



Omnitrade Health Trust

Employer Group Administrative Guide

Effective January 1, 2011

Letter from the Omnitrade Trustee



Dear Omnitrade Member,

The Omnitrade Health Trust is pleased to provide this Group Administrative Guide **effective January 1, 2011**. This guide is a ready reference to employers who participate in Omnitrade's benefit programs. This reference material will provide your company ongoing assistance with the day-to-day administration of the benefit programs. When your group completes the Group Master Application to participate in Omnitrade, you agree to the Terms of Selection and Participation in Omnitrade including adhering to the rules established in this guide and the health service contracts, insurance policies, and other service contracts between Omnitrade and each respective carrier.

Your organization, as an ERISA benefit plan sponsor, needs to administer the plans based on a clear understanding of your responsibilities under the law. Please become familiar with the general terms, conditions and limitations of the health service contracts, insurance policies, booklets/certificates of insurance, and Omnitrade's rules as expressed in this guide.

As Trustee, I would like to acknowledge the following Omnitrade advisors for their collaboration in putting this guide together:

Benefit Solutions, Inc. – Third Party Billing and Eligibility Administrator

Davis, Wright, Tremaine LLC – Legal Counsel

Wells Fargo Insurance Services – General Agent

Premera Blue Cross – Health Service Contractor

Washington Dental Service – Health Service Contractor

Vision Service Plan - Health Service Contractor

Unum – Health Service Contractor

It is a pleasure to have your organization as a participating member of Omnitrade Health Trust.

John Scates

Trustee

Please Note: This Group Administrative Guide is a summary of the terms, conditions and limitations by which Omnitrade, Premera and any other service contractors or insurance companies administer the eligibility rules and the plans of benefits i.e. "coverage." While we have attempted to make this Group Administrative Guide as accurate and complete as possible, it is not to be construed as an insurance contract, a booklet, or a certificate of insurance. The contracts between Omnitrade and the service contractors or insurance companies, and the benefit booklets and certificates of insurance set forth the actual terms, conditions and limitations of coverage.

Table of Contents

LETTER FROM THE OMNITRADE TRUSTEE	2
TABLE OF CONTENTS.....	3
PARTICIPATING VENDORS:.....	5
<i>GROUP ELIGIBILITY</i>	8
<i>EMPLOYEE ELIGIBILITY</i>	8
<i>Additional Guidelines and Assumptions</i>	9
NON-COMPETE PROVISIONS	10
HEALTH SAVINGS ACCOUNT (HSA) UNDERWRITING ASSUMPTIONS.....	10
<i>PRODUCER ELIGIBILITY</i>	11
ELIGIBILITY & ENROLLMENT	12
<i>EMPLOYEE ENROLLMENT:</i>	12
<i>ELIGIBLE EMPLOYEE:</i>	12
<i>ELIGIBLE DEPENDENT:</i>	12
<i>ENROLLMENT APPLICATION:</i>	13
<i>SPECIAL ENROLLMENT RIGHTS:</i>	13
<i>NEWBORN & ADOPTED CHILD ENROLLMENT:</i>	13
<i>ENROLL A NEW EMPLOYEE</i>	14
<i>FILLING OUT THE OMNITRADE ENROLLMENT AND CHANGE FORM:</i>	14
<i>EFFECTIVE DATE:</i>	14
<i>DEPENDENT ENROLLMENT RULES:</i>	15
<i>HOW TO ENROLL A NEWBORN:</i>	15
<i>HOW TO ENROLL A NEW SPOUSE:</i>	15
ELIGIBILITY & TERMINATION	16
<i>HOW TO TERMINATE COVERAGE FOR AN EMPLOYEE:</i>	16
<i>TO TERMINATE COVERAGE FOR A DEPENDENT ONLY:</i>	16
<i>COVERAGE TERMINATION</i>	16
WHEN COVERAGE ENDS	18
<i>TERMINATION OF COVERAGE</i>	18
<i>CONTINUATION OF HEALTH COVERAGE (WHEN NOT ELIGIBLE FOR COBRA)</i>	18
<i>LEAVE OF ABSENCE</i>	18
<i>MEDICAL CONVERSION PROCESS</i>	18
<i>LIFE INSURANCE CONVERSION PRIVILEGE AT TERMINATION</i>	18
<i>LABOR DISPUTE</i>	19
<i>CERTIFICATE OF HEALTH COVERAGE</i>	19
RENEWALS.....	20
<i>RENEWAL PROCESS</i>	20
OMNITRADE WELLNESS PROGRAM NEW & RENEWING GROUPS.....	21
<i>WELLNESS PROGRAM QUOTE ASSUMPTIONS</i>	21
<i>WELLNESS PROGRAM PROCESS</i>	21
<i>GUIDELINES FOR EMPLOYER COMMUNICATION</i>	21
COBRA ADMINISTRATION.....	24
<i>OVERVIEW OF COBRA LAW</i>	24
<i>QUALIFICATIONS FOR COBRA</i>	24
<i>BENEFIT SOLUTIONS, INC.'s (BSI) COBRA ADMINISTRATIVE SERVICES</i>	24

<i>EMPLOYER'S RESPONSIBILITY FOR COBRA ADMINISTRATION</i>	25
GROUP & INDIVIDUAL INFORMATION UPDATES	26
<i>HOW TO CHANGE A NAME OR ADDRESS:</i>	26
<i>REQUEST A NEW ID CARD:</i>	26
MAINTAINING ADMINISTRATIVE RECORDS	26
BILLING	27
<i>ABOUT YOUR BILLING STATEMENT</i>	27
<i>PROCESSING BILLING STATEMENT</i>	27
<i>REMITTING YOUR PREMIUM PAYMENTS</i>	27
<i>REPORTING ELIGIBILITY CHANGES</i>	27
<i>DELINQUENT PAYMENT PROCEDURES</i>	28
<i>LATE PAYMENT CHARGES</i>	28
<i>REINSTATEMENT POLICY</i>	28
<i>RETURN CHECK POLICY</i>	29
APPLICABLE LAWS	30
<i>HIPPA PORTABILITY</i>	30
<i>HIPPA PRIVACY RULES</i>	30
<i>FMLA ADMINISTRATION</i>	30
<i>MEDICARE SECONDARY PAYER (MSP) RULES</i>	30
<i>QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)</i>	30
<i>USERRA ADMINISTRATION</i>	31
FREQUENTLY ASKED QUESTIONS	32
GLOSSARY OF TERMS	35
CONTACT LIST	37

