxes in the "Plan Selection" section that match the coverage you have through the BHT. If you are unsure of your coverage, consult your Group Master Application or Producer.
- Have your employee enter information about their dependent coverage and any prior coverage.
- On the signature page the employee sign and date the left box and the group administrator sign and date the right box.

DEPENDENT ENROLLMENT RULES

If Employee has Coverage Below...	Apply corresponding coverage rules.	
Medical	Dental	Vision
EE Only	EE only	EE only
Dependents Covered	MUST cover same dependents	MUST cover same dependents
EE Waived	May enroll dependents; MUST cover same dependents	May enroll dependents; MUST cover same dependents
Dental	Medical	Vision
EE Only	EE only	EE only
Dependents Covered	May cover dependents	MUST cover same dependents
EE Waived (Cannot be Waived if Employer pays for Employee Coverage)	May enroll and cover dependents	May enroll; MUST cover same dependents
Vision	Medical	Dental
EE Only	EE only	EE only
Dependents Covered	May enroll and cover dependents	May enroll; MUST cover same dependents
EE cannot waive if Vision is offered by group		

HOW TO ENROLL A DEPENDENT

Using the Business Health Trust Consolidated Enrollment Form

- q Put the first day of the first month of intended coverage in the "Effective Date" box.
- q In the Hire/Event date box, put the event date.
 - o This is the date that the dependent lost coverage, married the employee, was born, etc.
- q Indicate the qualifying event in the "Reason for Enrollment" box.
- q Enter the employee's information in the "Employee Information" section.
- q Enter the dependent's information in the "Dependent Information" section.
 - o Circle "add" next to the dependent's name.
- q On the signature page have the employee sign and date the left box
- q Sign the group administrator line and date the right box.

NEWBORN & ADOPTED CHILD ENROLLMENT

For the subscriber's natural newborn child, coverage will be retroactive to the date of birth provided the administrator receives the subscriber's application for the new dependent's coverage within 60 days following birth.

ERIN ACT: Regular Benefits for this plan will be provided for routine care, illness, accidental injury, or physical disability, including congenital anomalies, for the newborn child for up to 21 days following birth when the subscriber, or subscriber's spouse is eligible for maternity benefits of this plan.

For the subscriber's adopted child, coverage will be retroactive to the date of placement for adoption or the date the subscriber assumed total or partial legal obligation for the child's support in anticipation of adoption if the Administrator receives the subscriber's application for the new dependent's coverage

within 60 days following placement or the subscriber's assumption of legal obligation for the child's support.

For the subscriber's natural newborn, adoptive child under age 18, or child placed for adoption under age 18, none of the preexisting limitations or preexisting condition waiting periods of this plan will apply to such child, if enrolled for coverage under this plan within 60 days of birth, adoption, or placement for adoption. For both newborns and adopted children, the administrator should receive applications within 31 days to prevent delays in claims processing.

HOW TO ENROLL A NEWBORN

Using the Business Health Trust Consolidated Enrollment Form

- q Follow the same procedure for enrolling a dependent, putting the newborn's date of birth in the effective date box and the event date box.
- q What if the newborn doesn't have a Social Security Number yet?
 - o Send in the enrollment without the SSN. When one is assigned, notify Benefit Administration Company so it can be added to the file.
- q Check the birth/adoption box in the "Reason for Enrollment" section.

HOW TO TERMINATE COVERAGE FOR AN EMPLOYEE

Using the Business Health Trust Consolidated Enrollment Form

- q Put the last day of the last month of coverage in the effective date box.
- q Put the employee's actual last day of work/date of termination in the "event date" box.
- q Check "Termination" in the "Reason for Enrollment" box.
- q Enter all of the employee information.
- q Sign the right box of the 3rd page and date it.
 - o You do not need an employee signature when an employee terminates employment or you can send other written documentation providing information on the termination.

Life, AD&D and LTD coverage does not extend to end of month. It is terminated the same day employment terminates.

Premium for after termination is not pro-rated.

TO TERMINATE COVERAGE FOR A DEPENDENT ONLY

Using the Business Health Trust Consolidated Enrollment Form

- q Enter the last day of the last month of coverage in the effective date box.
- q Choose "delete dependents" in the "Reason for Enrollment" section.
- q Enter the all employee information.
- q Enter the dependent information, circling "delete" next to the dependent name.
- q The employee must sign the left box on the last page. The group administrator should sign the right box on the last page.
- q Please Note that if you terminate coverage for a dependent, you cannot re-enroll them in coverage without a qualifying event or open enrollment period.

HOW TO ENROLL A NEW SPOUSE

Enroll a new spouse like you would a dependent, entering the date of marriage in the event date box and the 1st of the month after the event date in the effective date box. Check the "Other" box in the

“Reason for Enrollment” section, and write “marriage” in the blank. A domestic partner is enrolled similarly to a spouse, though a signed affidavit is necessary.

PROBATIONARY PERIOD

A probationary period cannot generally be waived. However, it may be waived, at the discretion of the insurer, for key employees only for groups with more than 10 employees. To do this, you will need to write a letter on company letterhead stating that the employee is indeed a key employee and that the waiver is a condition of employment.

Key employees are defined as those employees who are at or above the highest paid 10% of all the employees employed by the employer and who reside within 75 miles of the employer's worksite.

A waiver request is not a guarantee of enrollment. As such, benefits should not be offered as a condition to employment without written approval from Business Health Trust and/or insurer. Be sure to include the employee's name, date of hire, and requested effective date. These requests will need to be reviewed and approved by the insurer on a case-by-case basis. Benefit Administration Company will notify the group if the request has been denied.

HOW TO CHANGE A NAME OR ADDRESS

Send an email or fax to Benefit Administration Company that includes the current information and, in the case of a name change, the previous name. This information should be changed with the administrator and they will then update the insurer's files.

REQUEST A NEW ID CARD

The member can order replacement ID Cards from Regence at www.myregence.com. Click on the "My Navigator Tab" and then Member Cards.

Alternatively, you can send an email to Benefit Administration Company listing the names of the employees who need new ID cards. If you have already ordered new cards and have not received them, please note it can take 12-14 business days for cards to arrive. You may request a new card directly from customer service at the insurer. If an employee needs to obtain care prior to receiving their card, they can generally use their social security number and the group number.

WDS does not issue individual cards. Instead, there are tear-out cards in Summary of Coverage booklets and also available online at www.businesshealthtrust.com.

VSP does not issue individual cards. VSP members and their covered dependents simply provide the last 4 digits of the member's SSN and complete name to a VSP Provider to access benefits.

HOW TO TRANSITION AN EMPLOYEE FROM PART-TIME TO FULL-TIME EMPLOYMENT

Fill out a change form as you would for a new employee, including both the original date of hire and the date of transition from part-time to full-time employment. Please note the event next to each date. Check your Group Master Application for information regarding probationary periods for part-time to full-time transitions.

HOW TO TERMINATE COVERAGE THROUGH BHT AT A GROUP LEVEL

Send a letter on company letterhead to Benefit Administration Company and Wells Fargo Insurance Services USA. The letter should indicate the last day of coverage and list all coverage being terminated. Your coverage can only terminate at the end of a coverage month. Mid-month termination dates are not allowed. After your plan has been cancelled you will be provided with a final billing that will outline any additional funds needed for adjustments prior to the plan termination, or with a check to cover any overpayments prior to plan termination.

BILLING

It is our policy to receive payment on or before the effective month of coverage. Employer groups are billed the first week of the month two months prior to the month of coverage, and payment is due on or before the 20th day of the month before the month of coverage. Please pay as invoiced. Credits or charges for enrollment changes that were received after the cutoff period will be reflected on the following month's invoice. Premiums that are not paid as billed may be returned, and/or result in a delay of processing resulting in pended coverage.

When payment is remitted you can submit a change form, which outlines the credits you feel, should be reflected the following month. Premiums should not be adjusted for these changes. Credits or Charges will be reflected on your following months invoice.

If you feel that your billed amount is incorrect, please contact Benefit Administration to review. We will review your account with you and ensure that any issues are resolved promptly.

Bills included both detail page(s) and a summary of the premiums due. The summary page will reflect any past due premiums and their delinquency period. The tiering structure for benefits and the codes reflecting these are listed below.

Your bill may also include dues or fees owed to the sponsor or an endorsed sponsor. BHT collects these amounts and pays them directly to the sponsor or endorsed sponsor.

Medical				Dental				Vision	
RBS/ANH		GHO		WDS		Dental Health		VSP	
RE	Employee Only	HE	Employee Only	DE	Employee Only	DE	Employee Only	VE	Employee Only
RS	Employee + Spouse	HS	Employee + Spouse	DS	Employee + Spouse	D1	Employee + 1 Dependent	VS	Employee + Spouse
RC	Employee + Child(ren)	HC	Employee + Children	DC	Employee + Child(ren)	D2	Employee + 2 Dependents	VC	Employee + Child(ren)
RSC	Employee, Spouse + Child(ren)	HSC	Employee, Spouse + Children	DSC	Employee, Spouse + Child(ren)	D3+	Employee + 3 or more Dependents	VSC	Employee, Spouse + Child(ren)

BILLING TIME FRAMES & DELINQUENCY POLICY

It is Business Health Trust's policy to receive premium payments prior to the coverage effective date. This document outlines the billing time frames and the subsequent delinquency policy if payment is received outside of the timelines.

Membership dues must also be in good status in or to maintain participation in the program. If you are delinquent on your membership dues, your premium may not be considered to have been paid and your coverage may be pended or delayed. If you are invoiced monthly for your dues, your premium will not be posted without your dues payment.

