AMERICAN TRUST
Administrators, Inc.
7223 West 95th Street, Suite 301, Overland Park, Kansas 66212-2291

SERVICE MANUAL

AMERISHARE

MEDICAL REIMBURSEMENT PLAN

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SECTION I

INTRODUCTION

Thank you for selecting American Trust Administrators, Inc. (ATA) as the service organization for your employer-sponsored medical reimbursement plan. The purpose of this Service Manual is to provide a quick source of information that may be used in answering some of the basic questions pertaining to your plan. The primary focus of this manual addresses the areas of Eligibility, Administration, Billing, and Claims.

Please be advised that this manual is intended to be used for informational and instructional purposes only. The Master Contracts and the Plan Document determine rights and coverages.

If you have questions regarding the information contained in this manual or your Plan Document, please contact your agent or American Trust Administrators, Inc. at **(800) 843-4121. Please contact an ATA employee directly using one of the following phone extensions:**

5500 Preparation Service	**Ext. 9860**	**jana.berg@ataamerica.com**
Administration	**Ext. 9869**	**rochelle.llamas@ataamerica.com**
Billing	**Ext. 9861**	**kathy.vadnais@ataamerica.com**
COBRA	**Ext. 9869**	**rochelle.llamas@ataamerica.com**
Customer Service – Claims	**Call**	**1-800-843-4121**
Eligibility	**Ext. 9869**	**rochelle.llamas@ataamerica.com**
Underwriting	**Ext. 9871** **Ext. 9867**	**tina.strange@ataamerica.com** **pam.troxel@ataamerica.com** **nancy.legere@ataamerica.com**

SECTION II

ELIGIBILITY

This section describes how to:

- Add new employees and dependents.
- Make changes to the coverages of existing employees and dependents.
- Add dependents who do not reside with a single or divorced employee.
- Terminate existing employees and dependents.
- Handle coverage for a temporarily laid off employee.
- Handle coverage for rehired employees and their eligible dependents.

Important: The following procedures are based upon the provisions of our standard plans. Your plan document may have been altered to incorporate a provision that is specific to your plan. In the event there is a conflict between this manual and your plan document, the provisions of your plan document prevail.

Procedures for Adding New Employees and Dependents

Important: All requests to add new employees and their dependents must be signed and dated by the employee within 30 days of becoming eligible for coverage. In addition, the request for coverage must be received by the service organization (ATA) within 52 days from the date the employee first becomes eligible for coverage.*

Any enrollment form that is not signed or received within the specified time indicated above will be considered late entrants. The employee and any dependent to be added will be subject to the 6-month late entrant waiting period. The late entrant date is calculated from the date ATA receives the enrollment form.

Please refer to your Plan Document regarding the enrollment period that is specific to your Plan, as PLAN ELECTION PERIODS, LIMITED OPEN ENROLLMENT AND **OPEN ENROLLMENT PERIODS ARE NOT ALLOWED ON SOME PLANS**.

All newly hired employees **must complete, sign, and date** an **ATA Enrollment / Refusal form[1]** regardless of whether or not they are electing to participate in the plan. If any benefit is Non-Contributory, the employee and/or dependent(s) must enroll in the coverage.

- All employee's and/ or dependents who are aliens, legally residing in the U.S.A., must submit a copy of their resident alien card, work visa, approval notice for a nonimmigrant worker, or a copy of their temporary social security card.
- Under Non-Contributory plans (the employee does not pay any of the cost), all eligible employees and dependents MUST elect coverage.

Under Contributory plans (the employee pays part of the cost), eligible employees and dependents may refuse a coverage or all coverages as long as group participation is met (75% of total eligible employees and dependents, excluding those with similar coverage elsewhere).

ATA Enrollment / Refusal Forms[1] should be mailed to the following address:

American Trust Administrators, Inc.
Attn: Eligibility Department
7223 West 95th Street, Suite 301
Overland Park, Kansas 66212-2291

Detailed information pertaining to the definition of Employee, **D**ependent, etc. can be found in the "Definitions" section located in **Appendix A.**

*** The employee must first elect coverage before his/her dependents are eligible for coverage. Employees within the same group that are married may elect coverage and rate structures that best fit their needs, however, dual coverage is not allowed.**

[1] ATA Enrollment / Refusal Form is located in **Appendix F**.