Participating Vendors:



Washington Dental Service is a member of the
Delta Dental Plans Association



Wellspring Family Services EAP
It's to Your Benefit



GroupHealth®

Omnitrade Health Insurance Trust Contact Sheet

Wells Fargo Insurance Services USA, Inc. – Endorsed Sponsor Product Representative	
Nathan Edmondson Phone: 206.892.9576 Fax: 866.972.2881 nathan.edmondson@wellsfargo.com	Servicing The Benefit Programs Of: Washington Biotechnology & Biomedical Association www.washbio.org Washington Clean Technology Alliance www.wacleantech.org

Wells Fargo Insurance Services USA, Inc. – Accredited Broker Services	
Customer Service Omnitrade Producer Line: 206.892.9565 Fax: 866.972.4187 601 Union St., Suite 1300 PO Box 91143 Seattle, WA 98111-9243	Send quote submissions to: omnitrade.ins@wellsfargo.com Send renewal or new business submissions to: programservices@wellsfargo.com www.omnitradebenefits.com

Wells Fargo Insurance Services USA, Inc. – Quality Control & Operations	
Keith VanderZanden Sr. VP and Managing Benefit Consultant Phone: 206.892.9582 keith.vanderzanden@wellsfargo.com	

Benefit Solutions, Inc. (BSI) – Third Party Administrator		
12121 Harbour Reach Dr., Suite 105 PO Box 6 Mukilteo, WA 98275-0006 Phone: 425.771.7359 Fax: 425.771.1226	Katie Alioto Account Lead kalioto@bsitpa.com	Sheryl Dwyer Account Manager sdwyer@bsitpa.com

Premera BlueCross – Medical Insurance		
Customer Service 7001 220th St. SW MS 313 Mountlake Terrace, WA 98043 Phone: 800.722.1471	Jen Diaz Account Executive jen.diaz@premera.com Phone: 425.918.4407 Fax: 425.918.5853	Mike White Account Coordinator michael.white@premera.com Phone: 425.918.4486 Fax: 425.918.5853

Group Health Options, Inc. – Medical Insurance

Customer Service
PO Box 34750
Seattle, WA 98124
Phone: 888.901.4636
www.ghc.org

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Account Manager
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Ian Tusher
Account Specialist
Phone: 206.448.4177
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Washington Dental Service (WDS) – Dental Insurance

Customer Service
PO Box 75688
Seattle, WA 98125
Phone: 800.554.1907
Fax: 206.524.0913
www.deltadentalwa.com

Debra Liming
Account Manager
dliming@deltadentalwa.com
Phone 206.528.2329
Fax 206.524.0913

Vision Service Plan (VSP) – Vision

Customer Service
Phone: 800.877.7195
600 University St. Suite 2004
Seattle, WA 98101
www.vsp.com

Deborah Suchoski
Account Manager
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Fax: 206.621.7515
deborah.suchoski@vsp.com

Unum – Life/AD&D and Disability

Customer Service
1111 Third Ave, Suite 2850
Seattle, WA 98101
Phone: 800.672.1600
Billing Fax: 207.771.4018

Laurel Berry
Account Consultant
lberry@unum.com
Phone: 206.442.0273
Fax: 206.442.0366

Wellspring Family Services EAP – Employee Assistance Plan

Customer Service
Phone: 800.553.7798
Fax: 866.495.0441
1191 Second Avenue, Ste 680
Seattle, WA 98101
www.wfseap.org

Ed Emerson
Director Business Development
Phone: 206.903.2302
Fax: 866.495.0441
info@wfseap.com

Omnitrade Health Trust Underwriting Guidelines

Group Eligibility

- 1) All groups must be an active, dues-paying member of an Omnitrade 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 Omnitrade. 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 Washington state. For Group Health Options coverage, 80% of all covered subscribers must reside within the Group Health Options service area.
- 3) 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.
- 4) All Omnitrade 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.

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. 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) Omnitrade 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. Omnitrade 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 a bundled medical and dental plan is 2 enrolling employees. Bundled vision coverage is available to groups of 5 enrolling employees or more. Life/Ad&D, coverage is available to groups of 5 or more enrolling employees. The maximum group size eligible for coverage is 199 employees.
- 4) Broker commissions are 5% for medical, dental, vision and basic life/ad&d.
- 5) A minimum of \$10,000 basic life/AD&D coverage is compulsory for groups of 5 or more.
- 6) The 3-visit EAP plan is compulsory for all groups.
- 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 Omnitrade.
- 8) Groups of 5 or more may select dual choice within Premera BlueCross product offerings. A minimum of 2 employees must enroll on each plan. Deductible amounts must be within \$1,500 for all dual choice scenarios involving a Health Savings Account (HSA) plan.
- 9) Dual choice between Premera BlueCross and Group Health Options is allowed for any group renewing or sold, assuming 90% of eligible subscribers enroll with Premera and a minimum of 5 employees enroll on each plan. Omnitrade Plan A cannot be offered in a dual carrier situation however all other plan combinations are allowed.
- 10) 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.
- 11) New business paperwork is due no later than the 15th of the month prior to the effective date.
- 12) Requests for proposals received after the 10th of the month prior to the requested effective date may be declined.
- 13) A copy of either a Letter of Authorization (Search Letter) or Broker of Record Letter may be requested from each accredited producer in a multiple quoting scenario.

