

IAC Group Health Plans

Simple Solutions for Small Group Employers

Producer Guide

Administered and Marketed by:



**Insurers Administrative
Corporation**

Independence Holding Group

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THE INFORMATION IN THIS PRODUCER GUIDE IS OF GENERAL NATURE AND MAY NOT CONTAIN STATE SPECIFIC VARIATIONS. PLEASE CONSULT THE CERTIFICATE OF COVERAGE, SCHEDULE OF BENEFITS AND RIDERS FOR ADDITIONAL DETAILS.

BECOMING A PRODUCER

Producer Agent Appointment Contracting Requirements

New Producers

Contact an IAC General Agent to determine licensing, appointment, and contracting rules for the state(s) in which you do business before submitting any group health plan applications. An IAC General Agent will need to recommend you for an appointment with the insurance companies and will become your contact for sales, service, and training. You must have a current life/health insurance license for the state(s) in which you do business, be in good standing with the Department of Insurance, and not have been convicted of a felony involving moral turpitude. Some states will allow a Producer to submit a request for an appointment to represent an insurance company at the same time as an initial employer group submission.

Several states require a Producer appointment to be completed before writing business. Consult your general agent for confirmation.

Before or upon submission of your first group case, please provide your IAC General Agent with each of the following documents, properly completed, signed, and dated:

- Legible photocopy of your current state life/health insurance license(s), and, if applicable, legible photocopy of your current state life/health agency insurance license(s)
- IAC Requisition for Appointment form and Fidelity Security Life Insurance Company (FSL) Agent Data Sheet
- IAC Group Insurance Plans Producer's Agreement form
- State-required appointment forms, if applicable

Non-resident appointments

Producers must also provide a legible photocopy of their life/health license for the state(s) for which they desire non-resident appointment. Standard Security Life Insurance Company of New York pays appointment fees for medical, life, and dental. The agent is responsible for the appointment fee for Fidelity Security Life vision.

You will be notified when the insurance carrier appointment is completed and you will be sent a copy of your executed Producer's Agreement. Until the insurance company completes your appointment, IAC may hold any commissions that are due.

You will receive notification of renewal of your appointment(s) and requests will be sent for updated copies of your insurance license.

Commissions

You will receive monthly commissions subject to the terms and conditions of the IAC Group Insurance Plans Producer's Agreement. Some states may have different commission rules. Please see the IAC Group Insurance Plans Producer's Agreement for complete details.

Commissions are paid on the 15th of the month for premium that has been received and posted, by the last day of the previous month, providing that the amount is greater than \$25. For amounts less than \$25, commissions will be paid when the amount accumulates to \$25.

If for any reason we refund any premium or part of a premium on any policy you have written, you will be required to repay to IAC any commissions you have received on that refunded amount. Such refunds may be shown as adjustments on your commission statement.

To continue to receive commissions, the case must remain in-force, the premiums must be paid, and you must actively service the account. Refer to your Producer's Agreement for further details.

QUALIFYING A GROUP

Employee Choice

Employers can allow their employees to choose different benefit plans to fit their needs, based on group size:

Groups enrolling 2-9 employees

- Employers can select up to three choices within one plan type
For example, employees can choose from three copay/deductible/out-of-pocket options within the same plan
- Employers can include an HSA Qualified Plan as one of their choices

Groups enrolling 10 or more employees

- Employers can select up to three plan designs (one plan or a mix of plans)
For example, 3 different plans can be offered. (When mixing plan types, a minimum of 20% participation in any one of the plan choices is required.)
- Employers can include an HSA-qualified plan as one of their choices

Industry Guidelines

Certain types of businesses are subject to a premium load for medical and maternity coverage, as they are considered a “non-standard” industry. If you are having difficulty classifying a group, please contact your IAC General Agent for assistance.

Non-standard industries*

Amusement Parks	Farms & Ranches	Pawn Shops
Arms & Ammunition	Florists	Pharmacies
Asbestos	Gambling-Related Businesses	Pool Halls
Attorneys	Gas Stations	Real Estate (Agents, Development, Mgmt)
Auto Repossession	Health Care Facilities & Practitioners	Religious Groups
Bail Bondsmen	Hotels	Restaurants
Barber & Beauty Shops	Liquor Stores	Sawmills & Logging
Barges	Massage Parlors	Schools
Bars	Mines & Quarries	Social Services
Building Cleaning Maintenance	Motor Vehicle Dealerships (Auto, Boat, RV, Cycle)	Transportation Services (Passenger)
Car Washes	Municipalities & Government Agencies	Trucking (Long Haul)
Clinics	Nursing Homes	Waste Management
Clubs	Oil & Gas Extraction	Wrecking & Demolition
Counseling Centers	Parking Lots	
Dance Halls		
Entertainers		
Exterminators		

*The above non-standard industry guidelines do not apply in the states of Alabama, Arizona, Iowa, New Mexico, Virginia and Wisconsin.