Groups may be termed for non-payment per the delinquency policy. Checks returned for Non-Sufficient Funds (NSF), Account Closure, or Payment Stopped will not be considered as having been paid in terms of the delinquency timeline. If any of these events occur, a group must provide a Cashier's Check or Wire Transfer with proof that the business is still active. If payment is not received within the payment due period the groups coverage will be pended. If payment is not received by the end of the coverage month coverage will be terminated retroactively to the last paid-thru date.

Employers who collect employee deductions for employee or dependent coverage and do not promptly pay those premiums towards coverage may be in violation of ERISA and subject to penalties. The timeliness of payments may also affect COBRA coverage, if you are responsible for forwarding COBRA premium on your former employees' behalf. Their coverage is dependent on being in good standing with their coverage premiums. If either situation applies to your group please contact your legal advisor for more information. Business Health Trust, its Program Manager, and its Billing Administrator are not tax or legal consultants and cannot provide further information on your responsibilities.

There are two steps followed for cancellation due to lack of premium payment

1. Letter sent requesting payment
2. Letter sent notifying group of cancellation

Example for May Invoice

April 1-10	May invoice is calculated and mailed
April 20	May payment is due – payments after this date are considered late
June 1	Group is considered delinquent if May premium is not received. <ul style="list-style-type: none">□ Letter is sent to the group requesting payment of all past due premiums within 10 days, broker is also included on this communication
June 11	Notification of retroactive termination sent to group, broker, program manager, endorsing sponsor, and all applicable carriers

If a group is delinquent three times in a calendar year, the third notification will instruct the group to pay in full within 10 days. If a group is delinquent four times within a calendar year, they may be terminated.

Payment in full is due by the 20th of the prior month; for example, payment for May benefits is due April 20. Payment received after the cutoff period is considered late and may be subject to late fees and the temporary pending of coverage by the carrier until payment is received. If payment is not received by the last business day of the coverage month, the group will be considered delinquent. The group will be notified in writing that if payment is not received within 10 days from the date of the letter the group will be terminated for non-payment. If a group is delinquent four times within a calendar year, they may be terminated.

If a group is terminated for non-payment, they have one reinstatement opportunity, which must occur within 60-days of the last paid thru period. Reinstatement will be at the discretion of the insurers and must be requested in writing and submitted to the billing administrator. If group is not reinstated, they cannot reapply for coverage thru the program for 12 months.

LATE FEE POLICY

The Business Health Trust has a late fee policy for all premium remitted after the due date of the 20th. Please note this does not affect BHT's delinquency policy.

Here's an example of the late fee schedule for illustrative purposes:

May 20th June payment is due.

June 1-10th During the calculation of your July invoice, if your June payment was not received by the premium deadline (May 20th) a late fee may be added to the July invoice based on the fee structure below.

Late Fee Structure	
Company Size	Amount
< 15 employees	\$55.00
15 - 25 employees	\$75.00
26 - 50 employees	\$125.00
51 - 75 employees	\$200.00
76+ employees	\$225.00

All fees are assessed each month. If a group's balance is past due, the late fee will be charged for each period in which the invoice was outstanding.

If a late fee is assessed on an invoice and the premium is remitted without the late fee, payment may be returned "NOT PAID AS BILLED".

BILLING FAQs

I know my payment is going to be late. Whom do I call?

If your payment will be late, contact Benefit Administration Company. Please be aware that late payment may result in your coverage being pended.

Is there a grace period?

Payments are due on the 20th of the month prior to coverage. For example, May premiums are due on April 20. Late payments may result in your coverage being pended.

I sent in a change and it is not reflected on my invoice. Why?

Changes received by Benefit Administration Company after 3:00 pm on the 20th of the month will not be reflected on the next invoice. For example, if a termination notice was received on March 24 that change would be reflected on the June invoice. Benefit Administration Company will issue retroactive charges and credits for enrollments and terminations on future invoices.

When do I need to submit changes to ensure that they are on my next invoice?

Please submit enrollment changes as soon as possible. To ensure they are on the next invoice, changes must be received by Benefit Administration Company no later than 3:00 pm on the 20th two months prior to the month of coverage.

I have a new employee that should have coverage this month but I have already paid this month's bill. What should I do? What is the effect on the employee's coverage?

Please send the enrollment forms to Benefit Administration Company and pay as billed. Benefit Administration Company will charge retroactively on the next invoice for unpaid premiums. There will be no effect on the employee's coverage.

I believe my invoice is incorrect. What should I do?

If you believe the rates are incorrect or you are owed a credit that was not issued, please contact Benefit Administration Company to discuss possible inaccuracies. Please do not make adjustments without first contacting Benefit Administration Company. Incorrect or unexplained adjustments could result in delay processing your payment and the pending of your coverage. Checks remitted for amounts that differ from the billed invoice may be returned.

If there are additions or deletions that have been submitted to Benefit Administration Company and are not yet reflected on your bill, please remember that bills are prepared approximately 6 weeks in advance of the month of coverage, and anything not received by the 20th two months before the coverage period will not be reflected on the invoice (that is, for a change to be reflected on the May invoice, Benefit Administration Company must receive notification no later than March 20th). If you have not submitted the enrollments or terminations to Benefit Administration Company yet, please do so.

I have been told my coverage is "pended." What does that mean?

Usually this has something to do with payment information that is inconsistent between the insurer and administrator. Pended coverage is not cancelled. However, when coverage is pended rather than cancelled, this does not guarantee payment of claims. If you are told your coverage is pended and you

believe your premium payments are current, please contact Benefit Administration Company to verify that all payments have been received.

I did not receive an invoice this month.

Please contact Benefit Administration Company to request that an invoice be resent via fax or emailed to you.

How do I change the billing/administrative contact or address for the group?

Please send Benefit Administration Company notification in writing of the new administrative contact or address for the group. An email is sufficient.

What is my balance forward? I thought I paid my bill last month, why is it showing up?

If your payment was received after the 20th of the month, it is possible your next invoice will show a balance forward. If you have specific questions about a balance forward, please contact Benefit Administration Company.

How is the money I remit going to be applied? Will I be notified?

Each payment is applied to the most dated outstanding month. If you remit payment for your November invoice but have not paid your October invoice, payment will be applied to October premiums. You will be sent a letter notifying you if this occurs.

How do I request a billing adjustment?

Please pay as billed. Submit enrollment changes and any billing adjustments you feel are necessary to Benefit Administration Company for adjustment on a future invoice.

What is an eligible employee?

Any employee of a BHT participating company who satisfies the terms set forth in your Group Master Application is an eligible employee. Your Group Master Application outlines how many hours per week an employee must work as well as the length of the probationary period.

What is an eligible dependent?

Spouses and children under the age of 25 are considered eligible dependents. Under some circumstances, domestic partners (with signed affidavits) and former spouses of employee are also eligible.

What is a Group Master Application?

This is the agreement the employer signs during the renewal or open enrollment process. It indicates the plan selected as well as the employer's policies regarding probationary periods, part-time to full-time transfer, and domestic partner coverage. If you do not have a copy of your Group Master Application, please contact your producer.

What is my group number?

This is a number assigned to you by the insurer to identify your company. Medical group numbers are six digits for Regence/Asuris and five digits for Group Health Options Inc. If you are unsure of your group number feel free to contact Benefit Administration Company and we will be happy to provide that information to you.

What is my location number?

This number is assigned to you by Benefit Administration Company. It is four digits long and begins with 1. If you do not know your location number, please check your most recent invoice. It is located on the payment stub.

What is a retroactive adjustment?

It is an adjustment applied to an invoice for past premiums that should be credited or charged. For example, if an employee was added effective January 1 and Benefit Administration Company received the enrollment form January 5, the employee would not be added to the invoice until March. On that invoice, there would be a charge for the January and February premiums in addition to the March premium. Please pay as billed and allow Benefit Administration Company to make premium adjustments for you.

What is an effective date?

This is the date that an employee's coverage through the BHT goes into effect. The effective date is the first of the month following the end of the probationary period or, for groups with no probationary period, the first of the month following date of hire. If an employee's date of hire is the first working day of the month and the group does not have a probationary period, the effective date is the first of the month. If you have questions about what an employee's effective date should be, please contact Benefit Administration Company.

What is a hire date?

This is the first day that an employee actually worked for your company.

What is a termination date?

This is the last day an employee worked for your company. In some instances, an employee will be terminated following a period of absenteeism. In this case, the last day that the employee worked is the termination date.

FAQs

What is a qualifying event?

It is an event that qualifies an employee or a dependent for a change in coverage other than open enrollment. In general an employee cannot change (add or drop) coverage for him or herself or dependents, except at open enrollment. Some common examples of qualifying events are loss of other coverage, marriage, birth/adoption, or change in employment status. Below is a chart of qualifying events and what action is allowed.