- 14) Omnitrade reserves the right to adjust rates for a new member group if any information is different from the original quote. Omnitrade reserves the right to decline coverage if the group does not meet all the established underwriting guidelines.

Non-Compete Provisions

- 1) Premera Blue Cross parity rating rules apply to Omnitrade. Any company currently enrolled with Premera or through another Premera association health plan is eligible for coverage through the Omnitrade Health Trust at price neutral level ("price parity"). Companies with less than 50 employees who are currently enrolled with Premera on a direct basis are eligible for coverage through Omnitrade. Parity also applies to groups that are over 50 employees, whether direct or with another association.
- 2) The Group Health Options non-compete rules apply to Omnitrade. They are:

Groups currently covered under a medical plan underwritten directly by Group Health Options, Inc. 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 Omnitrade renewal. No quotes will be allowed for groups off anniversary.

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.

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 given 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) The HSA plan cannot be offered alongside a medical plan underwritten by another carrier.

- 3) The employer may fund up to 80% of the deductible.
- 4) The rates do not include any transaction and/or administrative fees charged directly by the HSA administrator.
- 5) Rollover funds combined with HSA contributions cannot exceed federal limits.

Producer Eligibility

- 1) All producers must be fully accredited through Wells Fargo Insurance Services to promote Omnitrade products and services. Among other requirements, producers must maintain all endorsed insurance carriers appointments. Please reference the Omnitrade Accreditation Agreement for a list of requirements and further details.
- 2) All accredited producers are required to obtain and maintain dues membership with the Omnitrade endorsed sponsors. Accredited producers are eligible to request and receive quotes without becoming a dues paying member of an Omnitrade endorsed sponsor, however, membership must be secured at the time of the insurance placement with Omnitrade. No commissions will be paid until the accredited producer becomes an active, dues-paying member. It is the responsibility of the accredited producer to ensure their membership status is active.
- 3) Broker of Record Letters and Letters of Authorizations (Search Letters) will not be accepted for participating member companies of Omnitrade.

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

Eligibility & Enrollment

Employee Enrollment:

In order to participate in the Program the employer must agree to define the enrollment requirements on their annual Participation Agreement 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. 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 broker.

Eligible Employee:

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

- Employees who chose 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.
- The OMNITRADE 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.
- Retirees, including early retirees, are not eligible for coverage unless otherwise specified.

Eligible Dependent:

Eligible dependents include:

- The lawful spouse of the subscriber, unless legally separated. However, if the spouse is an owner, partner or corporate officer of the employer who meets the requirements in "Subscriber Eligibility" the spouse can only enroll as a subscriber.
- 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.
- A child under 26 years of age, without student status verification. An eligible child must meet the following requirements.
 - A natural offspring of either or both the subscriber or spouse, a legally adopted child of either or both the subscriber or spouse, a child legally placed with the subscriber for adoption in accordance with state law. "Placed for adoption means assumption and retention by the subscriber of a legal obligation for total or partial support of a child in anticipation of adoption of such child, a legally placed ward of the subscriber or spouse living permanently in the home of the subscriber. Foster children are not eligible for coverage.

Enrollment Application:

To become covered under this plan, an employee must first complete an application for themselves and include each family member they wish to cover. For employees, coverage begins on the first day of the next month following the completion of the probationary period. For dependents that are eligible and are included on the subscriber's application, coverage begins on the subscriber's effective date.

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 event
 - Marriage
 - Effective 1st of the month following event
 - Birth
 - Effective on the date of birth
 - Death
 - Effective on the date of death
 - Divorce
 - Effective first of the month following event
 - 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.

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. Premium billing will take place first of month following event.

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.

Enroll a New Employee

Use the OMNITRADE Health Trust Employee Enrollment/Change form. A copy of the form can be found in our form library, which can be located at www.Omnitradebenefits.com. Alternatively, contact customer service at Benefit Solutions, Inc. to have a copy of the form sent to you.

Medical	EE can waive
Dental	If the group offers it, ALL employees must be enrolled
Basic Life	If the group offers it, ALL employees must be enrolled
EAP	If the group offers it, ALL employees must be enrolled
Vision	If the group offers it, ALL employees must be enrolled.
Supplemental Life	Voluntary
Dependent Life	Voluntary

Filling out the OMNITRADE Enrollment and Change Form:

No other enrollment forms will be used except the OMNITRADE specific Enrollment/Change 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. Forms with any missing information, such as date of birth, date of hire, or enrollment reason, will not be processed and will be returned. You must print clearly or type the form.

1. Write the company name in the "Employer Name" box.
2. 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 Participation Agreement 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 1st 2007 and the group had a 30-day probationary period, the effective date would be February 1st. If the same employee were hired January 8th 2007, the probationary period would end February 6th and the employee's effective date would be March 1st. If an employee's probationary period ends on the 1st of the month, that will be the effective date.

3. Check the "Hire/Rehire" box in the "Reason for Enrollment" section.
4. Enter the employee's name, date of birth, gender, Social Security Number, and mailing address in the "Employee information" section.
5. Check the boxes in the "Plan Selection" section that match the coverage you have through the OMNITRADE Benefit Program. If you are unsure of your coverage, consult your Participation Agreement or Broker.
6. Have your employee enter information about their dependent coverage and any prior coverage. See Dependent Enrollment Rules.

Dependent Enrollment Rules:

****Groups with uncommon eligibility in place at the time of publication of this Group Administrative Guide will be allowed to maintain the uncommon enrollment for their employees who do not meet these requirements. However, any new employees' or changes to employees' enrollment must meet the following requirements without exception.**

If Employee has Coverage Below...		Apply corresponding coverage rules.
Medical	Dental	Vision
EE Only	May Cover Dependents	May Cover Dependents
Dependents Covered	MUST cover same dependents	MUST cover same dependents
EE Waived	May enroll dependents	May enroll dependents
Dental	Medical	Vision
EE Only	EE only	EE only
Dependents Covered	May cover dependents	MUST cover same dependents
EE Waived	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 VSP is offered by group		

How to Enroll a Newborn:

Using the Omnitrade Health Trust Consolidated Enrollment Form

- 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.
- What if the newborn doesn't have a Social Security Number yet?
 - Send in the enrollment without the SSN. When one is assigned, notify Benefit Solutions, Inc. so it can be added to the file.
- Check the birth/adoption box in the "Reason for Enrollment" section.