Obtaining a Proposal

Group proposals may be obtained only from your IAC General Agent by providing the following information:

- A complete census including gender, age and dependent status of each employee;
- Company name, address and nature of business;
- Desired plan design and PPO network; and
- Health history on all known medical conditions (see Pre-Screens section of this guide)

Many factors affect the final premium rate, including medical underwriting. As a result, proposals are for illustrative purposes only and valid for 30 days. Final rates will be determined after all required information is received and the underwriting process is completed.

Employer Eligibility

Only eligible employers who elect to participate in and adopt the Multiple Unit Security Trust (the Trust) for the purpose of establishing a group insurance plan for their eligible employees and their dependents may participate in the program. The employer is considered the plan administrator, as defined by the Employee Retirement Income Security Act (ERISA). The Trust is the policyholder of this plan of insurance.

Composite Rates

Composite rates are available for groups of 10 or more employees applying for medical coverage. Age and gender banded rates are available for groups of 2-50 employees.

Pre-Screens

An initial estimate of any premium load that may apply can be obtained by submitting a pre-screen. In order to calculate the load, if any, please disclose all known medical conditions (including medications being taken) of all employees and their dependents within the group. **A copy of the group proposal must be attached.**

Your IAC General Agent will work with IAC's underwriting team to determine how the health status information may affect the outcome of your proposal. Groups with exceptionally high risks may need to be reinsured through state reinsurance pools or be adequately reserved by the insurance company. As a result, groups that have any of the medical conditions shown in Table 1 (see below) will require a pre-screen evaluation.

Please allow a 48-hour turn around.

Table 1

<i>Health Condition</i>	<i>Parameters</i>
Alzheimer's Disease	Date diagnosed, current treatment, current mental status, assisted living
Alcoholism, Drug Addiction, Alcohol Abuse, or Substance Abuse	Currently drinking or using drugs, history of hospitalization or DUI within one year, date last used substance
Aneurysm	Date diagnosed, location, size, type of treatment
Brain Tumor or Abscess	Cancer type, stage I, II, III, size, type of treatments, recurrence or metastasis, date first diagnosed
Cancer – Malignant	Cancer type, stage I II III, size, type of treatments, recurrence or metastasis, date first diagnosed
Cardiomyopathy (Enlarged or Congestive Heart Disease)	Date diagnosed, type of treatments, prescriptions, cardiac function
Crohn's Disease	Date diagnosed, surgeries, hospitalizations, prescriptions
Cerebral Palsy	Date diagnosed, extent of physical or mental impairments, current treatments
Chronic Renal Failure	Present or history of dialysis, history of or planned kidney transplant
Congenital Heart Defects (i.e., Atrial Septal Defect, Ventricular Septal Defect, Tetralogy of Fallot, Patent Ductus Arteriosus)	Type of defect, type of treatments and dates, surgeries, current problems or limitations, current prescriptions
Cystic Fibrosis	Date diagnosed, current treatments and prescriptions, hospitalizations
Emphysema (COPD)	Date diagnosed, current use of oxygen, prescriptions
Gastric Bypass/Balloon	Date of surgery, complications, pre-surgical weight, current weight
Heart Attack, Myocardial Infarction, Coronary Artery Disease	Currently experiencing chest pain (angina), treated with nitroglycerin pending angioplasty or CABG. Prior treatments of angioplasty or CABG
Hemophilia	Date diagnosed, type of Hemophilia, prescriptions, hospitalizations
Hepatitis C	Date diagnosed, type/dates of treatments, completed Interferon, ribavirin treatment
Hemochromatosis (Iron Storage Disease)	Present with complications, spleen removed.
HIV+, AIDS, ARC	Date diagnosed, current prescriptions, infected with Hepatitis A, B, C or D
Huntington's Chorea	Present or history
Hydrocephalus	Date diagnosed, shunt placement, physical limitations
Leukemia or Hodgkin's Disease	Date diagnosed, type of Leukemia, current treatments
Liver Cirrhosis or Hepatic Failure	Date diagnosed, cause of cirrhosis, rectal bleeding
Lou Gehrig's Disease, ALS	Date diagnosed, extent of disability, biopsy, LFT
Lupus Discoid or Systemic	Systemic or Discoid Lupus, date diagnosed, hospitalizations, current prescriptions
Meningitis, Encephalitis	Present or with residual impairment
Multiple Sclerosis	Date diagnosed, current prescriptions, planned use of Interferon prescription
Muscular Dystrophy	Date diagnosed, type of Dystrophy, type of treatments and prescriptions, hospitalizations
Organ or Bone Marrow Transplants	Dates planned or completed, reason for transplant, current prescriptions
Parkinson's Disease	Date diagnosed, types of treatment, prescriptions
Paralysis	Severe or quadriplegia, date of occurrence, reason for paralysis, ventilator
Prosthetic Heart Valve	Present or contemplated, if present, date of placement
Pending or recommended surgery (any)	Diagnosis and procedure to be completed
Pregnancy	Twins or triplets (multiple gestation), treatment for pre-term labor, infertility treatment (dates/type)
Spina Bifida	Present or history
Stroke (CVA) (TIA)	Recurrent or with impaired mobility, balance or speech, date of occurrences
Suicide Attempt	Multiple attempts within one year, dates of attempts