Quick Reference Table of Authorized Change of Election Events	Insurance Plan
Change in Legal Marital Status or Number of Dependents:	
Marriage, Divorce, Legal Separation, Annulment	Yes
Death of Spouse or Dependent	Yes
New Child (birth, adoption or placed for adoption)	Yes
Gain or Loss of Employment	
Going from Full-Time to Part-Time or Part-Time to Full-Time	Yes
Change in Work Schedule Due to Strike or Lockout Resulting in a Loss of Eligibility	Yes
Return from or Commencement of Unpaid Leave of Absence	Yes
Significant Change in Employed Spouse's Health Plan	Yes
Gain/Loss of Coverage under Participant or Dependent's Health Plan	Yes
Change of Employment Status Impacting Eligibility for Health Plan	Yes
Dependent Satisfies or Ceases to Satisfy Requirements for Dependents	
	Yes
Change in Residence or Work Site That Affects Eligibility	
	Yes
Judgment, Decree or Order:	
Plan Receives Qualified Medical Child Support Order	Yes
Employee/Dependent Medicare or Medicaid Eligibility Change	
Significant Change in Health Insurance Premiums or Coverage	Yes
Employee Entitled to Special Enrollment Rights under HIPAA	Yes
A Change in Status Occurs that Entitles an Employee, Spouse or Dependent to COBRA Coverage	
	Yes
Dependent wants to enroll because they were previously uninsured	No – Not without other qualifying event.

Incomplete Forms

Will I be notified if I send in an incomplete form?

Generally, yes. Benefit Administration Company and the Business Health Trust Administration Team will attempt to contact you if you have not completed a form or if there are discrepancies. If Benefit

Administration Company is unable to contact the group, incomplete forms will be returned with a letter explaining why the form could not be processed.

What are some common processing issues?

- ❑ Effective date: Please consult the “How to enroll” section for information on effective dates. If you have questions about your probationary period or what the effective date should be for an employee the Business Health Trust Administration Team at Benefit Administration Company will be happy to help you and answer any questions you may have.
- ❑ Illegible handwriting: If handwriting is hard to decipher, it is more likely an error will be made when enrolling an employee that will cause coverage problems later. Please ensure all forms are completed legibly or typed.
- ❑ Mailing address: Employees should include their street address, city, state, and zip code in the “Employee Information” section. Frequently employees write their street address but neglect to include a city, state, or zip code.
- ❑ Signature: Both the employee and employer need to sign the enrollment form.
- ❑ Outdated Forms: Please check the BHT website for the most up-to-date forms. Forms are located in the Forms Library in the “Employers” section of the website: www.businesshealthtrust.com

What is open enrollment?

Open enrollment is the month before the plan renews. During this period, employees may add and drop coverage with no other qualifying event. Employers may also change the coverage that is offered. To find out which month your group renews, consult your Group Master Application or your producer. For Regence Life & Health, coverage EOI is required for late enrollment. For employer paid coverage's all eligible employees are to be enrolled from their effective date. For employee paid coverage's satisfactory evidence of insurability is required. Once approval is provided by RLH insured would be effective first of the month following date of approval.

WHERE DO I FIND...

Enrollment forms?

Enrollment forms can be found on the BHT website www.businesshealthtrust.com. To locate the forms, go to the “Employer” section and choose the “Forms Library” link. Alternatively, you can contact BAC and request one be emailed or mailed to you.

Plan Information

Plan information is available on the BHT website, www.businesshealthtrust.com. Plan information is also included in benefit booklets.

Benefit Booklets

Booklets were sent to your group when you initially enrolled. If you are in need of additional materials, please contact Benefit Administration Company. You can use the Supplies Request form in the Appendix of this guide to submit your requests. Please note that Benefit Administration Company will not have

new annual plan booklets until four months after the program renewal. The program website, www.businesshealthtrust.com, will have plan highlights and booklets for download as well.

Benefit Summaries

Benefit Summaries are available online at www.businesshealthtrust.com they are listed under the line of coverage, and then select "Highlights". If you have addition questions about your coverage, please contact the insurer or your producer.

I do not understand what my plan offers. Whom can I call to get further clarification?

For information relating to what types of services are covered, reimbursement, and claims, please contact customer service at the insurer or your producer.

Whom do I ask about my bill?

Billing questions should be directed to Benefit Administration Company.

My renewal?

Specific questions about your renewal, including definition of terms and the difference between options should be directed to your producer. Renewal information is provided by Wells Fargo Insurance Services USA directly to your producer. If you believe you should have received renewal paperwork and have not yet received it, please contact your producer.

New Groups

Where do I find out about the status of quote?

Please contact your producer for the status of your quote.

How do I verify that my enrollment has been processed?

Please contact Benefit Administration Company for enrollment questions. Benefit Administration Company will be able to confirm if enrollment has been processed and what the effective date of coverage is. However, Benefit Administration Company is unable to answer premium rate or quote questions.

Enrollments/changes?

Please send enrollment/change questions to Benefit Administration Company. Enrollments should be submitted no later than the 20th of the month in order to be reflected on the following months billing. For example, changes that you want reflected on your May invoice need to be submitted to Benefit Administration Company by March 20.

Claims?

Questions about claims should be asked of the insurer. Please note that neither Benefit Administration Company nor Wells Fargo Insurance Services USA adjudicate claims nor do they have any information about pending, denied, or approved claims.

Pre-existing conditions?

Generally, pre-existing condition claims questions are handled by the insurer. If the insurer has told an employee there is a "prior coverage" issue, Benefit Administration Company can confirm with the insurer that prior coverage information submitted on the enrollment form has been communicated accurately with the insurer.

Credit for deductible paid to prior provider?
This question would be handled by the insurer.

Certificate of prior coverage?

If you need a certificate of prior coverage, please contact the insurer of that coverage. In general, Certificates of Prior Coverage will be sent to employee's homes directly after the termination of coverage for a qualified plan.

GLOSSARY OF TERMS

Asuris Northwest Health: Non-BlueShield subsidiary of Regence BlueShield. Provides healthcare coverage to people in Adams, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Grant, Kittitas, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla, and Whitman Counties where Regence BlueShield does not have approval from the Blue Cross and Blue Shield Association to use the BlueShield brand and logo.

Benefit Extension: For Groups who are not subject to COBRA there is a 6-month employee paid benefit extension available for health plan coverage.

Blue Cross and Blue Shield Association (BCBSA): A nonprofit corporation formed by Blue Cross and Blue Shield plans to act as the national coordinating agency for independent licensees of BCBSA. Located in Chicago, Illinois.

Carrier: Term used to describe the insurance company.

Centers for Medicare and Medicaid Services (CMS): A division of the federal Department of Health and Human Services that is responsible for the administration of the Medicare and Medicaid Contracts.

CHAMPUS: The federal health care program for military dependents and retirees.

Claim: Service rendered to the participant that is sent to the insurance company for payment.

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal regulation requiring certain employers to allow eligible employees and eligible family members to continue Group Health Options Inc care coverage when specific events occur that would normally result in loss of coverage.

Coinsurance: The member's percentage cost share for any benefits provided at less than 100%.

Coordination of Benefits (COB): A provision designed to avoid duplicate payments or payments in excess of charges for benefits covered under more than one individual or group contract.

Copay: The amount, in addition to the rate, that the member is required to pay for certain services and supplies provided under the contract. The member is responsible for the payment of any copay directly to the provider of the service or supply.

Cost Sharing: Provisions of a health insurance contract that require the covered individual to pay some portion of covered medical expenses. Forms of cost sharing are deductibles, coinsurance, and copays. In addition to being used to reduce rates, cost sharing is used to manage utilization of covered services (for example, by requiring a copay for a service that is likely to be overused).

Deductible: Members' stated portion of the cost of care before certain contractual benefits are paid.

Dependent: the subscriber's lawful spouse or domestic partner; a natural child, adoptive child, a child legally placed for adoption, stepchild, or legally designated minor ward of the subscriber who is

primarily dependent on the subscriber, spouse, or non-covered legal parent for support. Dependent children of or over a certain age (to age 25) can be excluded from coverage, unless they are incapacitated.

Diagnosis: The statement of a medical condition or disease, the cause of which may not be determined.

Effective Date: The date coverage begins.

Eligible Out-of-Pocket Expenses: a member's share of payment for benefits covered by a plan that is used for the accumulation of a stoploss provision.

Emergency: The sudden and unexpected onset of a condition or the exacerbation of an existing condition requiring medically necessary care to safeguard the patient's life or limb immediately after the onset of the emergency. For the purpose of benefit determination, consideration will be given to the symptoms of the condition and to the actions that would have been taken by a prudent person under such circumstances.

Employee Assistance Program (EAP): is a comprehensive program that helps employees resolve personal problems that may adversely impact their work performance, conduct, health and well-being.

Enrollment: The act of becoming covered under a contract; also the total number of members covered under a contract.

ERISA – Employee Retirement Income Security Act of 1974: A federal law primarily enacted to affect pension equality, ERISA also contains provisions to protect the interests of group insurance plan participants and beneficiaries. It requires, among other things, that insurance plans be established pursuant to a written instrument that describes the benefits provided under the plan, names of the persons responsible for the operation of the plan, and spells out the arrangements for funding and amending the plan.

Exclusions: Provisions in the contract stating situations, services, or conditions, for which benefits are not provided.

General Practitioner – GP: A licensed physician who is engaged in general practice including surgery, medicine, and obstetrics, but who does not specialize in a particular branch of medicine.

Group Health Options, Inc.: Group Health Options, Inc. was incorporated in 1990 as a wholly owned subsidiary of Group Health Cooperative. It offers a variety of health plans in Washington and Idaho that provide choice and flexibility to meet the needs of large and small employers. These range from a defined physician-network plan to point-of-service plans in which members can get care from outside the network for higher out-of-pocket costs.

HIPAA: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides expanded rights and protections for participants and beneficiaries in Group Health Options Inc plans. Understanding this amendment is important to your decisions about future health coverage. If you find a new job that offers health coverage, or if you are eligible for coverage under a family member's employment-based plan, HIPAA includes protections for coverage under Group health plans that:

- Limit exclusions for pre-existing conditions.