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.

Eligibility & Termination

How to terminate coverage for an employee:

Using the Omnitrade Health Trust Enrollment/Change Form

- Put the last day of the last month of coverage in the effective date box.
- Put the employee's actual last day of work/date of termination in the "event date" box.
- Check "Termination" in the "Reason for Enrollment" box.
- Enter all of the employee information.
 - You do not need an employee signature when an employee terminates employment.

To terminate coverage for a dependent only:

Using the Omnitrade Health Trust Enrollment/Change Form

- Enter the last day of the last month of coverage in the effective date box.
- Choose "delete dependents" in the "Reason for Enrollment" section.
- Enter all the employee information.
- Enter the dependent information, circling "delete" next to the dependent name.
- The employee must sign the enrollment/change form. The group administrator should sign the right box on the last page.
- 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.

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 the employee and dependents when ANY of the following occur

- The contract between the Program 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

Employees who are rehired within 30 days of termination will not have to re-satisfy their probationary benefits period.

- For a spouse/dependents:
 - When his or her marriage to the employee is annulled
 - When he or she becomes legally separated or divorced from the employee.
 - For a domestic partner when his or her domestic partnership relationship with the subscriber is ended. (See Appendix).
 - 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, BSI, 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). Also, if the plan is not subject to COBRA (employer had less than 20 employees in the preceding calendar year), the employer must be aware of the continuation of group health 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

When Coverage Ends

Termination of Coverage

Coverage will end on the last day of the month when one of the following happens.

- The employee terminates employment.
- The employer fails to remit current monthly premium payment due.
- The employer fails to meet Trust participation requirements.
- The employer notifies the Trust it wishes to terminate its participation.
- The Trust itself terminates.
- Coverage will end for a spouse when his/her marriage to the employee is annulled, or when there is a legal separation or divorce from the employee.
- The domestic partnership agreement with the employee ends and the appropriate form submitted to BSI.
- Children will terminate when they no longer meet the requirements for dependent coverage.

It is the employer's responsibility to notify BSI within thirty (30) days of any of these events. Retroactive cancellations are not allowed.

Continuation of Health Coverage (When not eligible for COBRA)

A participant may be eligible under one of Premera's Conversion Plans when their coverage under this Plan ends. For more information they should contact Premera's Customer Service Department. Note: The rates, coverage and eligibility requirements of the Conversion Plans differ from those of the current group Plan.

Leave of Absence

Coverage for a subscriber and enrolled dependents may be continued for up to ninety (90) days when the employer grants the subscriber a leave of absence and subscription charges continue to be paid.

The ninety (90) day leave of absence period counts toward the maximum COBRA continuation period, except as prohibited by the Family and Medical Leave Act of 1993.

Medical Conversion Process

You may choose to extend your coverage under this plan for up to six (6) months past the date your coverage ended if:

- The employer is not subject to the COBRA regulations.
- The participant is not eligible for COBRA coverage.
- The coverage ends for reasons other than group rescission.

The Plan booklet(s) offers more details on eligibility and payments. See the Section titled "6-Month Continuation of Group Coverage"

Life Insurance Conversion Privilege at Termination

An employee may be eligible to continue their Life and AD&D coverage. To apply, they must complete a Life Insurance Election of Portability Coverage form (see Forms) and send it to UnumProvident within 31 days after their group insurance coverage ends. They are not eligible to apply for portable coverage for themselves and their dependents if they have a medical condition which has a material effect on life expectancy. Also, any dependent is not eligible for portable coverage if he or she has a medical condition which has a material effect on life expectancy. If they are not eligible to apply for portable coverage or their portable coverage ends, they or their dependents may qualify for conversion coverage. A conversion

application form (which includes cost information) is included at the back of this Guide under "Forms."

Labor Dispute

Coverage can be continued for up to six (6) months in the event of a labor dispute, subject to the premium being paid. This period will count toward any COBRA continuation periods (if applicable).

Certificate of Health Coverage

A participant will receive a "Certificate of Health Coverage" when they terminate. The certificate will provide information about their coverage period under this Plan. They will need this certificate for their new health plan to receive credit toward any waiting period for preexisting conditions. More information can be found in the Plan booklet(s) under the Section titled "Certificate of Health Coverage."

Coverage Requirements and Selections

- Compulsory
 - Medical coverage for groups of 2 or more employees
 - \$15,000 Basic Life & AD&D for groups of 5 or more employees
 - 1-3 visit Employee Assistance Program for groups of 2 or more employees
- Bundled
 - Dental benefit for groups of 2 or more employees
 - Vision benefit for groups of 5 or more employees
 - Buy-up Basic Life and AD&D \$50,000 Benefit for groups of 10 or more employees
 - Voluntary Life and AD&D Benefit (1x Salary to \$100,000 or \$200,000) for groups of 10 or more employees (employee must be enrolled in the Basic Life and AD&D benefit.
 - 1-6 Visit Employee Assistance Program – groups of 2 or more employees

Renewals

The renewal date depends on the type of coverage and inception date.

- Premera Blue Cross: The renewal date will be 12 months from the effective date of issue. If coverage begins on August 1st, the renewal will be August 1st of the following year.
- Group Health Options Alliant Plans: The renewal date will be 12 months from the effective date of coverage.
- Dental, Vision, Life, and EAP: The renewal date will be 12 months from the effective date of coverage starting. If a group adds a line of coverage during the year other than the medical effective date, the renewal for these lines of coverage will be effective at the time of the medical renewal. All groups must have common anniversary dates for all lines of coverage. For example, a group's effective date for medical is January 1st and the group adds dental on August 1st of the same year, the renewal for the dental will be the following January 1st to coincide with the medical renewal.