Procedures for Making Changes to the Coverages of Existing Employees and Dependents

Important: Requests to change the coverages of existing employees and their dependents will be effective the first of the month following ATA's receipt of the request. However, late requests and requests to add or re-add new dependents or employees will require further underwriting review to determine their effective date. Coverage changes for plans that include Plan Election Periods, Limited Open Enrollment or Open Enrollment can only be made in the time period specified in the Plan Document Amendment attached to the Plan Document.

Please note: A request to add medical coverage for an employee and/or dependent who has experienced a special enrollment event (HIPAA Qualifying Event) due to loss of medical coverage, must be submitted on a change form including documentation to verify the loss of prior health coverag (see appendix B, Section 2, Part D, Subpart 4).

All requests to change coverage on an existing employee and dependent **must be completed, signed, and dated** by the employee using the **Change Form.**[1] Use this form to make following types of changes to an existing employee's coverage:

- ❑ Name change.
- ❑ Address change.
- ❑ Provide Missing Social Security Number.
- ❑ Request to Add Benefits for existing employees.
- ❑ Request to Add Benefits for existing dependents.
- ❑ Request to Add Benefits for **new** dependents.
- ❑ Request to Discontinue Benefits for existing employees.
- ❑ Request to Discontinue Benefits for existing dependents.

Change Forms[1] should be mailed to the following address:

American Trust Administrators, Inc.
Attn: Eligibility Department
7223 West 95th Street, Suite 301
Overland Park, Kansas 66212-2291

Detailed information pertaining to the definition of Employee, Dependent, Full-Time, Effective Dates, etc. can be found in the "Definitions" section located in **Appendix A**.

[1] Change Form is located in **Appendix F**.

Procedures for Single or Divorced Employees Adding Dependent Children That Do Not Reside With the Employee

Timely employees and employees requesting to add dependents after their initial enrollment period are required to provide:

- Qualified Medical Child Support Order (Subject to the provisions of Appendix B number 11) or;
- A Complete Divorce Decree or;
- Tax records to verify that the employee provides 50% support and maintenance of the dependent(s);

ATA Enrollment / Refusal Forms[1], Change Forms[2], Qualified Medical Child Support Orders, Divorce Decrees and Tax Forms should be mailed to the following address:

American Trust Administrators, Inc.
Attn: Eligibility Department
7223 West 95th Street, Suite 301
Overland Park, Kansas 66212-2291

Detailed information pertaining to Employee Eligibility, Dependent Eligibility, Qualified Medical Child Support Order, etc. can be found in the "Definitions" section located in **Appendix B.**

[1] ATA Enrollment / Refusal Form is located in **Appendix F**.
[2] Change Form is located in **Appendix F**.

Procedures for Terminating the Coverages of Existing Employees and Dependents

Important: Requests to terminate the coverages of existing employees and their dependents will be effective the first of the month following ATA's receipt of the request.

Any eligible employee and/or dependent who wants to discontinue benefits must complete the **Change Form**.[1] Approval of this request depends on the effect it may have on your group's employee and dependent participation levels. A Change Form[1] may also be used to send notice that an existing employee has been terminated, is no longer working the minimum number of hours required to be considered a full-time employee, or is no longer actively at work.[2] In addition, you may indicate terminated employees on your monthly billing statement but **you must provide the employee's last date of employment.**

If your plan is subject to COBRA [3], you must send the COBRA Form A[4] to ATA within the time frames specified in the COBRA guidelines. Failure to do so may subject your plan to penalties and damages.

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), all members will automatically receive a certificate of coverage when their coverage terminates. The certificates will be mailed by ATA directly to the member's last reported home address.

Change Forms[1] should be mailed to the following address:

American Trust Administrators, Inc.
Attn: Eligibility Department
7223 West 95th Street, Suite 301
Overland Park, Kansas 66212-2291

[1] Change Form is located in **Appendix F**.
[2] Information pertaining to Termination of Coverage can be found in **Appendix C**.
[3] Information pertaining to COBRA administration can be found in **Appendix E.**
[4] COBRA Form A is located in **Appendix F**.