- Prohibit discrimination against employees and dependents based on their health status.

HIPAA Certificate: A HIPAA certificate is provided to verify continuous coverage. This certificate is issued as documentation of your prior health insurance coverage. Give a copy of your HIPAA certificate to your new employer's health insurance plan administrator to offset any pre-existing condition clauses and to verify you had no lapse in coverage.

Identification Card: The ID card presented to providers by participants to establish positive coverage identification. It does not give authorization for services nor is it a guarantee of payment.

Inpatient: A person confined overnight in a hospital or other facility as a regularly admitted bed patient to whom a charge for room and board is made in accordance with the hospital's or facility's standard practices.

Mandated Benefit: A benefit required by either State or Federal law to be included in the health care contracts.

Maximum Amount: Total dollar amount allowed under a contract.

Medically Necessary: A service or supply that is required to diagnose or treat the condition; is consistent with the symptoms of diagnosis and treatment of the condition; is the most appropriate supply or level of service that is essential to the need; when applied to an inpatient, it cannot safely be provided on an outpatient basis, including diagnostic studies; is not an investigational service or supply; is not primarily for the convenience of the patient or provider. Medical necessity is determined by the insurer.

Medicare – Title XVIII of the Social Security Act: The portion of the Social Security Act that provides health care benefits to citizens age 65 and older and to citizens who are disabled. Includes Medicare Part A (hospitalization) and Medicare Part B (medical and surgical benefits supplementary to Part A).

Medicare Beneficiary: An individual, who has attained the age of 65, is a resident of the United States and is either a citizen or an alien lawfully admitted as a permanent resident who has resided in the United States continuously during the five years immediately preceding the month in which he or she applies for enrollment under Medicare. The individual must also be eligible to enroll in the insurance program established by Medicare, and be entitled to hospital insurance benefits of the Medicare Program. May also be a disabled individual under age 65.

OBRA: An 11-month extension, not to exceed a total of 29 months of coverage provided to a qualified beneficiary who is currently on COBRA under an 18-month qualifying event. This extension is granted to qualified beneficiaries who have been deemed disabled by the Social Security Administration. The disability date, as determined by the Social Security Administration, must exist either prior to the COBRA qualifying event or at any time during the first 60 days of COBRA coverage. To take advantage of the extension, the qualified beneficiary must inform SHPS in writing of the determination before the expiration of the 18 months of COBRA and within 60 days of receiving it. The extension would be granted to the qualified beneficiaries covered under COBRA, not just to the individual that was deemed disabled. Premiums may increase to 150 percent of the active premium during the OBRA period.

Open Enrollment Period: The period once each year (usually 30-days prior to the groups' anniversary date) when employees can enroll for coverage or add dependents to their coverage. Coverage is usually effective on the anniversary date of the group's contract.

Out-of-Area Provider: A provider outside of the service area, acting within the scope of that provider's license who belongs to a category of providers whose services or supplies would be covered if furnished in the service area. The out-of-area provider must have qualifications and license or certification equivalent to the qualifications and license of certification required for comparable provider category inside the service area.

Outpatient: A patient who is not officially admitted as an inpatient, but who receives hospital care without occupying a hospital bed overnight.

Paid through Date: The date your coverage will terminate if you do not make subsequent payments.

Participating Provider: A provider who entered into a current participating agreement with the insurer and whose name is included on the current updated list of participating providers for that contract as prepared by the insurer.

Probationary Period: The period of time during which a new employee is not yet eligible for benefits.

PHI - Protected Health Information: Protected health information (PHI) under HIPAA means individually identifiable health information. Identifiable refers not only to data that is explicitly linked to a particular individual (that has identified information). It also includes health information with data items, which reasonably could be expected to allow individual identification.

Provider: An individual, institution, or organization, qualified to provide medical care services or supplies (e.g., hospital, physician, or skilled nursing facility).

Regence BlueShield: A health care service contractor in Washington State. Also an affiliate of the Regence BlueShield Group. It provides medical, surgical, hospital, prescription drug, vision, and or dental benefits on a prepaid basis to individuals and groups in Clallam, Columbia, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Klickitat, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, Walla Walla, Whatcom, and Yakima Counties. Corporate headquarters are located in Seattle, Washington.

Registered Nurse: A nurse who has passed the state board qualifying examination and who has been registered and legally licenses to practice by state authority.

Renewal: The period each year when benefits and or rates may be adjusted for the next contract year. The renewal date is usually the same as the contract anniversary.

TEFRA: A federal law that amends the Age Discrimination in Employment Act of 1967 by requiring any company with 100 or more employees to offer the same health benefits to employees and spouses aged 65 and over that is provided to younger employees.

Third-Party Administrator: An organization that provides certain administrative services to group benefit plans, including premium accounting, consolidated billing, and maintenance of employee eligibility records in the case of Business Health Trust.

TRICARE: Nationwide Department of Defense (DOD) managed care program, operated in partnership with civilian contractors, that is designed to ensure high-quality consistent health care benefits; preserve beneficiaries' choice of health care providers; improve access to care and contain care costs. The program offers a choice of health maintenance organization, a preferred provider organization, or a fee-for-service program (the former CHAMPUS program).

Waiting Period: The period of time between the members' effective date of coverage and the date that the insurer will provide benefits for certain services.

USERRA: The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) provides for the continuation of health plan coverage for up to 18 months for those persons on military leave. Because this overlaps with COBRA, there was no functional difference between COBRA and USERRA.

APPENDIX A

CONTACT LIST



Business Health Trust – Endorsed Sponsor Product Representatives		
Nathan Edmondson Phone: 206.892.9576 Fax: 866.972.2881 nathan.edmondson@wellsfargo.com Greater Seattle Chamber of Commerce, Greater Spokane, Inc., Tri City Regional Chamber	Jeffrey Johnson Phone: 253.396.5507 Fax: 253.396.4507 jjohnson@bbtacoma.com South Sound & Tacoma Pierce County Chamber	
Wells Fargo Insurance Services USA USA, Inc. – Accredited Broker Services		
Customer Service Broker Line: 206.892.9562 Fax: 866.972.2881 601 Union St. Suite 3400 Seattle, WA 98101	Send quote submissions to: bht.ins@wellsfargo.com Send renewal or new business submissions to: programservices@wellsfargo.com www.BusinessHealthTrust.com	
Wells Fargo Insurance Services USA USA, Inc. – Quality Control & Operations		
Keith VanderZanden Sr. VP and Managing Benefit Consultant Phone: 206.892.9582 keith.vanderzanden@wellsfargo.com	Colette Graddy Operations Supervisor Phone: 206.892.9579 colette.graddy@wellsfargo.com	
Benefit Administration Company (BAC) – Third Party Administrator		
Customer Service Billing Phone: 206.812.1325 ext. 319 Broker Commission Phone: 206.812.1325 ext. 323 PO Box 2735 Seattle, WA 98111-2735 bhtadmin@baclink.com	Korri Marie Treves Administration Manager Phone: 206.812.1325 ext. 251 ktreves@baclink.com	
Regence Blue Shield & Asuris Northwest Health – Medical Insurance		
Broker Support Phone: 206.464.7822 1800 Ninth Avenue, PO Box 21267 Seattle, WA 98111-3267 www.regence.com	Carolyn Thompson Membership/Accounting Phone: 800.343.8915, x2978 Fax: 888.734.3807 carthomp@regence.com	Diane Fisher Back-up membership/accounting Phone: 800.343.8915, x3565 Fax: 888.734.3807 dfisher@regence.com
Group Health Options, Inc. – Medical Insurance		
Customer Service Phone: 888.901.4636 320 Westlake Avenue, Suite 100 Seattle, WA 98109-5233 www.ghc.org	William Wiggins Account Manager Phone: 206.448.4127 Fax: 206.877.0655 wiggins.w@ghc.org	Jennifer Dhaliwal Account Specialist Phone: 206.4177 Fax: 206.877.0655 dhaliwal.j@ghc.org

Washington Dental Service (WDS) – Dental Insurance		
Customer Service Phone: 800.554.1907 9706 4 th Avenue NE Seattle, WA 98115 www.deltadentalwa.com	Nancy Buchanan Client Account Coordinator Phone: 206.528.7334 Fax: 206.985.7145 nbuchanan@deltadentalwa.com	Carol Rawlings Group Administration Rep Phone: 800.572.7835, x3574 Fax: 206.685.6734 crawlings@deltadentalwa.com
Dental Health Services (DHS) – Dental Insurance		
Customer Service Phone: 800.248.8108 936 N. 34 th Street, Suite 208 Seattle, WA 98103 www.dentalhealthservices.com	Toby Miller Group Service Specialists Phone: 206.788.3412 Fax: 206.624.8755 tmiller@dentalhealthservices.com	Thuha Nguyen Sales and Service Coordinator Phone: 206.788.3414 Fax: 206.788.3415 tnguyen@dentalhealthservices.com
VSP (Vision Service Plan) – Vision Insurance		
Customer Service Phone: 800.877.7195 333 Quality Drive Rancho Cordova, CA 95670 www.vsp.com	Eligibility Phone: 1.866.213.2249 Fax: 916.463.3914 fieldclientwestteam@vsp.com	Deborah Suchoski Account Manager Phone: 206.623.5178 Fax: 206.621.7515 deborah.suchoski@vsp.com
Regence Life and Health – Basic Life, AD&D, Voluntary Life & AD&D and Disability Insurance		
Customer Service Phone: 800.794.5390 100 SW Market St., M/S E3A Portland, OR 97207 www.regencelife.com	Cindy Funk Lead Account Representative Phone: 206-332-5801 Fax: 206-332-6779 clfunk@regence.com	
Wellspring Family Services EAP – Employee Assistance Plan		
Customer Service Phone: 800.553.7798 1900 Rainier Avenue South Seattle, WA 98144 www.wfseap.org	Ed Emerson Director Business Development Phone: 206.903.2302 Fax: 866.495.0441 eemerson@wfseap.org	
21 st Century Legal Plan – Legal Services		
Customer Service Phone: 425.882.7805 Fax: 206.542.5107 11426 238 th Street SW Woodway, WA 98020	David Sadick Attorney-at-Law Phone: 206.443.0800 Fax: 206.682.5556 djlawoffice@comcast.net	