Renewal Process

All renewal information is sent to the credentialed broker. No renewal rates or other renewal information is sent to the group. The broker is responsible for contacting the group regarding the new rates and any benefit changes.

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

The renewal package includes a letter explaining any benefit and administrative changes to the plans, the renewal rates for all plans and a summary of benefits. A new Employer Participation Agreement is required for all renewing groups. 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) no later than 10-days before the renewal date.

OMNITRADE Wellness Program New & Renewing Groups

The OMNITRADE Health Risk Management (HRM) program gives employers and employees helpful tools to identify and reduce personal and workforce health risks. This program provides employers the opportunity to create a culture of well-being and foster improved health and productivity among their employee population.

Wellness Program Quote Assumptions

1. Quoted price assumes the employer will elect the Wellness Program.
2. There will be an adjustment to the quoted rate if the employer elects not to participate in the program.
3. Requires 50% Health Risk Assessment participation. A participant is defined as a covered employee, spouse, or domestic partner (if eligible).
4. Employer must offer participants a \$75 cash incentive for completing the Health Risk Assessment.
5. Employer has 90 days from the plan's effective date to meet the wellness participation requirements.

Wellness Program Process

1. Employer Group elects to participate in the Wellness Program on the Participation Agreement.
2. The Program Administrator will send a Welcome Kit to the Employer once the implementation process is complete.
3. Employer is encouraged to utilize the communication materials available in the Welcome Kit to promote the availability of the Health Risk Assessment and cash incentive of \$75.
4. Each participant should complete the online Health Risk Assessment within the time period outlined by the employer. Arrangements must be made by the employer if there are computer access issues with participants.
5. A Personal Health Report Coversheet will be produced for the participant upon completion of the Health Risk Assessment, which must be provided to the employer's Benefit Administrator to receive the cash incentive.

Guidelines for Employer Communication

To achieve better health, people need to understand their health risks and make the behavioral changes necessary to reduce and manage these risks. The Health Risk Management program was created to help people take this important step. The program has been designed with the following main components:

Employer Promotion

Employers have several motivating factors for offering a Health Risk Management (HRM) program. These include the reduction of absenteeism, managing health insurance costs and the promotion of healthcare consumerism. However simply offering an HRM program is not enough. Building a communication campaign and an incentive based participation system ensures that the useful tools and resources available will be utilized. As noted in the OMNITRADE Participation Agreement, to

offer HRM services the employer agrees to meet participation requirements equal to 50% of the total enrolled employee count. Additionally, employers are required to offer **a cash incentive of no less than \$75** to all who initially participate in HRM by taking the Personal Health Assessment (PHA)*.

Personal Health Assessment

Designed to elicit health risk information, this confidential questionnaire provides the key metrics for health planning and evaluation. Each participant* completing a voluntary questionnaire receives a personal health report. This report includes an overall wellness score, information about any identified health risks, a list of health habits on which to focus and a personal summary to share with a doctor if desired.

Telephone Health Coaching

This component is offered to participants who have been assessed with elevated risk. By telephone, health educators help high-risk participants interpret their health risk appraisal results and set personal goals for improving their health. Throughout the year, health coaches provide additional resources and support. Enrollment is automatic however there is an opt-out feature as participation is optional.

***A PHA participant is defined as an enrolled employee, spouse or domestic partner (if domestic partners are indicated as eligible for coverage at the group level).**

Health Risk Management Toolkit

Health Risk Management works by educating, empowering, and providing on-going support to employees to improve their current state of health and become more productive. In addition to providing the right tools at the right time, active employer support, leadership, and participation are critical to the success of the program.

The Health Risk Management Toolkit provided includes customizable materials to increase awareness and promote employee participation at the workplace. Tailor these resources to meet the specific needs of your company and help you:

- Inform your employees about the Health Risk Management program overall
- Execute an overall communication plan to raise general awareness and interest in better personal health management
- Communicate and promote the opportunity to participate in the Personal Health Assessment.

Toolkit Components

The Health Risk Management Toolkit includes tools for display and print, electronic communications, presentations, and member samples. These materials may be categorized and combined to meet specific business objectives:

Health Risk Management - Strategy & Communications Plan Development

The Employer Presentation offers you and your managers an overview of the program and its benefits for your company. This Communication Strategy Guidelines document is designed to help you plan an effective communication strategy, by introducing and sustaining employee interest in the program.

- Employer Presentation

Health Risk Management - Program Education

The Employee Presentation introduces the health risk management concept and the opportunity to participate in the free online personal health assessment and telephonic health coaching.

- Employee Presentation

Customizable Employer Communications

To complement the materials that employees will automatically receive, you can provide additional, customizable workplace communications to educate and encourage employees to take part in the Personal Health Assessment. These materials include:

- CEO Letter
- Personal Health Assessment Poster
- Personal Health Assessment Flyer
- Announcement Email
- Go-Live Email
- Reminder Email
- Voicemail Scripts

Personal Health Assessment – Awareness, Education and Promotion

As members of OMNITRADE, employees will have access to materials informing them of the opportunity to take the voluntary Personal Health Assessment. These materials are sent to the employer for distribution at different stages to maximize awareness and participation:

- A one-page flyer announcing the availability of the Personal Health Assessment is included in the Member Benefit Packet.

The table below provides suggestions of complementary communications to increase participation in the Personal Health Assessment—bringing you one step closer to creating a healthier, more productive work environment.