Procedures for an Employee Who Is Temporarily Laid Off

Important: Your company can use a continuation of coverage for up to three months for "temporary layoffs" (six months if initially elected and the group is not subject to COBRA).[2] If a temporary layoff applies, ATA must receive written notification for each employee who has been laid off, the duration of the continuation, and that this layoff is "temporary". The employer is required to provide written notification to ATA once the employee returns to full-time active work. If the employee does not return to full-time active work after the specified continuation has lapsed, the employer should then submit in writing to the Service Organization (ATA) that the employee has not returned to work. The employee will be terminated at the end of the month the continuation exhausts. The written notification can be a completed COBRA form A[4] (if your group is subject to COBRA) provided to the COBRA department for each employee not returning to work within the specified time period noting that the employee was on "temporary lay-off" and has not returned to work. If an individual is re-hired after 3 months, the employee is required to complete a new Enrollment / Refusal Form[1] and is subject to your company's specified waiting period for new employees. Remember, all requests to add new employees and their dependents must be signed and dated by the employee within 30 days of becoming eligible for coverage, and the request must be received by the service organization (ATA) within 52 days from the date the employee first becomes eligible for coverage.

ATA Enrollment / Refusal Forms[1] and COBRA Forms should be mailed to the following address:

American Trust Administrators, Inc.
Attn: Eligibility Department
7223 West 95th Street, Suite 301
Overland Park, Kansas 66212-2291

[1] ATA Enrollment / Refusal Form is located in **Appendix F.**
[2] Information pertaining to Termination of Coverage can be found in **Appendix C**.
[3] Information pertaining to COBRA administration can be found in **Appendix E.**
[4] COBRA Form A is located in **Appendix F**.

Procedures for Rehired Employees and Their Eligible Dependents

Important: All requests to reinstate rehired employees and/or their dependents must be completed on an Enrollment / Refusal Form[1]. The employee must complete the required waiting period, and the Enrollment / Refusal Form[1] must be signed within 30 days of becoming eligible for coverage. In addition, the request for coverage must be received by the service organization (ATA) within 52 days from the date the employee and/or the dependents first become eligible.

ATA Enrollment / Refusal Forms[1] and/or Change Forms[2] should be mailed to the following address:

American Trust Administrators, Inc.
Attn: Eligibility Department
7223 West 95th Street, Suite 301
Overland Park, Kansas 66212-2291

Detailed information pertaining to the definition of Employee, Dependent, Full-Time, Effective Dates, etc. can be found in the "Definitions" section located in **Appendix A.**

[1] ATA Enrollment / Refusal Form is located in **Appendix F.**
[2] Change Form is located in **Appendix F**.

SECTION III

ADMINISTRATION

This section includes the following information:

- Information regarding ATA's relationships with external networks.

ATA's Relationships with Other Service Providers

The Administration Department is responsible for establishing and maintaining relationships with other service providers, including medical provider networks, a prescription drug network, and a vision provider network. Each relationship is summarized below:

1. Medical Provider Networks

- ATA contracts with many medical provider networks throughout the continental United States. The employee identification card contains information for a particular provider network, including:

  - Name of the provider network.
  - Claim filing information.
  - Pre-treatment review information.

2. Prescription Drug Network

- ATA has contracts with a national Pharmacy Network. All of the information needed by a participating pharmacist is readily available on the employee identification card. The Pharmacy Network includes a majority of the chain pharmacies located throughout the country as well as thousands of independent pharmacies located in rural areas.

- It is the employer's responsibility to notify American Trust Administrators, Inc. of all terminations on a timely basis. This will prevent employees from using the prescription drug card after their termination date. It is advisable to collect the ID cards from any employee who terminates their employment with your firm on their termination date.

SECTION IV

Monthly Billing Procedures

Your monthly invoice is routinely generated around the 19th of each month and mailed around the 21th of the month. You will receive a file copy for your records and a remittance copy to be returned with your payment.