Premium Rates and Rate Guarantee

The insurance company has the right to determine the premium rates available to new participating employers applying for the coverage under the policy.

Rate Guarantees

Each employer that is accepted for insurance under the group policy has an initial 6-month rate table guarantee. An initial 12-month rate table guarantee may be available, based on underwriting determination and applicable state regulations.

Premium Changes

Premiums may change during an initial rate table guarantee period if:

- The employer adds or deletes employees
- The employer moves to another geographic area
- The employer modifies the plan of benefits
- The benefits change due to new state or federal rules or regulations
- The PPO provider network fees, or other administrative fees, change

Groups with Multiple Locations

Groups with fewer than 10 employees

Simply quote the employer's main location for the entire group.

Groups with 10 or more employees

When **at least 50%** of the total eligible employees are in the home office, a request for blended rates from IAC is **not necessary**.

Simply quote the employer's main location for the entire group.

Multiple location groups qualify only if the secondary site(s) has a physical office location (i.e., not employees' homes). Any other situations require IAC home office approval before quoting.

If, when writing a multiple location group, the group has more than 25% of the enrolled employees in a state other than the employer's domicile state, the group will not be accepted. Any employer located in or has employees in New York are ineligible for coverage under the *Health Plan*.*

**There may be other states that are not eligible for coverage, please contact IAC.*

Replaced Plan Deductible Credit

Replaced plan deductible credit is available for employees and dependents that were covered under the employer's replaced plan the day prior to the employer's effective date of coverage under their Health Plan.

Replaced plan deductible credit is available for charges that were applied by the replaced plan towards an individual's calendar year deductible for the part of the calendar year that was immediately prior to the effective date of coverage under the *Health Plan*.

Replaced plan limitations

- Credit does not apply toward prescription drug expense, coinsurance, copays, out-of-pocket maximums, or any other deductible.
- Credit provided for coverage under the replaced plan is not intended to relieve a prior carrier of its responsibility to provide coverage for charges incurred by an insured person under the replaced plan's extension of benefits provision or conversion plan.

Eligibility Guidelines

Employers

Employers with 2-50 employees applying for coverage that are located in a state where the health plans are available are eligible. For employers with more than 100 employees, several plans are available on a self-funded basis. Contact your IAC General Agent for information regarding these plans.

For the purposes of defining an employer group, we rely upon federal agencies' interpretation of the federal Health Insurance Portability and Accountability Act (HIPAA) unless a state regulation would change the interpretation.

When Both Spouses are Covered Under the Same Group Plan

If both the husband and wife are eligible employees of the employer and not constituting the only two employees of the employer group, then:

- 1) Each person can apply as an employee. Insured dependent children may be covered under either employee, but not both.

or

- 2) The husband and wife employees can enroll as an employee and spouse. Whichever employee is oldest must be considered the employee for plan coverage/rating purposes. If the husband and wife employees are enrolling under employee and spouse coverage, Life Coverage will only be offered to the person considered the employee.

North Carolina Only

The following guidelines apply to one-person groups:

- Husband and wife groups with no other employees are considered one-person groups
- These groups are eligible only for the North Carolina Mandated Small Employer Health Benefit Plans (the Basic Plan, the Standard Plan or the Standard PPO Plan)
- These groups must be in business for at least one year *and* must show a profit in one of the past two years
- These groups must prove they are eligible for coverage. If we request documentation of eligibility and it cannot be provided, the group will be considered ineligible. Determination of a one-person group's eligibility is subject to investigation by credit bureau sources.