For updated contact information please go to our website www.businesshealthtrust.com and select the



Program Management Provided By

Wells Fargo Insurance Services

Business Health Trust (BHT) Employee Benefit Program

2009 - 2010 UNDERWRITING GUIDELINES

Agent/Broker Eligibility

1) All agents and brokers must be fully accredited through Wells Fargo Insurance Services USA to promote Business Health Trust's (BHT) products and services. Among other requirements, all agents and brokers must maintain all endorsed insurance carriers appointments. Please reference the BHT Accreditation Agreement for a list of requirements and further details.

2) All accredited agents and brokers are required to obtain and maintain dues membership with one or several of the BHT endorsed sponsors. Accredited agents and brokers are eligible to request and receive quotes without becoming a dues paying member of an affiliated BHT endorsed sponsor, however, membership must be secured at the time of the insurance placement with BHT. No commissions can be paid until the accredited agent or broker becomes an active, dues-paying member with the applicable endorsed sponsor. It is the responsibility of the accredited agent or broker to ensure their membership status is active.

3) Broker of Record Letters and Letters of Authorizations (Search Letters) will only be accepted from fully-accredited BHT agents and brokers. Broker of Record letters from accredited agents/brokers will be processed within 2-3 business days of receipt and will become effective the first of the month following the date of receipt (for commission purposes). All Broker of Record Letters must be dated within thirty days of receipt to be valid. Broker of Record changes require the agent/broker to be fully accredited with BHT. Among other requirements, the agent/broker must have one active group with BHT at time of transfer.

Group Eligibility

- 1) All groups must be an active, dues-paying member of a BHT endorsed sponsor. Proposals issued to qualified prospective groups are released on the condition that membership will be secured by the prospective group prior to the insurance placement with BHT. Proof of membership is required.

- 2) An enrolling group must be headquartered in Washington state. Additionally, at least 51% of the enrolled employees must reside in the areas serviced by The Regence Group. For Group Health Options coverage, 80% of all covered subscribers must reside within the Group Health Options service area. There can be no more than 10% of the group enrolled in any specific state outside of the service area.

- 3) Annual tax forms are required for groups with 2-3 employees. The employer must satisfy the definition of "Small Employer" as stated under ESHB 1046 and submit the necessary tax forms.
 - A. IRS Form 1040 with Form 1065 and Schedule K-1 (for partnerships)
 - B. IRS Form 1040 with Schedule F (for farms)
 - C. IRS Form 1120 or 1120S (for corporations)
 - D. 5208 Quarterly Wage and Tax Form
 - E. For partnerships, if a married couple has filed a joint IRS Form 1040 and one spouse has a separate business or occupation from the one applying for coverage, copies of that spouse's W-2, 1099 or business tax return may be required.
 - F. Nonprofit groups that do not file any of the above tax forms may instead submit copies of Washington State Employee Quarterly Tax Form 5208 Parts A and B to verify an employee's work status.

- 4) Sole proprietors and partners are eligible for coverage if they are full-time, active in the business and 75% of the owner's income is derived from the business.

- 5) All BHT selected product offerings must have the same anniversary date. Additional lines of coverage can be added off-anniversary however these policies will renew on one common renewal date.

- 6) Groups that fall under the Regence BlueShield Restricted Industry designation have additional criteria that must be met to be eligible for coverage through BHT. To review a list of restricted industries and the additional guidelines surrounding these industries please execute the following link: [Restricted Industry Quoting Profile](#).

Employee Eligibility

- 1) An employer-employee relationship must exist. An eligible employee must be permanent, full-time and work a minimum of 20 hours per week. Commissioned salespeople and independent contractors whose earnings are reported on IRS form 1099 are not considered eligible employees. Eligible employees must be reported on the company's regular payroll and appear on their quarterly report of wages filed with the Washington State Employment Security Department. Documentation sustaining this relationship may be required.
- 2) Employees who choose not to enroll themselves or their dependents when initially eligible, must wait until the next open enrollment unless a qualifying event occurs. For supplemental life, guarantee issue amounts are only available to new employees within the first 31 days of eligibility. A member group can only make changes to their eligibility hours or probationary period at their anniversary date.
- 3) The Business Health Trust administers common eligibility between all lines of coverage. Dependent eligibility must flow through the enrolled subscriber (employee). To clarify, if a spouse (or domestic partner if applicable) or dependents are to be covered, their coverage must be identical to the subscriber's (employee's) coverage.
- 4) Retirees, including early retirees, are not eligible for coverage unless otherwise specified.
- 5) Group eligibility policies may vary by employer. BHT only requires the employer to meet the minimum eligibility qualifications.

Additional Guidelines and Assumptions

- 1) The company must contribute a minimum of 75% towards the employee premium. For non-contributory products such as basic life/AD&D, the employer must pay 100% of the employee premium.
- 2) A minimum of 75% of all eligible employees must participate within each member group. Employee waivers will be required. Qualified reasons for waiving coverage are coverage under spouse, TRICARE, Medicare as primary, collective bargaining unit, Christian Scientist or under COBRA provisions.
- 3) The minimum group size to offer bundled medical, dental or basic life/AD&D plan is 2 enrolling employees. Bundled vision coverage is available to groups of 3 enrolling employees or more. Disability coverage is available for groups of 5 or more enrolling employees. The maximum group size eligible for coverage is 149 employees.
- 4) Broker commissions are 5% for medical, WDS dental, vision and compulsory life/AD&D. For additional commission details please reference the following link: [BHT Broker Commission Schedule](#).

- 5) A minimum of \$15,000 basic life/AD&D coverage is compulsory and must be included with all medical products offered through BHT. The EAP plan is not compulsory however it can only be purchased when a BHT medical plan is also selected.
- 6) WDS Dental, vision, life/AD&D and disability coverage may be sold on a stand-alone basis, as long as the group has a minimum of 10 enrolling employees. The minimum group size to offer Dental Health Services products is two 2 enrolling employees.
- 7) Rates will be guaranteed for twelve months, regardless of the group's effective date with the exception of products added off anniversary. This assumes there are no regulatory or related legislative changes that affect the benefits provided through BHT.
- 8) Groups of 10 or more may select dual choice within Regence BlueShield/Asuris Northwest Health product offerings. A minimum of 2 employees must enroll on each plan. Please see the [BHT Dual Choice – Regence](#) or [BHT Dual Choice – Asuris](#) for available plan combinations.
- 9) Groups of 10 or more may select dual choice within the Group Health Options product offerings. A minimum of 5 employees must enroll on each plan. Each BHT Group Health Options plan can be offered in combination with another.
- 10) Dual choice between Regence BlueShield/Asuris Northwest Health and Group Health Options is allowed for any group renewing or sold, assuming 75% of eligible subscribers enroll with Regence/Asuris and a minimum of 5 employees enroll on each plan. Regence/Asuris H.S.A. products cannot be offered alongside any Group Health Options product. The rate variation between the two products cannot exceed 10%.
- 11) Rates quoted assume that none of the deductible, coinsurance or co-payments will be self-insured by the company, except those specifically identified as such.
- 12) New business paperwork, along with a copy of the Broker of Record letter, is due no later than the 20th of the month prior to the effective date (except for January 1 renewals which are due on the 10th of December).
- 13) Requests for proposals received after the 10th of the month prior to the requested effective date may be declined.
- 14) A copy of either a Letter of Authorization (Search Letter) or Broker of Record Letter may be requested from each accredited agent or broker in a multiple quoting scenario.
- 15) BHT reserves the right to adjust rates for a new member group if any information is different from the original quote. BHT reserves the right to decline coverage if the group does not meet all the established underwriting guidelines.

BHT Non-Compete Provisions

- 1) The Regence BlueShield/Asuris Northwest Health non-compete rules apply to BHT. For an overview of these rules, please access the following link: [Regence BlueShield/Asuris Northwest Health Non-Compete Policy](#).
- 2) The Group Health Options non-compete rules apply to BHT. They are:
 - A. Groups currently covered under a medical plan underwritten directly by Group Health are eligible for Association coverage, provided the Group has been a member of the Association for at least six months, and meets all other requirements for coverage. Quotes must be developed and approved by the Group Health Underwriting department. Rates will not be lower than the current and renewal direct quote. At first renewal, rates will be based upon the overarching Business Health Trust renewal. No quotes will be allowed for groups off anniversary.
 - B. Groups of any size that are currently covered by a Group Health Association may be eligible for coverage through another Association plan underwritten by Group Health, as long as the Member Firm has been a member of the other Association for at least six months, and meets all other requirements for coverage of the other association and Group Health. Quotes must be developed and approved by the Group Health Underwriting department. No quotes will be allowed for groups off anniversary.
 - C. Groups of any size that are currently covered by a Group Health Association have the right to request a quote for a direct contract. For small groups (under 50 employees) they will be offered the in-force plan and rate options filed with the State of Washington for small group plans offered at that time. For large groups, the group will be rated separately, but not give a rate that is lower than that being offered through the Association for a period of 12 months. If direct rating would produce a rate higher than the rate they were being offered through the Association, that rate will become the default rate for contracting directly with Group Health and Group Health Options, Inc.