In order for ATA to provide you the best service possible, please follow these guidelines:

1. Amount Due

- **Please pay the amount due in full as stated on your invoice.** Any adjustments resulting from additions, changes, or terminations will be reflected on your next invoice. **Please indicate any and all discrepancies on your remittance.**

2. Due Date

- Payments are due on the **1st** of the coverage month. It is important to send your payment by the due date to ensure that your next statement reflects any changes.

- Payments must be postmarked prior to the end of the grace period (30 days) as stated in your Excess Loss Reinsurance policy or your coverage may be terminated.

3. Terminated Employees

- You may utilize the section on the back of your remittance to indicate employees who have terminated employment with your company. Please indicate the last day the employee was actively at work.

- Please also submit the **ATA Change Form**[1] to reflect terminated employees and dependents (see Procedures for Terminating the Coverages of Existing Employees).

[1] Form MCCF01 is located in **Appendix F**.

4. New Employees

- Do not submit a payment for new employees not listed on your bill. Please have them complete, sign, and date the **ATA Enrollment / Refusal Form**[2] and submit it to the attention of the Eligibility Department. Adjustments (if applicable) will appear on your next bill.

5. Remittance

- Please send your payment and the remittance copy of your invoice using the return envelope included with your original invoice.

Payment should be mailed to the following address:

American Trust Administrators, Inc.
P.O. Box 410193
Kansas City, MO 64141-0193

[2] ATA Enrollment / Refusal Form is located in **Appendix F**.

Analysis of the Monthly Invoice

The following analysis is based on a typical invoice for a group that has elected the maximum funding option:

1. Invoice Header

This is the date the invoice was generated by ATA's Billing Department.

American Trust Administrators, Inc.
PO Box 410193
Kansas City. MO 64141-0193
Kathy Vadnais: Phone (913) 378-9861 - Rochelle Llamas: Fax (913) 378-9936

A return envelope with this address will be included with your monthly invoice.

Customer: Group # 99999
ABC Company
123 Main Street
Johnson, KS 66200

Group name and billing address.

Invoice Number
00000001
Invoice Date:
7/20/2017
Due Date:
8/1/2017
Period:
08/2017

This is the date your payment is due. All payments must be postmarked prior to the end of the grace period to avoid termination.

Type	Description	Sub Total	Amount
FIXD	**Fixed Costs**		**3000.00**
CFND	**Claims Funding**		**300.00**
		TOTAL:	**$ 3300.00**

FIXD **The insurance company excess loss insurance premium billing and American Trust Administrators statement for services are combined for the convenience of employer plan administrators. The excess loss insurance policy insures the employer and the premium for such coverage should be paid by the employer, not from plan assets. Employee contributions may not be used to pay excess loss premiums.**

CFND **This amount represents reserve funding to pay claims. Collected employee contributions are applied to this reserve.**

2. Invoice Detail

Group Number		Member Name	Member Number	YY MM	Med/ Den	Cur Cnt	Ret Cnt	Total Dollars	FIXD	CFND
		[A]			[B]		[E]		[C]	[D]
09999-0001		Doe, John	S409999X0000001	2017 08	EE/	1	0	1100.00	1000.00	100.00
09999-0001		Ott, Ed	S409999X0000002	2017 08	EE/	1	0	1100.00	1000.00	100.00
09999-0001		Bee, Meg	S409999X0000003	2017 08	EE/	1	0	1100.00	1000.00	100.00
_____						_____	_____	_____	_____	_____
Totals:						4	0	3300.00	3000.00	300.00
Cur Cnts:								4	4	4
Ret Cnts:								0	0	0
** Description of Billing Categories can be found on the Invoice.										
** Medical/Dental Tiers: EE-Employee Only ES-Employee plus Spouse EC-Employee plus Child FM-Family										

[A] Employee:

- Employee name

[B] Coverage

- Description of the current level of coverage.

[C] Fixed Cost

- This is the portion of the payment that is independent of claims activity. The payment includes specific, aggregate, and medical conversion premium, utilization management fees, and administrative service fees. It may also include managed care, COBRA, HIPAA, Form 5500 Preparation, and Terminal Liability fees, if applicable.