Additionally, these groups are required to provide the following documents

- A copy of the group's most recent North Carolina Quarterly Wage and Tax Report
- A copy of the group's most recent IRS Form Schedule C or F with line 31 showing a minimal profit
- An IAC Risk Assessment for Employer Groups form
- A North Carolina One- and Two-Person Group Underwriting Pre-screen Worksheet/Quote Request

Definition of employer

An employer is a sole proprietorship, partnership, or corporation that is actively pursuing business interests and is applying for coverage in connection with its own employee welfare benefit plan. An employer must complete a Trust Adoption and Participation Agreement agreeing to all the terms specified by us, meet the underwriting requirements, meet and maintain the trust and policy participation requirements, and meet all other requirements

of the state in which the Agreement is signed. The employer will be deemed the plan administrator for the purposes of compliance with and duties arising under the Employee Retirement Income Security Act (ERISA) and Consolidated Omnibus Budget Reconciliation Act (COBRA).

Ineligible small employer groups

- Employee leasing companies
- Seasonal, part-time, or temporary employment situations
- Two person groups consisting of just a husband and wife (this guideline does not apply in the states of NC, NV, OK, SC and TX)

Definition of an eligible employee

An eligible employee is an individual who is:

- 1) Working at least thirty (30) hours per week in the service of the employer at its usual place of business. (In AZ, an employee is an individual working at least the number of hours per week in the service of the employer as determined by the employer at the inception of coverage or the annual renewal date);
- 2) A partner or proprietor actively engaged in the business of the employer on a full time basis.
- 3) New employees who are added from time to time as they become eligible.
- 4) Compensated for such service by a regular periodic wage or salary that is subject to FICA and federal income tax withholding by the employer; and
- 5) A non-seasonal or temporary employee scheduled to work at least 9 months per year.

or

- 1099 employees are also eligible if they meet the following minimum criteria:
 - The 1099 Employee must have been in the employ of the group for at least one year on a permanent, full-time basis, working at least 30 hours per week (or as otherwise mandated by the respective State) for the group.
 - The employer group must have been the source of at least 80% of the 1099 employee's total income for the past year.
 - A copy of the 1099 employee's most recent federal income tax filing will be required at the time of initial underwriting to verify that these criteria are met and is also required every year at renewal.

- The eligible 1099 employees applying for coverage should not exceed 50% of the total number of eligible employees applying for coverage within a group. Otherwise, the group will not be considered eligible.

No director of a corporation shall be deemed an employee solely because of such a directorship.

Definition of dependent

Eligible dependents are an insured employee's:

- Lawful spouse.
- Unmarried Child who is primarily dependent upon the Insured Employee for support and maintenance and is:
 - a. Less than 19 years of age; or
 - b. Between 19 and 25 years of age; provided however, that the Child is dependent upon the Insured Person for support and maintenance and a full-time student actively attending an accredited college, vocational or high school. Full-time, as used in this definition, means actively attending at least 12 hours of class a week or, if less, attending the minimum hours of class the school considers as full-time status;

Effective Dates of Coverage

Plan Waiting Period: When initially applying for coverage, the employer chooses a plan waiting period employees must satisfy before they become eligible for benefits under the group health plan. Generally, an employer will choose a waiting period of 30, 60, 90 or 180 days, depending on the nature of their industry. Some states, however, mandate a maximum waiting period (e.g., North Carolina, Iowa and Ohio mandate a maximum waiting period of 60 days). Employees are deemed eligible for benefits the 1st of the month following the plan waiting period chosen by the employer.

Employer groups may request that coverage become effective either the 1st or the 15th of the month. To accommodate a requested effective date, **underwriting must receive a fully completed employer group submission by the first of the month of the requested effective date.** If received after the 1st of the month, a later effective date may be

implemented. A request for a specific effective date is not a guarantee. There may be situations that prevent us from making an offer for a requested effective date. Should this occur, the coverage will be made effective the 1st of the month following the date we are able to make an offer of coverage. Applications that are more than 60 days old upon receipt will be returned to the producer.

Note: If a 15th of the month effective date is selected, one month's premium is required with the case submission. Once the case is issued, the premium due date will revert to the first of the following month and thereafter. Refer to Billing Date for additional details.

Important: Always advise your clients to continue their current health coverage with their present carrier until IAC notifies you that the group is approved for coverage.

Waiving of Waiting Period is not allowed.

Late Applicants

A person who declines coverage during an initial enrollment period or who requests coverage outside of an initial enrollment period is a late applicant. Applicants who are eligible under HIPAA and who qualify for a special enrollment period because of a "qualifying event" will not be considered late applicants, unless coverage is not selected during the special enrollment period. Qualifying events include loss of coverage due to legal separation, divorce, death, termination of employment, or a reduction in the number of hours of employment. The following qualifying events apply to eligibility of new dependents: marriage; birth; adoption and placement for adoption. Employees and their new dependents may be added following one of these qualifying events within 30 days of the event.