Timing	Activity	Purpose/Intent
45-55 days after effective date	Printed Material: Customize and distribute CEO letter	Let employees know that their company is committed at the senior executive level to improving the health and productivity of its employee population. If a goal for participation has been set, make it known.
	Electronic Communications: Distribute kick-off email and/or voicemail Display Materials: Customize and display posters; distribute flyers.	Generate excitement immediately before the online assessment period begins. Reinforce the effort with closely staggered and varied types of communications. The more often employees see the message, the more likely they are to take advantage of the opportunity to participate.
60 days after effective date	Electronic Communications: Send "go-live" email and voicemail	On the first day the assessment is available online, remind employees that the Personal Health Assessment is available. This will provide another opportunity to supply the log-in instructions.
75-80 days after effective date	Electronic Communications: Send reminder email and voicemail	Let employees know that time to take the Personal Health Assessment is running out.

COBRA Administration

Overview of COBRA Law

COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985. This legislation allows plan participants and/or their dependents to continue coverage for a period of 18 to 36 months (depending on their qualifying event). The following section explains which employers are subject to this legislation.

An employer may elect to have BSI handle the administrative functions of this legislation. To do so, an employer must sign a COBRA Administration Agreement. The agreement can be effective only on a prospective basis. Without the agreement, the employer is responsible for all administration of the COBRA regulations.

Qualifications for COBRA

It is extremely important for an employer to be accurate in their decision concerning their obligations under the COBRA regulations. The following information is provided only as a guide. We recommend you seek advice from your legal counsel or financial advisor.

Small employers are not subject to the federal COBRA regulations in any calendar year that they employed fewer than 20 employees on a typical business day during the preceding calendar year. Under the regulations, all common-law employees are counted (go to <http://www.irs.gov/publications/p15a/ar02.html#d0e397> for an explanation of common-law employee), not just those covered as a plan participant. You may also go to <http://www.dol.gov/dol/topic/health-plans/cobra.htm> to find out more about COBRA.

An employer is considered to have normally employed fewer than 20 employees during a particular calendar year if it had fewer than 20 employees on at least 50% of its typical business days during that year. When counting employees, keep the following in mind:

- Count both full-time and part-time employees
- Count employees of related employers (and successors)
- Count out-of-country employees

You may wish to consult with your company's legal and/or financial advisor(s) for assistance with this decision. The actual COBRA regulations are much more complex and cannot be completely explained here.

Benefit Solutions, Inc.'s (BSI) COBRA Administrative Services

If an employer wishes BSI to administer COBRA, they must sign the appropriate agreement and submit it to Benefit Solutions, Inc. Benefit Solutions will notify groups of the effective date that Benefits Solutions, Inc. will administer the COBRA. Without the executed agreement, each employer must administer COBRA on their own.

If BSI is handling the Administration of your COBRA, BSI will send a monthly billing statement to the COBRA participant. The COBRA participant will remit premiums directly to BSI. If you handle your own COBRA administration, you will collect the premiums from the COBRA participant and remit premiums with your monthly billing statement provided for your active employees.

Employer's Responsibility for COBRA Administration

An employer who uses BSI's COBRA administration services will:

- Provide an initial notice describing COBRA rights to all covered employees and their spouses at the time coverage under the Plan commences.
- Provide eligibility information to BSI. The Employer will notify BSI of individuals who have experienced a Qualifying Event within 30 days of the Qualifying Event. The notification will be provided by noting termination or other changes of employment status on the monthly employer report, or by separate written notification to BSI. The information provided in the notification will include the following:
 - Name, Social Security Number
 - Date and Type of Qualifying Event
 - Current Mailing Address of Qualified Beneficiaries
- Provide BSI with address changes of its employees covered by COBRA.

Group & Individual Information Updates

How to change a name or address:

Send an enrollment/change form, email or fax to Benefit Solutions, Inc. that includes the current information and, in the case of a name change, the previous name. This information will need to be changed with the administrator and they will then update the insurer's files.

Request a new ID card:

Send an email or fax to Benefit Solutions, Inc. 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 10-14 business days for cards to arrive. You may also 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 to obtain ID numbers from the carrier.

WDS does not issue individual cards. Instead, there are tear-out cards in Summary of Coverage booklets.

There are no ID cards for VSP.

Maintaining Administrative Records

Groups are responsible for keeping accurate and complete records of plan beneficiaries relating to eligibility, enrollment, payroll deductions, hours worked, premium payments, and other records necessary to administer the benefit plan. The Program and its plan sponsors, have the right 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 at any time during the employer's regular business hours.

BILLING

About Your Billing Statement

Every billing report will be at least two (2) pages. The first page will be a reconciliation page and will list the previous month's amount billed, any payments that were made in the past month, and any billing adjustments applied. The following pages will list the current month's billing detail. Subscribers will be listed in alphabetical order. Premiums due are listed in the appropriate column, i.e. medical, dental, life, etc.

There is a total for each subscriber on the right-hand side of the bill. The column heading "elections" describes the coverage level being billed.

1 = Employee Only	M = Medical
2 = Employee/Spouse	D = Dental
3 = Employee/Spouse/Children	V = Vision
4 = Employee/Children	

Coverages are totaled at the bottom of each column. If there are no employee or dependent changes, please pay the pre-printed Billing Total listed.

Processing Billing Statement

Premiums are due on the first day of the month that coverage is for. Premiums are considered late if not received by Benefit Solutions, Inc. (BSI) on or before that date. Benefit claims are not paid unless BSI notifies the insurance carriers that the premiums have been paid in full for each eligible employee. **All premium checks should be made payable to "OMNITRADE Benefit Program" and mailed to BSI along with a copy of the Billing Statement and any new enrollment forms not previously sent to BSI.** Premiums must be remitted with one company check from the group.

Remitting your Premium Payments

Premium payments should be sent to OMNITRADE Health Trust, PO Box 6, Mukilteo, WA 98275-0006. At this time BSI does not accept ACH transactions. A business check, money order, or cashiers check is acceptable. Do not send cash.

Reporting Eligibility Changes

To delete an employee, draw a line through that employee's name and enter the appropriate employment status code and the date the status becomes effective. The employment status legend is located above the far right column. You may subtract the deleted employee's premium from the billing total at the bottom of the bill. Adjustments will show on the next month's billing report.