[D] Claim Funding

- This column applies to groups electing the maximum funding option. This portion of the payment (net of claim fees) is credited to the employer's reserve account.

[E] Adjustments

- This is the section of the invoice that displays the prior month(s) adjustments (if any) by period.

2. Remittance Section

The following information is reflected on the back page of your remittance copy:

Remittance Information:

Please Enter the Amount Remitted ⟶ _____

Amount to be Applied to Reserve Account ⟶ _____

Note! Please pay invoice in full. All adjustments received prior to the 15th of the month will be reflected on next month's invoice.

Use this space to designate a portion of your payment to your reserve account.

Employee Information for the Current Month

Please Note:

- **Complete Enrollment/Refusal forms for new enrollees. Please be advised that Enrollee Enrollment/Refusal forms must be signed within 30 days of first becoming eligible, and received by ATA no later than 52 days from the date the new enrollee became eligible to enroll under the plan. Do not remit premium for new enrollees until they appear on your invoice. Send the form directly to:**

American Trust Administrators, Inc.
7223 West 95th Street, Suite 301
Overland Park, Kansas 66212-2291

- **Please submit a change form to report enrollee address or coverage changes.**
- **Use the reconciliation below to report <u>TERMINATION OF EMPLOYMENT or COBRA ONLY</u>!**

NAME	SSN OR DATE OF BIRTH	REASON FOR TERMINATION	LAST DAY AT WORK

<u>COBRA CONTINUATION REMINDER:</u>

If you are subject to COBRA, you must send American Trust Administrators, Inc. the COBRA FORM A for anyone eligible for COBRA CONTINUATION. This coverage will not be provided until American Trust Administrators, Inc. receives and approves the COBRA ELECTION FORM.

If any of the covered persons listed on the invoice are continuing coverage under COBRA, such person's COBRA premium must be paid within 31 days of the due date or their COBRA continuation will terminate. Please indicate on the invoice reconciliation section above if any COBRA continuees who are making payments directly to you have failed to make timely payments and advise of the last month through which premium was paid.

Claim History Reports

In addition to the monthly invoice, you will receive a claims history report for the previous period. This report shows a summary of your reserve account history and lists all of the claims processed and paid during the calendar month period.

See sample on next page:

AMERICAN TRUST ADMINISTRATORS, INC.
Print Date: 07/14/2017 7223 West 95th Street, Suite 301, Overland Park, KS 66212-2291
Page: 1
Print ID: 00000001
clmhis

BILLING DATE 02/01/2017 ***** C L A I M S H I S T O R Y R E P O R T
*****

****
* This report contains personal and confidential information. It should not *
* be disclosed for any purpose other than evaluating this medical plan *
****

ABC Company S409999 CLAIMS PAID BETWEEN 12/01/2016 AND 12/31/2016

Reserve Account Activity Summary

Prior Month Ending Reserve Balance	31,314.84
Employer Deposits	9,098.42
Deposits from COBRA Individuals	0.00
Aggregate Advances by Ins Co	0.00
Claims Paid This Month	-2,789.30
Interest Credit	7.72
Current Month Ending Reserve Balance	37,631.68

This is the period that is being reported on.