Loss of eligibility due to failure to pay premiums on a timely basis or by our termination of coverage for cause does not fall under the definition of a qualifying event under HIPAA. (Examples of a loss of coverage for cause include the making of a fraudulent claim or an initial misrepresentation of fact in connection with a group health plan.)

A late applicant's coverage:

- **Approval date** will be the first of the month following the date we receive the application for coverage.

- **Effective date** will be the first of the month following the approval date. However, covered charges will be subject to the pre-existing limitation period described below.
- **Pre-existing limitation period** will be the eighteen (18) consecutive months following the approval date. During the pre-existing limitation period, any eligible charges incurred in connection with a condition that was pre-existing within the 6-month period preceding the applicant's "approval date" will not be covered.

The pre-existing limitation period may vary by state.

Pre-Existing Condition Limitation Credit

An insured person who has creditable coverage as defined by HIPAA to a date no more than 63 days (or more, if required by state law) before the enrollment date under the *Health Plan* will be given credit for the full or partial satisfaction of a pre-existing condition limitation waiting period by such creditable coverage. Pre-existing condition limitation waiting periods under this plan will be reduced to the extent of the insured person's prior creditable coverage.

Employee & Dependent Unit Participation & Maintenance Requirements

Who must apply?

All eligible employees are expected to apply for coverage during the employer's initial enrollment period, including those who may not be eligible for coverage yet because they are still in their plan/eligibility-waiting period.

Waiving the benefit waiting period for initial enrollment

Although optional, we encourage the employer to waive the "plan/eligibility waiting period" at the initial enrollment period to maximize plan participation. After the initial enrollment period, the waiting period cannot be waived.

Employee and dependent participation requirements

Test 1

In calculating the employee and dependent percentage of participation:

- Employees and dependents that have other group health coverage under a creditable group health plan as defined by HIPAA or state law are not counted when determining the percentage of participation.
- Each individual who is "eligible" but is not applying for group health coverage and does not have other group health coverage is counted when determining the percentage of participation. All individuals and their dependents not applying for coverage must complete the Waiver of Coverage section on the application. Individuals who waive coverage during the employer's initial enrollment period but subsequently apply for coverage will be considered late applicants (see Late Applicant section of this guide for additional information including special enrollment situations).
- Subtract the number of employees waiving coverage due to having other coverage from the total number of full-time employees to determine the number of "eligible" employees in the group.
- Divide the number of remaining full-time, eligible employees applying for coverage by the number of employees applying for coverage to determine the percentage of participation.

Test 2

- Divide the number of "all employees", regardless of whether they are applying for coverage, by the number of "full-time employees" who are applying for coverage. This is your percentage of participation. We expect that 50%* of all full-time eligible employees will participate, regardless of waivers.

The following table shows the minimum required participation* by number of eligible employees, for both the employee and dependents:

Group Size	Employee Participation	Dependent Units (No Maternity)	Dependent Units (With Maternity)
2-4 Employees	100%	50%	N/A
5-9 Employees	75%	50%*	75%*
10+ Employees	75%	None	None

*Not applicable in Texas, Oklahoma, or any other state where participation requirements are otherwise mandated.

Dependent Unit

For purposes of defining dependent participation, count “one” dependent unit for each employee applying for coverage with a dependent spouse or dependent spouse and child(ren).

Participation Maintenance Requirements

An employer must maintain at least the minimum employee and dependent participation requirements of the plan that were in effect at the time the employer application was submitted. Periodically, the employer will be requested to assist in the verification of employee participation by providing documentation, such as a copy of a state quarterly unemployment tax report or other documentation. Failure to cooperate with the participation verification or failure to meet minimum participation requirements may result in coverage termination or loss of protection under HIPAA.

Employee and/or Dependent Carve-Out Groups

As a special underwriting accommodation, we may consider employer groups that desire to “carve-out” a subset of the employees to apply for coverage if:

- The employees to be covered can be clearly identified as being subject to a collective bargaining agreement that provides for their health and welfare or as a group of employees who can be clearly characterized as a distinct class of employee; and
- The total number of employees to be covered is greater than 10.

Employers who desire to specifically exclude coverage for dependents for the entire period that coverage remains in force, may also be considered. The availability of “employee only

coverage” will be determined based on the applicable regulations for the state in which the business is domiciled. A letter on the employer’s official letterhead requesting that no dependent coverage is desired for the duration of the plan is required.