Health Savings Account (HSA) Underwriting Assumptions

- 1) All underwriting assumptions previously released remain applicable, unless specifically superseded by the underwriting assumptions within this document.
- 2) In the event of dual option plans (wherein Regence BlueShield/Asuris is the sole carrier), the dual choice matrix must be followed.
- 3) The HSA plan cannot be offered alongside a medical plan underwritten by another carrier.
- 4) The employer may fund up to 100% of the deductible.
- 5) The rates do not include any transaction and/or administrative fees charged directly by the HSA administrator.
- 6) Rollover funds combined with HSA contributions cannot exceed federal limits.

7) The HSA product is only available in the Regence BlueShield/Asuris service area.

Additional Life and Disability Underwriting Assumptions

- 1) The guarantee issue for Basic Life/AD&D is based on group size. For groups of 5 to 9 employees, the guarantee issue is \$50,000. For groups of 10 to 49 employees, the guarantee issue is \$75,000. For groups over 50 employees, the guarantee issue is \$100,000.
- 2) The guarantee issue for Supplemental Life/AD&D is based on group size. For groups of 5 to 49 employees, the employee guarantee issue is \$25,000 and \$10,000 for spouses. For groups over 50 employees, the employee guarantee issue is \$50,000 and \$25,000 for spouses.
- 3) For Long Term Disability, evidence of insurability is required for employers with less than 6 employees.

This is a general overview of the Underwriting Guidelines for the Business Health Trust. Should there be any discrepancy, the contract between the Business Health Trust and the insurance carriers will be the determining underwriting document.

For the most recent version of the Underwriting Guidelines please go to our website www.businesshealthtrust.com and select the 2009 - 2010 Underwriting Assumptions & Guidelines found under the Broker Tab > Broker Reference Tools.

BHT 108_2009_10 Underwriting Guidelines

Revised 10/26/2009



LATE FEE POLICY

The Business Health Trust has a late fee policy for all premium remitted after the due date of the 20th. Please note this does not affect BHT's delinquency policy.

Here's an example of the late fee schedule for illustrative purposes:

May 20th June payment is due.

June 1-10th During the calculation of your July invoice, if your June payment was not received by the premium deadline (May 20th) a late fee may be added to the July invoice based on the fee structure below.

Late Fee Structure	
Company Size	Amount
< 15 employees	\$55.00
15 - 25 employees	\$75.00
26 - 50 employees	\$125.00
51 - 75 employees	\$200.00
76+ employees	\$225.00

All fees are assessed each month. If a group's balance is past due, the late fee will be charged for each period in which the invoice was outstanding.

If a late fee is assessed on an invoice and the premium is remitted without the late fee, payment may be returned "NOT PAID AS BILLED".

For the most recent version of the Late Fee Policy please go to our website www.businesshealthtrust.com and select the BHT Late Fee Policy found under the Broker Tab > Broker Reference Tools.



BILLING TIME FRAMES & DELINQUENCY POLICY

It is Business Health Trust's policy to receive premium payments prior to the coverage effective date. This document outlines the billing time frames and the subsequent delinquency policy if payment is received outside of the timelines.

Membership dues must also be in good status in or to maintain participation in the program. If you are delinquent on your membership dues, your premium may not be considered to have been paid and your coverage may be pended or delayed. If you are invoiced monthly for your dues, your premium will not be posted without your dues payment.

Groups may be termed for non-payment per the delinquency policy. Checks returned for Non-Sufficient Funds (NSF), Account Closure, or Payment Stopped will not be considered as having been paid in terms of the delinquency timeline. If any of these events occur, a group must provide a Cashier's Check or Wire Transfer with proof that the business is still active. If payment is not received within the payment due period the groups coverage will be pended. If payment is not received by the end of the coverage month coverage will be terminated retroactively to the last paid-thru date.

Employers who collect employee deductions for employee or dependent coverage and do not promptly pay those premiums towards coverage may be in violation of ERISA and subject to penalties. The timeliness of payments may also affect COBRA coverage, if you are responsible for forwarding COBRA premium on your former employees' behalf. Their coverage is dependent on being in good standing with their coverage premiums. If either situation applies to your group please contact your legal advisor for more information. Business Health Trust, its Program Manager, and its Billing Administrator are not tax or legal consultants and cannot provide further information on your responsibilities.

There are two steps followed for cancellation due to lack of premium payment

1. Letter sent requesting payment
2. Letter sent notifying group of cancellation

Example for May Invoice

April 1-10	May invoice is calculated and mailed
April 20	May payment is due – payments after this date are considered late
June 1	Group is considered delinquent if May premium is not received. □ Letter is sent to the group requesting payment of all past due premiums within 10 days, broker is also included on this communication
June 11	Notification of retroactive termination sent to group, broker, program manager, endorsing sponsor, and all applicable carriers

If a group is delinquent three times in a calendar year, the third notification will instruct the group to pay in full within 10 days. If a group is delinquent four times within a calendar year, they may be terminated.

Payment in full is due by the 20th of the prior month; for example, payment for May benefits is due April 20. Payment received after the cutoff period is considered late and may be subject to late fees and the temporary pending of coverage by the carrier until payment is received. If payment is not received by the last business day of the coverage month, the group will be considered delinquent. The group will be notified in writing that if payment is not received within 10 days from the date of the letter the group will be terminated for non-payment. If a group is delinquent four times within a calendar year, they may be terminated.

If a group is terminated for non-payment, they have one reinstatement opportunity, which must occur within 60-days of the last paid thru period. Reinstatement will be at the discretion of the insurers and must be requested in writing and submitted to the billing administrator. If group is not reinstated, they cannot reapply for coverage thru the program for 12 months.

For the most recent version of the Billing Time Frames & Delinquency Policy please go to our website www.businesshealthtrust.com and select the BHT Delinquency Statement found under the Broker Tab >

IF SUMMARY PLAN DESCRIPTION INFORMATION

for Plan Participants and Beneficiaries of the
BUSINESS HEALTH TRUST
as of January 1, 2009

This insert contains Summary Plan Description information for the programs and benefits provided to Plan Participants and Beneficiaries through the Business Health Trust (the "Plan"). The benefits provided by the Plan (including information about who is eligible to receive benefits) are summarized in the booklet or benefits summary issued by the insurance provider providing the benefits. This insert is intended to be read in conjunction with and as a supplement to the benefit summaries and other plan documents that may be provided to you.

Plan Administrator.

The Plan is administered by your Employer (the Plan Administrator).

Plan Administrator's Discretion.

The Plan Administrator is the named fiduciary under the Plan. In exercising fiduciary responsibilities, the Plan Administrator will have discretionary authority (a) to determine whether and to what extent Participants and Beneficiaries are entitled to Plan benefits, and (b) to construe the Plan terms. The Plan Administrator will be deemed to have properly exercised such discretionary authority unless the Plan Administrator has abused his or her discretion hereunder by acting arbitrarily and capriciously.

Plan Sponsor.

The sponsor of this Plan is the Business Health Trust and your Employer as a member of an Endorsing Sponsor of the Trust. You may receive from the Plan Administrator, upon request, information as to whether your employer is a sponsor of the Plan and if so, the contact information for your employer.

Employer Identification Number and Plan Identification Number.

The employer identification number as assigned by the Internal Revenue Service to the Trust is 36-741494. The Plan Number is 501.

Plan Year.

The Plan Year is October 1 through September 30. All records of the Plan are maintained on this Plan Year.

Type of Plan.

This is an insured employee welfare benefit plan. Each benefit under the plan is administered by the insurance provider for that benefit, as described in the applicable booklet or benefits summary. The funding medium through which benefits are provided is a trust called the Business Health Trust (the "Trust"). The Trust is a multiple employer welfare arrangement established and maintained by Endorsing Sponsors. The primary function of the Trust is to act as the policyholder of the group policy issued by the insurance provider. The insurance provider is responsible for payment of claims according to the coverage levels described in the applicable booklet or benefits summary. Each eligible Employer shall pay to the Trust the amount of contributions required to maintain coverage for the Employer's Participants. Depending on the program, contributions may be made either wholly or partially by your Employer, and either wholly or partially by the Participants.

Trustees:

The Trustees of the Trust and their address are:

Phil Bussey
Karen Davren
Emmy Jordan
Business Health Trust
1301 Fifth Avenue, Suite 2500
Seattle, Washington 98101-2611

Legal Service.

The name and address of the agent for service of legal process for the Plan is:

Business Health Trust
1301 Fifth Avenue, Suite 2500
Seattle, Washington 98101-2611

Legal process may also be served upon the Plan Administrator.

Eligibility.

To determine eligibility for participation for you and your beneficiaries for a specific program, please review the eligibility information contained in the summary of benefits booklet issued by the insurance provider for the specific program.

Termination of Participation.

Your eligibility for Plan benefits will terminate according to the terms in the booklet or benefits summary issued by the insurance provider.