SAMPLE CLAIMS HISTORY REPORT

SSN	EMPLOYEE/ DEPENDENT	DEP CODE	CLAIM NUMBER	BC	DATE INCURRED	DATE PAID	AMOUNT PAID	EMPLOYER PAYMENTS TO PLAN CLMS-PD-MTH	EMPLOYER PAYMENTS TO PLAN CLMS-PD-YTD	INSURANCE COMPANY PAYMENTS TO PLAN CLMS-PD-MTH	INSURANCE COMPANY PAYMENTS TO PLAN CLMS-PD-YTD
999999901	APPLE, ALICE	E						0.00	0.00	0.00	0.00
999999902	BATES, BILLY	E	00000091-01	M	01012009	01152009	78.62				
			00000092-01	M	01012009	01152009	28.00				
			00000093-01	M	01012009	01152009	45.00				
			00000094-01	M	01012009	01152009	30.00				
								181.62	181.62	0.00	0.00
999999903	CRY, CANDICE	E	00000095-01	M	01192009	01282009	115.50				
								115.50	0.00	0.00	0.00
999999904	DILLION, DEB	E						0.00	0.00	0.00	0.00
999999905	FUNK, FRED	E						0.00	0.00	0.00	0.00
999999906	GOON, GREG	E						0.00	0.00	0.00	0.00
999999907	HANNA, HANK	E	00000096-01	M	01052009	01152009	42.60				
			00000097-01	M	01172009	01282009	76.02				
			00000098-01	M	01082009	01282009	39.90				
			00000099-01	M	01182009	01282009	57.42				
								215.94	215.94	0.00	0.00
							CLAIMS TOTALS	513.06	397.56	0.00	0.00
							SUMMARY BY BENEFIT TYPE				
							(M) Medical	513.06	397.56	0.00	0.00
							SUMMARY TOTALS	513.06	397.56	0.00	0.00
							CLAIM FEE PERCENTAGE	5%			
							CURRENT MONTH CLAIM FEE	25.65			

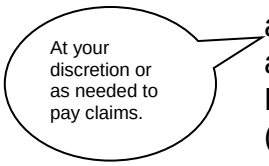
Funding Options

Groups may choose one of two funding options[1]:

1. Maximum Funding

- Under this method of funding, your monthly invoice will include a column titled "Line item CFND". You must pay the entire amount of the invoice. The portion of the payment that covers this cost (CFND) will be credited to your reserve account.

2. Minimum Funding



- Under this method of funding, you make periodic deposits to your reserve account. Your monthly invoice will reflect excess loss premiums and administrative service fees plus premium for fully insured coverages, including Life, AD&D, and Weekly Income, if elected. It also includes the claims fee (CFEE) (if any) for claims paid the prior month

- If you send reserve account funds with your monthly premium payment, you must indicate what portion of your check is to be credited to your reserve account by using the space provided on the back of your Billing Statement.

- If your reserve account has insufficient funds to pay claims, processed claims will go on hold pending funding. You will receive an Interim Billing statement advising of the dollar amount needed to release the claims on hold for funding[2].

[1] Changing from Maximum Funding to Minimum Funding or vice versa must be requested by the employer in writing and received by the ATA Billing Department 30 days prior to the requested change date. Requests not received timely will become effective the following month.

[2] Refer to the following page to see a sample "Interim Billing Statement". Please note that the "Interim Billing Statement" most likely pertains to the Minimum Funding Method. However, there are situations under the Maximum Funding Option that could result in having claims put on hold for funding. If you are a maximum funding group that receives an Interim Bill, the reason for the Interim Bill will be highlighted.

AMERICAN TRUST
Administrators, ® Inc.

Interim Reserve Account Billing
08/07/2017
S409999

ABC COMPANY, INC. **Email:PrivacyOfficer@ABCCompany.com**
Attn: Privacy Officer
1200 MAIN STREET
N. KANSAS CITY, MO 64116

Dear Privacy Officer,

This is the reserve balance as of the date of the Interim Bill. Should claims be processed for which the reserve is sufficient, they will not be released ahead of larger claims listed on the Interim Bill that are pending funding.

In addition, if your plan has a prescription drug card benefit, those claims will be processed regardless of the reserve balance and other claims on hold. You are expected to replenish any shortfall as a result of drug card processing immediately upon request.

The current balance in your claim reserve fund is $ XX.XX.

A minimum of $XX.XX must be remitted to release the enclosed list of claims on hold. Please make your check payable to American Trust Administrators, Inc. and mail to:

American Trust Administrators, Inc.
P O Box 410193
Kansas City, MO 64141-0193

SAMPLE INTERIM BILLING LETTER for MINIMUM FUNDED GROUP

Funds also may be wired to the following:

BANK NAME:	UMB Bank, n.a.
ACCOUNT NAME:	PBMR Claims Account#3
ACCOUNT NUMBER:	XX-XXXX-XXX-X
ABA ROUTING NUMBER:	XXXXXXXXX
REFERENCE/DESCRIPTION:	S409999

You have an obligation under the terms of the plan to provide those benefits for your employees. Please provide funds for payments of benefits immediately upon receipt of this notice. Please note that claims funding is not listed on your regular premium bill, but can be added to your monthly payment and should be considered every month. Once paid, the claims appear on your monthly claim history report.