SUBMITTING A GROUP

Employer Group Submission Documentation

- Employer application
- Employer Benefit Selection Form
- A business check from the employer in the sum of the first month’s payment
- Employee applications for **all** employees whether they are requesting coverage or declining coverage; if an employee is currently on COBRA, the COBRA election form is required.
- A copy of the employer’s most recent state quarterly unemployment tax report containing employee names, social security numbers, and earnings. Please include the summary page and the wages page with the totals listed on the bottom of the page.
 - If a quarterly wage and tax report was not filed, submit payroll records for the most recent two months. Also, submit a Partnership Agreement or Schedule K-1/Partnership form, the Sole Proprietor Schedule C or State/City License, the Corporation Schedule E or Articles of Incorporation.
- The most recent billing from the group’s present carrier, an outline of the coverage, and evidence of the prior carrier’s effective date for each employee written on the prior carrier bill for prior carrier credit.
- A copy of the proposal.
- Current status of each employee (i.e., full-time, part-time, or seasonal, or if terminated, the date of termination). The prior carrier’s bill or the wage & tax report may be used to identify each employee’s status.
- Copies of Certificates of Creditable Coverage (if possible).

The IAC General Agent must receive submissions three days before the requested effective date.

Again, please advise your client not to terminate, cancel, or lapse current coverage until you are notified of approval of this plan by IAC.

UNDERWRITING A GROUP

Underwriting applications

Our goal is to make a decision regarding each group submission (issue, pend, or decline) within 7 days from receipt.

You have an opportunity to affect how quickly your case can be underwritten by:

- Making sure you have all initial requirements included with your employer submission. (Review what is necessary under the Employer Group Submission Documentation section.)
- Reviewing all the applications for missing information and obtaining it before sending the case to your General Agent for submission. If obtaining the information will significantly delay the submission, include a note of explanation and when you anticipate getting the information. Forward this note along with the employer submission to your IAC General Agent.
- Encouraging the employer and employees to respond as quickly as possible to the telephone verification.
- **Changes in benefits during underwriting process once initial rates released will require a 24-hour turn around time.**

Telephone verifications

A telephone verification call will be made to every employer to verify specific information about the employer, clear up any spelling questions or missing information. Employees may also be contacted by telephone to obtain missing information or further details about their (or their dependent's) applications and health history. Please inform the employer that these calls will be made and encourage their employees to respond as promptly as possible to help speed up the underwriting process.

COVERAGE PROVISIONS

Minimum Employer Contribution

Employers are required to contribute a portion of the premiums under their *IAC Group Health Plan*. The minimum contribution is 50% of the employee cost or 25% of the employee and dependent cost.

Guaranteed Issue

HIPAA provides certain protections to “*small employers*” (2-50 employees), which includes the availability of currently marketed plans for eligible individuals on a guaranteed issue basis. In determining whether an employer is classified as a “*small employer*,” all full-time and part-time employees are counted. If the employer has over 50 employees, the employer group is not considered a HIPAA-eligible small group employer eligible for coverage.

Primary Preferred Provider Networks

Preferred provider network plans require an employer to select a provider network at the time of application. When insureds receive services from a provider within the selected network, their out-of-pocket costs may be reduced due to higher coinsurance percentages and discounts negotiated with the network provider.

Selecting a network

IAC contracts with more than 70 preferred provider networks. Each network maintains a Website and/or toll-free telephone number through which insureds can verify provider participation. Only one network is allowed for all covered employees of an employer group plan (except for multiple location groups). The selected network should be listed in the designated location on both the employer and employee application. When coverage is issued, the health plan identification card will indicate information about the selected network.

PHCS network

Employers may choose Preferred Healthcare Systems (PHCS) as their primary regional network. PHCS offers insureds access to participating providers in all 50 states. This allows insureds to have their benefits paid at in-network benefit levels when using a PHCS provider, even when traveling outside their local service area.

Networks for multiple location groups

In some cases, an employer may have employees residing outside of the state in which the business is located. In this instance, the employer may select additional contracted networks for those employees working in states where we are approved to do business. There must be a legitimate business location

established within that state for the business. Home-based office locations are not eligible. In most instances, groups with multiple locations within the same state cannot select more than one network. Refer to the section on multiple location groups.

Changing networks

An employer may change their choice of regional or national provider network at any time. Requests to change networks should be submitted in writing and faxed to (602) 678-4267. The new network selection must be available within the group’s local service area. New network choices will become effective the first of the month following receipt of the request and may require a rate adjustment. New identification cards, reflecting the change in network, will be issued after the change has been processed.