If coverage for you or a Beneficiary ceases, you may be entitled to purchase up to six months of continuation coverage under the Plan. If coverage for you or a Beneficiary ceases because of certain qualifying events specified by federal law, then you or your Beneficiary may have the right to purchase continuing coverage for a period of time. Refer to your COBRA notice previously provided to you or

contact the Plan Administrator for information about qualifying events, qualified beneficiaries, premiums, notice, election requirements and procedures, and duration of coverage.

Continuation coverage of up to 24 months and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to USERRA. More information about coverage available pursuant to USERRA is available from the Plan Administrator.

Claims Procedure.

You or your Beneficiary must file the appropriate forms to receive any benefits or to take any other action under any of the programs, as described in the applicable booklet or benefits summary. Completed forms should be submitted to the appropriate entity described in the applicable booklet or benefits summary. Generally, you or your provider on your behalf will initiate a claim for benefits with the applicable entity administering the benefits program (the claims administrator or the insurance provider). Please review the booklet or benefits summary to determine exactly how to initiate a claim for benefits.

You must exhaust all of the claims review procedures described in the applicable booklet or benefits summary before you are entitled to initiate a lawsuit in state or federal court.

The appeals procedures are described in the applicable booklet or benefits summary. All levels of appeal have been delegated to the insurance provider that is responsible for paying the claims. The insurance provider's decisions are conclusive and binding. You are not entitled to appeal the decision of the insurance provider to the Plan Administrator.

Qualified Medical Child Support Orders.

If the Plan receives a qualified medical child support order recognizing the right of any child of a Participant to enrollment under the Plan, such child shall be enrolled as required under the terms of the order and in accordance with ERISA section 609. A "qualified medical child support order" is a medical child support order which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a Participant or Beneficiary is eligible under this Plan, and which clearly specifies the following:

(i) The name and last known mailing address of the Participant and the name and mailing address of each alternate recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a state or political subdivision thereof may be substituted for the mailing address of any such alternate recipient.

(ii) A reasonable description of the type of coverage to be provided to each alternate recipient, or the manner in which such type of coverage is to be determined.

(iii) The period to which the order applies.

An "alternate recipient" is any child of a Participant who is recognized under the medical child support order as having a right to enrollment under this Plan with respect to the Participant.

The Plan Administrator shall promptly notify the Participant and each alternate recipient of the receipt of such order and the Plan's procedures for determining whether medical child support orders are qualified medical child support orders ("QMCSO Procedures"). The Plan Administrator shall permit each alternate recipient to designate a representative for receipt of copies of notices that are sent to the alternate recipient with respect to a medical child support order. A Participant or Beneficiary may obtain from the Plan Administrator, without charge, a copy of the Plan's QMCSO Procedures. The following QMCSO Procedures shall apply when any medical child support order is received by this Plan with respect to a Participant:

(i) The Plan Administrator shall promptly determine whether the order is a qualified medical child support order, as defined in Section 609(a)(2)(A) of ERISA. The Plan Administrator shall promptly notify the Participant and each alternate recipient of its decision.

(ii) An alternate recipient under a qualified medical child support order shall be considered a Beneficiary under the Plan.

(iii) Any payment for benefits made by this Plan pursuant to a medical child support order in reimbursement for expenses paid by an alternate recipient or an alternate recipient's custodial parent or legal guardian shall be made to the alternate recipient of the alternate recipient's custodial parent or legal guardian.

ERISA Rights.

This statement of ERISA rights is required by federal law and regulation. As a Participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

a. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

c. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

d. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such

coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

e. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-800-998-7542.

Right to Amend or Terminate Plan.

Your Employer intends this Plan to be a continuing program but reserves the right to amend or terminate this Plan at any time and to terminate benefits thereunder.

For the most recent version of the Summary Plan Description please go to our website www.businesshealthtrust.com and select the BHT Summary Plan Description Information found under the Broker Tab > Broker Reference Tools.

BHT 107 Summary Plan Description

BUSINESS HEALTH TRUST

HIPAA PRIVACY & SECURITY POLICY

Dear Employer,

This letter will review Business Health Trust's obligations under the HIPAA Privacy and Security regulations.

HIPAA, the Health Insurance Portability and Accountability Act of 1996, was created (and further modified by the American Recovery and Reinvestment Act of 2009) in part to provide protection to individuals with regards to their health information. The regulations are enforced by the Office of Civil Rights and apply to covered entities such health plans, health care clearinghouses, and health care providers.

Under the current privacy and security regulations, the Trust does not have any compliance obligations:

- Ø The Trust is not a "Group Health Plan" covered under HIPAA because it is not a welfare benefit plan under ERISA;
- Ø The Trust does not use, create, transmit or otherwise disclose any Protected Health Information electronically, or otherwise;
- Ø Your Insurance Carriers and other service providers may use or disclose Protected Health Information;
- Ø The Trust is Not a "Business Associate" under HIPAA because it is a funding mechanism for securing access to group insurance.

Insurance Carriers and other companies that provide services to your group health plan must comply with the requirements that protect an individual's health information. You and your group health plan may have separate obligations with regards to the privacy and security regulations. The Trust cannot provide you with legal advice about compliance. For advice on the compliance obligations of your group health plan, please contact your legal counsel.

Sincerely,

Business Health Trust

For the most recent version of the HIPAA Privacy & Security Policy please go to our website www.businesshealthtrust.com and select the BHT HIPAA Privacy & Security Policy found under the Broker Tab > Broker Reference Tools.

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BHT 106 HIPAA Privacy & Security Policy

APPENDIX B

PREMIUM ONLY PLAN

Business Health Trust does not offer flexible benefit plan services. However, you may contract for such services provided by BHT's partner, Benefit Administration Company.

Premium Only Plan Overview

Flexible benefit plans are covered under Section 125 of the Internal Revenue Code. Often referred to as cafeteria plans, they provide plan sponsors and their employees with a simple and convenient solution for paying out-of-pocket premium with pre-tax dollars. A cafeteria plan is a written benefit plan maintained by an employer for the benefit of its employees.

Who May Sponsor a Plan

- q C-Corporation owners may sponsor and participate in a cafeteria plan.
- q Subchapter S-Corporation shareholders of more than 2% ownership may not participate in a cafeteria plan, but they may sponsor a plan for their employees. In addition, the family members and certain relatives of the shareholder may not participate.
- q Members of a LLC, LLP, and Sole Proprietorship may not participate in a cafeteria plan. However, they too may sponsor a plan for their employees. Additionally, in some cases, a member's spouse, if a bona fide employee of the company, may participate and benefit the other family members.

The term employee includes both present and former employees, but not self-employed individuals as described in section 401(c). The plan may not be established primarily to benefit key or former employees.

Employer Benefits

- q Immediate tax advantages. The employer saves 7.65% - the employer share of FICA taxes on the employee elected pre-tax benefit amount.
- q Delivers better control of payroll and benefit costs.
- q Improves employee perception and appreciation of the company benefit package. The employer is offering tax breaks to employees that would otherwise be unavailable to them.

Employee Benefits

- q Immediate tax advantages. The employee saves the 7.65% on their pre-tax benefit election as well as federal income tax (15% to 40% depending on the employee's tax bracket).
- q Increased take-home pay.
- q Increased awareness of their employer's benefits package.

Plan Compliance

- q Premium Only Plans require the adoption of a formal plan document and delivery of certain required employee communication pieces. In addition, the plan is subject to various IRS rules dealing with non-discrimination.
- q BAC is available to assist employers with all technical requirements.

FEDERAL LEGISLATION AFFECTING BENEFIT PLANS

Business Health Trust is a funding arrangement to access health and other employee benefits. It is not a group health plan. However, employers that provide benefits to their employees through the Trust may be sponsors of group health plans, and may have legal compliance obligations. The burden of compliance with most of the laws and regulations described in this section rests with the employer. We are not legal experts and do not presume to give legal advice. We urge you to contact your legal counsel regarding any questions about your responsibilities under these laws.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The Employee Retirement Income Security Act of 1974 (ERISA) became law September 2, 1974. The law provides protection for employees covered by private benefit plans, including both pension plans (which provide retirement benefits) and welfare plans (which provide other kinds of benefits such as health, dental, life, and accident).

ERISA provisions applying only to pension plans include eligibility and vesting rules, funding rules and plan termination insurance. ERISA provisions applying to both pension and welfare plans include standards for governing plan administration, reporting requirements to the Department of Labor, disclosure information to plan participants and enforcement provisions for compliance with ERISA.

ERISA regulations applying to welfare plans require that certain information be distributed to plan participants. This information is called the "summary plan description." It is the basic document that informs participants of the terms of their plan. In addition, for self-insured plans, ERISA usually pre-empts any state insurance laws and regulations. Sample materials for a summary plan description are available in the appendix of this guide.

MEDICARE SECONDARY PAYER PROVISIONS

Medicare secondary payer rules fall into several categories and determine the circumstances under which an employer health plan must provide benefits primary to Medicare. The significant provisions are outlined below. Note that the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) made revisions to the methodology by which employer groups determine their size for compliance; Employers who are unclear about how they are affected should contact their legal counsel.

THE "WORKING AGED" (TEFRA)

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), amended by the Deficit Reduction Act (DEFRA) and the Consolidated Omnibus Budget Reconciliation Act (COBRA), has significant provisions affecting health care coverage for employees age 65 and over—commonly referred to as the "working aged". Specifically, TEFRA amends the Age Discrimination in Employment Act of 1967 so that employers must offer active employees age 65 and over, and their spouses age 65 and over, the same Group Health Options Inc care plans as offered to younger workers. Medicare "carve out" plans, which allowed the employer plan to pay only to the extent not covered by Medicare, are no longer permitted if the group is subject to TEFRA.