Groups with 12/15 or 12/18 contracts (specific and/or aggregate): Please remember that in order to be reimbursed for losses, eligible claims must be PAID within the applicable contract period. We encourage you to pay this Interim Bill promptly and in full, in order to take full advantage of any of the insurance company funding provisions of your excess loss policy. Groups with the Drug benefit should be aware that the semi-monthly processing of these claims decreases the balance in their reserve account. This is a billing for reserve funding only.

If you have questions regarding this billing or your claim reserve account, please call me at 913-378-9861. For questions regarding claims, please call customer service at 800-843-4121.

Sincerely,
Kathryn Vadnais Billing Department

AMERICAN TRUST
Administrators, ® Inc.

Interim Reserve Account Billing
05/18/2017 UPDATED
S409999

ABC COMPANY, INC. **Email:PrivacyOfficer@ABCCompany.com**
Attn: Privacy Officer
1200 MAIN STREET
N. KANSAS CITY, MO 64116

Dear Privacy Officer:

Amounts paid in January and February totaling $ XX.XX were paid from your claim fund for claims that had been incurred in the prior plan year, so they did not count towards this year's aggregate (see the enclosed list). This has left your claim fund $XX.XX Short to fund this year's claims.

The current balance in your claims fund is $XX.XX.
XX.XX must be remitted before the attached list of claims can be released. Please make your check payable to American Trust Administrators, Inc. and mail to:

American Trust Administrators, Inc.
PO Box 410193
Kansas City, MO 64141-0193

SAMPLE INTERIM BILLING LETTER for MAXIMUM FUNDED GROUP

Funds also may be wired to the following:

BANK NAME:	UMB Bank, n.a.
ACCOUNT NAME:	PSMR Claims Account
ACCOUNT NUMBER:	XX-XXXX-XXX-X
ABA ROUTING NUMBER:	XXXXXXXXX
REFERENCE/DESCRIPTION:	S409999

You have an obligation under the terms of the plan to provide those benefits for your employees. Please provide funds for payments of benefits immediately upon receipt of this notice. Once paid, the claim(s) will appear on your monthly claim history report.

Groups with 12/15 or 12/18 contracts (specific and/or aggregate): Please remember that in order to be reimbursed for losses, eligible claims must be PAID within the applicable contract period.

This is a billing for reserve funding only. Your premium billing will be mailed at the usual time.

If you have questions regarding this billing or your claim reserve account, please call the billing department at 913-378-9861. For questions regarding claims, please call customer service at 800-843-4121.

Sincerely,
Kathryn Vadnais, Billing Department

Interim Reserve Account Billing Claims

Group	Processed	Claim	Name	E/D	Incurred	Amount	Employer Pays
S409999	07/24/2017	A0999999-01	Doe, John	e	06/13/2017	770.23	770.23
S409999	08/04/2017	A0999999-02	Ott, Ed	e	07/05/2017	44.81	44.81
S409999	08/04/2017	A0999999-03	Bee, Meg	e	06/13/2017	304.03	304.03

ATA Annual Reports

Annual reports are generated approximately two months following your plan year-end. The annual report summarizes the plan costs of your employer-sponsored medical reimbursement plan. The report includes an executive summary, paid claims by individual, by provider, and by type of service. The report also includes sections on reimbursements under the specific and aggregate excess loss policies. Please refer to the sample annual report contained in the following pages.

A N N U A L R E P O R T

ABC COMPANY, INC.

P O L I C Y N U M B E R: S409999

P O L I C Y Y E A R: 01/01/2009 – 12/31/2009

SAMPLE ANNUAL REPORT

This report contains personal and confidential information.
It should not be disclosed for any purpose other than
evaluating this medical plan.