Out-of-network services and national network access

If employees use an out-of-network provider, they will be responsible for the full amount of services until they meet the out-of-network deductible and coinsurance/out-of-pocket maximum. However, they may receive a discount if the provider is contracted with our national network, **Private Healthcare Systems (PHCS)**. If the provider is not in the PHCS network, IAC may process the claim through a third-tier network to determine if any other discounts are available.

Usual, Reasonable and Customary Charges

Definition

“Usual, reasonable, and customary” means the usual charge made for necessary medical services and supplies generally furnished for sickness or injuries of comparable severity and nature in the geographic area in which the services or supplies are furnished.

Determination

In determining what should be considered usual, reasonable, and customary for services and supplies, we use and subscribe to a standard industry reference source that collects data and makes it available to member companies. The database used reflects the amounts charged by providers for health care services based on the smallest geographic zip code areas generating a

statistically credible charge distribution. This data is updated and published twice per year. The data is reflective of reported provider charges from the lowest to the highest for each service or supply. The data is also adjusted periodically to reflect negotiated fee schedules with providers who are not included in the database. We then use a specific representative percentile of that range of charges to determine the usual, reasonable, and customary charge for all people who are insured under the plan.

Life, Accidental Death and Dismemberment Benefits

Life insurance coverage is available for purchase with a group health plan and is subject to underwriting. Stand alone Life groups are not accepted. A minimum of \$10,000 and a maximum of \$100,000 in life and accidental death and dismemberment (AD&D) insurance is available. Benefits are available as a flat amount per covered employee, as a percentage of salary, or by employee classification. There is a maximum of three different classes, and the face amount of coverage per class cannot exceed two times the face amount of the previous class.

The original AD&D benefit amount is subject to the following standard age reduction schedule:

Age 65 – 69	Age 70 – 74	Age 75 – 79	Age 80 – 84	Age 85+
65%	40%	25%	15%	10%

Billing Date

Although plans may be issued with either a 1st or 15th of the month effective date, the billing cycle for *all* plans is the 1st of the month. Employers that request a 15th of the month effective date will receive a billing statement at the time of approval for one and one-half months of premium, to move the case into the regular 1st of the month billing cycle.

IN-FORCE ADMINISTRATION

Effective Dates of Coverage for Timely Additions to In-Force Plans

The effective date of insurance depends upon the date on which the employee applies for insurance

- If an applicant applies for insurance before he becomes eligible, coverage will become effective on the first day of the plan month following the date on which he first becomes eligible;
- If an applicant applies for insurance on or within 31 days after the date on which he becomes eligible, insurance will become effective on the first day of the plan month following the date the employee application is received by IAC; or
- If an applicant applies for Insurance more than 31 days after the date on which he becomes eligible, the person may be considered a late applicant. Late applicants have distinct pre-existing condition limitation provisions.

Changing Benefits

An employer may make changes to the group's benefits within 30 days of the annual renewal such as adding or eliminating benefit options. Employees may also make changes to their dependent coverage at this time. However, if an employer wishes to enhance the plan of benefits (i.e., lower the deductible), the group must be re-underwritten.

When Medicare is Primary

For groups with fewer than 20 employees, Medicare is primary. For groups with 20 or more employees, Medicare is secondary. The total of employees to be counted in determining whether Medicare is primary or secondary includes *all* employees employed in the business, *whether or not* they are applying for coverage under the plan.

Renewability of Coverage

We guarantee the employer the right to monthly renewal of coverage under the group policy, at the employer's option. However, we may refuse to renew or to modify coverage under certain circumstances, as indicated below:

- The employer has not paid required premiums, or if we do not receive a premium payment by the last day of the grace period
- The employer or employee has performed an act or practice that constitutes fraud or intentional misrepresentation of material fact under the terms of the group policy

- The employer fails to comply with a material group policy provision related to premium contributions or group participation rules
- We elect to discontinue offering this type of group health coverage, elect to discontinue all health insurance, or modify the coverage for a group product offered to an employer (subject to giving the insured advance written notice and in accordance with applicable state laws)

Conversions

*Conversion to an individual policy may be available in certain states **without evidence of insurability if:***

- The insured individual's employment is terminated or he/she loses eligibility and
- The insured individual is under age 65 and
- The insured individual has been insured for at least three consecutive months

Applications for conversion must be made within 31 days from the date the group coverage terminated

Termination of Benefits

Insurance will automatically terminate on the earliest of the following dates:

- The date of termination of the policy
- The last day of the month in which the insured employee is no longer actively at work (as defined in the Certificate of Coverage)
- The date the insured employee or employer fails to make the required premium contribution
- The date the insured employee enters into active duty with the armed forces of any country, state, or international organization, regardless of the branch of service
- The date the insured employee's employer ceases to be an insured employer under the policy
- The premium due date coinciding with or immediately following the employee's retirement

Prescription Drug Information

Discount-only drug feature

When an optional outpatient prescription drug benefit is not selected, a discount-only drug feature is included. This feature allows insureds to purchase drugs and other prescription items

at up to 25% off retail prices at more than 70,000 Express Scripts pharmacies across the nation. When using the discount-only drug feature, all prescription drugs are discounted, including "lifestyle" medications that are not covered under the plan's benefits.