To add an employee, write the name and social security number on the billing form with the appropriate status code and the date the status becomes effective. You may add the new employee's elections and premiums in the proper columns and add that amount to the adjustments totals at the bottom of the bill. Eligibility and premium adjustments will show on the following months billing. ****Important - You must include a signed enrollment application in order to add an employee or dependent**.**

If changing a dependents' status, BSI must receive an enrollment application in order to make the appropriate change. The eligibility and premium adjustments will be shown on the next month's billing.

Add all of the adjustments and enter into "Total Employer Adjustments" and then add/subtract this amount from the "Billing Total." Enter this amount into the "Total Remittance" box.

Please note: It is the employer's responsibility to report eligibility changes to BSI in a timely manner. A written or emailed request from the employer provides an audit trail of the specific instructions that BSI must follow on the employer's behalf. Employers may not report eligibility changes over the phone. A retroactive termination, addition, and other change may not be acceptable to the Trust unless there is sufficient documentation to justify such actions. Generally, BSI will not credit premium refunds retroactive more than 60 days. Therefore, it is important that group administrators reconcile their premium billings every month and immediately notify BSI to resolve any issues. Late enrollment applications may result in postponement of coverage until the next open or special enrollment period.

Delinquent Payment Procedures

Premium for OMNITRADE plan offerings is due on the first day of the month for that month's eligibility. These premiums are considered late if not received by BSI by the 8th day of the month for which premium is due. Late premiums will incur a late charge as described in the next paragraph.

Late Payment Charges

If the employer's premium is received by BSI after the 8th day of the month for which premiums are due, OMNITRADE will impose a late charge in the amount of the greater of \$20.00 or 1.5% interest per month on the unpaid balance. Participating employers that become more than 30 days late in payment of their premium may be terminated for non-payment of premium. Coverage will end the last day of the month for which premium was paid. Premium payments received by OMNITRADE more than thirty (30) days after the due date will be returned if the employer's eligibility information has already been terminated in the BSI system.

Reinstatement Policy

If an employer's participation in the Trust is terminated for non-payment of premium, the employer must wait six months before his broker may request a new quote for insurance coverage through OMNITRADE. If a group's coverage is cancelled for non-payment, they may apply for a one-time reinstatement of the contract, without interruption of coverage. To apply for reinstatement, the group will be required to submit a written request and include a certified check for all prior and current payments owed. Once reinstated, if the group contract is cancelled again for non-payment, the group will not have the option of reinstatement for a period of at least 12 months.

Following cancellation, employees whose benefits were terminated for non-payment will be responsible for payment of any charges for health care services received following the effective date of cancellation.

Return Check Policy

OMNITRADE charges fees for returned checks and requires specific check replacements as follows:

Non-Sufficient Funds (NSF)

- Checks returned due to non-sufficient funds: \$50.00 fee per check, per return
- Replacement must be made by cashier's check within ten business days.
- If a replacement check is received within the time allowed, there will be no adjustment in the group's eligibility.

Account Closed

- Checks returned due the account being closed: \$50.00 fee per check, per return.
- Replacement must be made by cashier's check within ten business days with proof that the business is active, such as the most recent payroll taxes paid to the State.
- If a replacement check is received within the time allowed with proof of continuing viability, there will be no adjustment in the group's eligibility.

Payment Stopped

- Checks returned due to payment stopped: \$50.00 fee per check, per return, unless the Administrative Office has been notified and the check has been replaced prior to the notice being received from the bank.
- If a replacement check is received within the time allowed, there will be no adjustment in the group's eligibility.

If a group submits two checks that are returned for any reason within a six month period, they will be required to make premium payments by cashier's check for six consecutive months. Timely payment by cashier's check assures continuing eligibility.

If a group submits three checks that are returned for any reason, the group may be cancelled by the Program and must wait six months before their designated agent or broker may request a new quote for insurance coverage. Eligibility will be adjusted back to the group's prior paid through date and any affect claims.

Employers are cautioned that: (1) If an employer withholds monies from an employee's pay for the purpose of contributing to the payment of premiums and the employer does not promptly make those payments, the employer may be in violation of ERISA and subject to penalties, and (2) The timeliness of payments may affect COBRA participants' eligibility since COBRA is only available when a COBRA eligible company remains in good standing with the Program. If this applies to your group, your legal counsel can advise you.

Applicable Laws

HIPPA Portability

If an employee and/or dependent had insurance coverage within ninety (90) days of becoming eligible for coverage under the Trust, the time spent on that plan will count toward satisfaction of the Trust's pre-existing condition waiting period. If the participating employer has a probationary period and the employee and/or dependent had coverage within the prior ninety (90) days, that coverage will still be counted toward the pre-existing condition waiting period upon enrollment in the plan. This is called "creditable coverage", and means Medicare, Medicaid, TriCare, FEHBP, Indian Health Service; State health benefits risk pool, Peace Corps plan, other public health plan, or prior group or individual coverage. There are certain prior coverages that do not apply; please contact your legal counsel or broker/agent for more information.

Benefits portability does not apply to the six (6) month transplant waiting period, unless the prior coverage was with another Premera plan.

HIPPA Privacy Rules

The OMNITRADE Benefit Program and its insurance carriers are subject to all federal privacy restrictions effective April 14, 2003. Procedures are in place to process protected health information as required. *Please note: Due to the restrictive nature of these federal requirements, Administration Office and carrier personnel will not be able to respond to unauthorized inquiries and requests for information.*

FMLA Administration

The FMLA applies only to employers that employed fifty (50) or more employees during each of the twenty (20) or more calendar work weeks in the current or preceding calendar year and that are required by federal law to comply with FMLA provisions. Under this provision, eligible employees may receive up to twelve (12) weeks of leave during a twelve (12) month period, as provided by FMLA, under the following circumstances:

- The birth of an employee's child.
- The placement of a child with the employee for adoption or foster care.
- Care for the employee's seriously ill spouse, parent or child.
- The employee's own serious physical or mental health condition.