DISABLED BENEFICIARIES ON LARGE GROUP HEALTH PLANS

The Omnibus Budget Reconciliation Act of 1986 (OBRA 86), amended by OBRA 93, provides that certain employer groups must pay benefits primary to Medicare benefits for disabled beneficiaries. This applies to all group coverage that the beneficiary may have as a result of his or her own current employment or the current employment of a family member.

END-STAGE RENAL DISEASE (ESRD)

Medicare provisions for end-stage renal disease patients were most recently amended by OBRA 93 and require that Medicare be the secondary payer for a specific time period for any individual eligible for Medicare due to end-stage renal disease. The Medicare Secondary Payer requirement applies to active and retiree plans, regardless of the beneficiary's original entitlement reason. For example, a Medicare beneficiary over age 65 who has end-stage renal disease would receive group benefits as primary for a specified time period from the date of the kidney transplant or the first dialysis treatment.

MSP APPLICATION TO THE BUSINESS HEALTH TRUST

Business Health Trust does not have a small employer exemption. All employers with health benefits thru the program are subject to MSP.

Employers should consult with their employment law or employee benefits counsel on compliance with TEFRA and the MSP Rules.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) amends the Internal Revenue Code, ERISA and other legislation and contains provisions that significantly affect employers with 20 or more employees in the preceding calendar year. Its provisions have been amended on several occasions. Effective July 1, 1986, the Act requires employer-sponsored Group Health Options Inc plans to provide certain employees and their dependents the opportunity to continue to participate in the employer sponsored health benefit plans after their coverage would otherwise cease. Coverage may continue for up to 18, 29, or 36 months, depending on the status of the beneficiary. In 1987, the IRS issued proposed regulations in a question-and-answer format to provide further guidance in COBRA issues. These proposed regulations continue to be helpful to employers, but it is important to note that they have never been adopted in final form and that they have not been amended in light of later changes to the COBRA statute. The employer may require the qualified beneficiary to pay both the employer and member share of the rates. All rate payments must continue to be submitted to us through your group's representative. Each member and his or her spouse must be notified of the continuation coverage options. COBRA also extended the "working aged" health benefits rules mandated by the Age Discrimination in Employment Act and TEFRA to employees over age 70.

The Department of Labor has issued the following information regarding The American Recovery and Reinvestment Act of 2009 (ARRA). The American Recovery and Reinvestment Act of 2009 (ARRA) provides for premium reductions and additional election opportunities for health benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly called COBRA. Eligible individuals pay only 35 percent of their COBRA premiums and the remaining 65 percent must be paid by the employer. The employer is reimbursed through a tax credit. Consult your benefits advisor or COBRA administrator for more information.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

PRE-EXISTING CONDITION EXCLUSION RULES

The health insurance provided through the Business Health Trust imposes a preexisting condition exclusion. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period prior. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan or who has other creditable coverage within 30 days after birth, adoption, or placement for adoption.

Under HIPAA and Washington law, this exclusion may last up to three months (nine months depending on the size of the group) from the first day of coverage or from the first day of the waiting period. However, individuals can reduce the length of this exclusion period by the number of days of their prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if the individual has not experienced a break in coverage of at least 63 days (in some cases under Washington law, up to 90 days). To reduce the exclusion period by your creditable coverage, the individual must provide a copy of any certificates of creditable coverage (HIPAA Certificates).

SPECIAL ENROLLMENT RIGHTS

For individuals who are eligible for enrollment in a Group health plan:

If an employee is declining enrollment for himself or herself or dependents (including his or her spouse) because of other health insurance or Group health plan coverage, he or she may be able to enroll himself or herself and his or her dependents in this plan if the employee or his or her dependents lose eligibility for that other coverage (or if, in the case of Group health plan coverage, the employer stops contributing toward his or her, or the dependents' other coverage.)

In addition, a special enrollment period triggered by a dependents loss of coverage provides a right for those already enrolled to change plans as long as it is offered by the group. However, the employee must request enrollment within 30 (or 60 days as defined by HIPAA) after his, her, or the dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If an employee gains a new dependent as a result of marriage, birth, adoption, or placement for adoption, he or she may be able to enroll himself or herself and his or her dependents. In addition, a special enrollment period triggered by a new dependent provides a right for those already enrolled to change plans as long as it is offered by the group. However, the employee must request enrollment within "31 days" after the marriage, or within 60 days after a birth, adoption, or placement for adoption.

PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION

HIPAA established rules to streamline health care administration and improve privacy and security protection for personal health information. Portability was implemented in 1997 as the first part of HIPAA. The regulations are enforced by the Office of Civil Rights and apply to covered entities such as health plans, health care clearinghouses, and healthcare providers. The Department of Labor, Centers for Medicare and Medicaid Services, and Health & Human Services released clarifications to the portability rules at the end of 2004.

Under the current privacy and security regulations, the Trust does not have any compliance obligations:

- Ø The Trust is not a "Group Health Plan" covered under HIPAA because it is not a welfare plan under ERISA;
- Ø The Trust does not use, create, transmit or otherwise disclose any Protected Health Information electronically, or otherwise;
- Ø Your Insurance Carriers and other service providers may use or disclose Protected Health Information;
- Ø The Trust is not a "Business Associate" under HIPAA because it is a funding mechanism for securing access to group insurance.

THE MOTHERS AND NEWBORNS HEALTH PROTECTION ACT

A federal law called The Mothers and Newborns Health Protection Act was passed to extend the usual length of a hospital stay for a new mother from 24 hours to two days. The law, effective January 1, 1998, is intended to ease concerns about "drive-through deliveries." We believe that the decision to discharge a new mother from the hospital should be made by the patient and her provider. There is nothing in our contracts that states hospitals must discharge mothers and babies after a certain amount of time.

A Washington State law, often referred to as the "Erin Act" of June 1996, also states that the decision about how much time a mother spends in the hospital is up to the patient and her provider. The Federal

Mothers and Newborns Health Protection Act will not have any impact in Washington State because the Erin Act is already in effect.

FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)

The federal Family and Medical Leave Act (FMLA) was signed into law in February 1993. The law took effect on August 5, 1993, and guarantees up to 12 weeks of unpaid leave each year to workers who:

- q Need time off for birth or placement of a child for adoption or foster care.
- q Need to care for a spouse or immediate family member with a serious illness, or
- q Are unable to work because of a serious physical or mental health condition.

The FMLA is an employer law—it covers employers with 50 or more employees and affects many job-related rights of employees. Among other things, this law also affects the health benefit plans maintained by employers that are required to comply. Employers are required by FMLA to continue to provide Group Health Options Inc benefits at the same level and under the same conditions as if the person had continued to be actively at work. A person entitled to COBRA continuation as a result of not returning to active employment following FMLA leave will be entitled to COBRA continuation coverage, the duration of which shall be calculated from the date the person fails to return from the FMLA leave.

For specific questions, call your account executive or contact the Department of Labor for a complete copy of the FMLA law and Department of Labor interim final rules.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

The Women's Health and Cancer Rights Act (WHCRA) provides protections for individuals who elect breast reconstruction after a mastectomy. Under WHCRA, Group Health Options Inc plans offering mastectomy coverage must also provide coverage for certain services relating to the mastectomy, in a manner determined in consultation with the attending physician and the patient. Required coverage includes all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedema.

Written notice about the availability of these mastectomy-related benefits must be delivered to participants in a Group Health Options Inc plan upon enrollment and then each year afterwards.



Administered by:
 Benefit Administration Company
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 T: (206) 812-1325, F: (206) 812-1326
www.baclink.com

SUPPLIES REQUEST

Request forms may be mailed, faxed, or emailed to bhtadmin@baclink.com Date: _____

Employer _____ Employer Location # _____

Requestor Name _____

Requestor Email _____ Requestor Phone # _____

Mailing address _____

	Plan Name	Quantity
Regence BlueShield - Medical		
<input type="checkbox"/> Booklet	_____	_____
<input type="checkbox"/> Summary	_____	_____
<input type="checkbox"/> Certificate	_____	_____
Asuris Northwest Health - Medical		
<input type="checkbox"/> Summary	_____	_____
<input type="checkbox"/> Booklet	_____	_____
Group Health Options Inc - Medical		
<input type="checkbox"/> Summary	_____	_____
<input type="checkbox"/> Booklet	_____	_____
WDS - Dental		
<input type="checkbox"/> Booklet	_____	_____
<input type="checkbox"/> Summary	_____	_____
DHS - Dental		
<input type="checkbox"/> Summary	_____	_____
<input type="checkbox"/> Booklet	_____	_____
VSP - Vision		
<input type="checkbox"/> Pamphlet	_____	_____
<input type="checkbox"/> Summary	_____	_____
<input type="checkbox"/> Certificate	_____	_____
Regence Life & Health – Life, LTD, STD		
<input type="checkbox"/> Summary	_____	_____
<input type="checkbox"/> Certificate	_____	_____
Legal		
<input type="checkbox"/> Summary	_____	_____
Wellspring - EAP		
<input type="checkbox"/> Summary	_____	_____
Consolidated Enrollment Forms		
<input type="checkbox"/>	_____	_____

BTA

Summary

Certificate

Voluntary Travel Accident

Summary

Certificate

Producer

Name

Phone #

Administrative Use

Sent by:

Date Sent:

New group

Delivery method:

Renewal

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