Prescription drug formulary

The prescription drug formulary is used to improve quality assurance and effective cost management within the outpatient prescription drug benefit. The formulary is a list of quality generic and brand name medications offering the potential for cost savings. Formularies are quite common in health care plans today and are used when two or more medications exist that achieve the same therapeutic effect. When a physician prescribes one of the listed medications, if medically appropriate, the insured will have a lower out-of-pocket cost for that prescription. Most physicians are aware of the need for cost effective drug therapy and will cooperate with formulary programs. In the event insureds or their physicians do not wish to choose a particular medication from the formulary list, they are not required to do so. The formulary system is voluntary and intended to help contain the ever-rising costs of drugs. When non-formulary brand name prescription drugs are used, higher copays apply.

When brand is preferred over generic

When a brand medication is dispensed because of an insured's preference and a less expensive FDA-approved generic medication could have been dispensed, the insured person's out-of-pocket costs may be higher. The out-of-pocket costs will be increased by the difference in the price of the insured's preferred brand medication and the established Maximum Allowable Cost (MAC) price for the generic equivalent unless the prescribing physician writes, "Do not substitute" or "DAW" for the brand name requested.

MAC pricing is a statistically derived maximum allowable base price that will be paid for prescription drugs for which a less expensive FDA-approved generic equivalent is available. This method assures that the cost to the plan does not increase when an insured person makes a decision to use a more expensive product. MAC pricing increases utilization of generic over brand name drugs and helps to equitably control the cost of outpatient prescription drugs dispensed.

Specialty Drugs

Specialty drugs and prescription medications that may be administered by a Physician as an Outpatient or self-administered in home setting and are listed on the Specialty Drug List. Specialty Medications must be obtained from CuraScript in order for the Specialty Medication to be covered at the In Network benefit level, even if the Specialty Medication is to be administered by a Physician or at a Physician's office. The CuraScript telephone number will be listed on the insured's identification card. The insured should call CuraScript to arrange for delivery of any prescribed Specialty Medication.

Specialty Medications are subject to the Pre-Determination requirements, a process used to establish medical criteria to determine whether any proposed Specialty Medication is medically necessary. It may also include proposing alternative treatment plans. **NO BENEFITS WILL BE PAID FOR SPECIALTY MEDICATION IN THE ABSENCE OF PRE-DETERMINATION.** As an industry leader of Specialty Pharmacy Services, CuraScript provides specialty medications to individuals with chronic illnesses requiring complex, high-cost treatment

Mail order, telephonic and Internet purchases

Mail order, telephonic and Internet prescription drug purchases offer both convenience and out-of-pocket savings for insureds when employers select an optional outpatient prescription drug benefit.

When selected, insureds can purchase up to a 90-day supply for the cost of just two months' prescriptions. (Not available on Rx SAAOI Plan).

Mail order service is not available in Oklahoma and Tennessee.

IMPORTANT INFORMATION

Medical, dental, life and accidental death benefits covered under the *IAC Group Health Plans* are underwritten by Standard Security Life Insurance Company of New York in all states where the *Health Plans* are available. Vision benefits are underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri. Provisions, benefits, and limitations described herein may vary according to the insured's state of residence. For additional details, see the Certificate of Coverage.

Some plan designs include services delivered through other vendors such as BanCorp Bank, TravelGuard, Optum®, Express Scripts, LabOne, TelaDoc® or Weight Watchers®, AskAFS or My Health Compass™. These services are not insurance benefits and are not underwritten by

Standard Security Life Insurance Company or Fidelity Security Life Insurance Company.

For complete details about the plan, consult the following materials:

For the health plan and life, accidental death and dismemberment, please refer to the Certificate of Coverage SSL MMC 0205, Policy number SSL GHP 0608, underwritten by Standard Security Life Insurance Company of New York. For details on dental, refer to Certificate of Coverage SSL TDEN-CER.001 1005, Policy number SSL TDEN-POL 1005, underwritten by Standard Security Life Insurance Company of New York. For details on the vision, refer to the Certificate of Coverage C-9004, Policy numbers VC037 and VC 20, underwritten by Fidelity Security Life Insurance Company.

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