Benefits must be continued for employees on FMLA leave. Any payroll deduction must continue to be paid by the employee. Please contact your legal counsel or broker/agent for more information.

To assist the employer in its FMLA obligations, the Trust will continue to receive premium payments as if the employee was actively at work.

Medicare Secondary Payer (MSP) Rules

The OMNITRADE Benefit Program will be primary over Medicare coverage for active employees and dependents.

Qualified Medical Child Support Orders (QMCSO)

The OMNITRADE Benefit Program will comply with any court ordered enrollment of a child for benefits, whether it be as a result of divorce or governmental requirements.

USERRA Administration

USERRA (Uniformed Services Employment and Re-Employment Rights Act) has provisions that allow an employee who is called up to military service has the right to continue coverage for up to eighteen (18) months by paying the monthly premiums. This is true even for groups that are too small to comply with COBRA. There are other employment related issues that go along with this legislation, including (but not limited to) having to hold the employee's position until s/he returns from service. For further information on USERRA, please contact your legal counsel or broker/agent.

Frequently Asked Questions

What is a qualifying event?

It is an event that qualifies an employee or a dependent for a change in coverage. Some common examples 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.

Table of Authorized Change of Election Events	Insurance Plan
Change in Legal Marital Status or Number of Dependents: Marriage, Divorce, Legal Separation, Annulment Death of Spouse or Dependent 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 Change in Work Schedule Due to Strike or Lockout Resulting in a Loss of Eligibility Return from or Commencement of Unpaid Leave of Absence Significant Change in Employed Spouse's Health Plan Gain/Loss of Coverage under Participant or Dependent's Health Plan 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	Yes
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

Incomplete Forms

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

Generally, yes. Benefit Solutions, Inc. and the Omnitrade Health Trust Team will attempt to contact you if you have not completed a form or if there are discrepancies. If Benefit Solutions, Inc. 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 pitfalls?

- 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 please contact Benefit Solutions, Inc. and we will be happy to answer any questions you may have.
- Illegible handwriting:** If handwriting is hard to decipher, it is more likely that 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, apartment number, 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 OMNITRADE Health Trust website for the most up-to-date forms. Forms are located in the Forms Library in the “Employers” section of the website: www.Omnitradebenefits.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 Participation Agreement or your broker.

Where do I find...

Enrollment forms?

Enrollment forms can be found at www.omnitradebenefits.com. To locate the forms, go to the “Employer” section and chose the “Forms Library” link. Alternatively you can contact Benefit Solutions, Inc.

Plan Information

Plan Information is available at www.omnitradebenefits.com.

Benefit Booklets

Booklets were sent to your group when you initially enrolled. If you are in need of additional materials, please contact Benefit Solutions, Inc. The website will have plan highlights and booklets for download.

Benefit Summaries

Benefit summaries are available online at www.omnitradebenefits.com. They are listed under the line of coverage, then select “Highlights.” If you have additional 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 broker.

Whom do I ask about my bill?

Billing questions should be directed to Benefit Solutions, Inc..

My renewal?

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

New Groups

How do I verify that my enrollment has been processed?

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

How do I join the Omnitrade Health Trust?

For information regarding Omnitrade Health Trust membership, contact Wells Fargo Insurance Services. Or you can go online to <http://www.omnitradebenefits.com> to download an application and investment schedule.

Enrollments/changes?

Please send enrollment/change questions to Benefit Solutions, Inc.. 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 Solutions, Inc. by March 20th.

Claims?

Questions about claims should be asked of the insurer. Please note that neither Benefit Solutions, Inc. nor Wells Fargo Insurance Services 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 Solutions, Inc. 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.

I sent an enrollment but I have not received an ID card. How can I make sure I am enrolled?

Please note that WDS and VSP do not issue individual ID cards. For medical coverage cards, after Benefit Solutions, Inc. communicates enrollment information with the insurer, ID cards take an additional 12-14 business days to be printed and mailed. If you have not received a card, please contact Benefit Solutions, Inc. to verify enrollment.

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 Participation Agreement for information regarding probationary periods for part-time to full-time transitions.

Glossary of Terms

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

Carrier: Term used to describe the insurance company.

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 care coverage when specific events occur that would normally result in loss of coverage.

COBRA FSA: Some employers may offer the continuation of a flexible spending account on COBRA for the current year only.

Effective Date: The date coverage begins.

HIPAA: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides expanded rights and protections for participants and beneficiaries in group health 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: SHPS generally provides a HIPAA certificate to verify continuous coverage through COBRA. 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.

Initial Rights Notification: Federal law requires that certain information about COBRA be provided to employees and their spouses at the time the employee is hired. This information is included in an Initial Rights Notification letter.

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.

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

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's identified information). It also includes health information with data items, which reasonably could be expected to allow individual identification.

Qualifying Beneficiary (QB): Generally, a qualifying beneficiary is any individual who, on the day before a qualifying event, is covered under a group health plan maintained by the employer of a covered employee by virtue of being: (1) the covered employee, (2) the spouse of the covered employee, or (3) the dependent child of the covered employee. Exceptions include certain nonresident aliens.

Qualifying Event (QE): A qualifying event is any one of the following events that would result in the loss of health insurance coverage: (1) the death of the covered employee, (2) the termination (other than for reasons of gross misconduct) of a covered employee's employment, (3) a reduction in a covered employee's hours of employment, (4) the divorce or legal separation of a covered employee from the employee's spouse, (5) a covered employee becoming entitled to Medicare benefits, (6) a dependent child ceasing to be a dependent child of the covered employee under the terms of the group health plan, and (7) with respect to certain retirees and their dependents, bankruptcy proceedings of an employer under Title 11 of the U.S. Code, commencing on or after July 1, 1986.

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.



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Vision Service Plan (VSP) – Vision	
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