T A B L E O F C O N T E N T S

EXECUTIVE SUMMARY

Employer: ABC COMPANY, INC.
Policy Number: S409999
Policy Year: 01/01/2009
12/31/2009

Total Paid Claims		17,418.69	(Section 2, 3, or 4)
Less Insurance Company Specific Reimbursements	(	0.00)	(Section 2 or 5.1)
Less Paid Claims Not Applied to Aggregate	(	955.76)	(Section 2, 5.1, or 5.3)
Equals Net Paid Claims		16,462.93	
Less Paid Claims Exceeding Attachment Point	(	0.00)	(Section 5.2)
Equals Adjusted Net Paid Claims		16,462.93	
Plus Paid Claims Not Applied to Aggregate		955.76	(Section 2, 5.1, or 5.3)
Plus Paid Fixed Cost		39,044.96	(Section 6)
Equals Total Plan Cost		56,463.65	

The sum of Adjusted Net Paid Claims and Paid Claims Not Applied to Aggregate equals employer paid claims including claim fees.

Includes reinsurance premiums and Administrative fees. (See Fixed Cost Report).

Employer paid claims listed throughout this report include the Administrator's claim fee.

Employer Paid Claims include the Administrator's Claim Fee. Section 1

PAID CLAIMS - BY INDIVIDUAL BY LOCATION

Employer: ABC COMPANY, INC.
Policy Number: S409999
Policy Year: 01/01/2009
12/31/2009

Location: 0001
Location Name: ABC COMPANY, INC.

May exceed one specific deductible due to claims run-in from prior policy year or due to a higher specific deductible placed on an individual at policy issue or due to the Administrator's claim fee which is charged on claims up to the specific deductible.

ID Number	Individual	Employer: Applied To Aggregate	Employer: Not Applied To Aggregate	Employer: Sub-Total	Insurance Company Specific Reimbs.	Total
999999901	ALICE APPLE	2000.00	0.00	2000.00	0.00	2000.00
999999902	BILLY BATES	534.09	0.00	534.09	0.00	534.09
999999903	CANDICE CRY	353.35	0.00	353.35	0.00	353.35
999999904	DEB DILLION	4136.92	0.00	4136.92	0.00	16,892.65
999999905	ED WADE	92.82	0.00	92.82	0.00	92.82
999999906	PAT WADE	297.39	0.00	297.39	0.00	297.39
999999907	SARA WADE	0.00	0.00	0.00	0.00	0.00
999999908	DON WADE	3388.54	0.00	3388.54	0.00	5,598.26
999999909	FRED FUNK	284.41	0.00	284.41	0.00	284.41
999999910	GREG GOON	2165.19	0.00	2165.19	0.00	2165.19
999999911	HANK HANNA	3064.12	955.76	4019.88	0.00	4019.88
999999912	HOLLY HANNA	0.00	0.00	0.00	0.00	0.00
999999913	HAL HANNA	146.10	0.00	146.10	0.00	146.10
	Report Total	16,462.93	955.76	17,418.69	0.00	17,418.69

Employer Paid Claims Include the Administrator's Claim Fee.

Section 2

PAID CLAIMS – TO PROVIDERS AND DIRECT TO INDIVIDUALS BY LOCATION
(paid claims include both the employer and specific reimbursements)

Employer: ABC COMPANY, INC.
Policy Number: S409999
Policy Year: 01/01/2009
12/31/2009

Location: 0001
Location Name: ABC COMPANY, INC.

Provider	Amount
ANDRIACCHI MD, FRANCES C	146.52
BARTON MEMORIAL HOSPITAL	39.96
BUMGARNER MD, TERRY	22.20
CAPITAL MEDICAL CENTER	8.88
CAPITOL MEDICAL CENTER	839.16
CHILDREN / UNIV MED GROUP	294.20
COOR DO, SAMUEL E	166.06
DE GIVE MD, HENRY L	1,089.06
DOOLITTLE MD, GARY M	729.14
GHC HSP #1/ MARK REED HSP	277.50
KARPEL MD, JOHN	129.65
MEMORIAL CLINIC LTD	164.28
MERCHANT MD INC PS, MICHAEL J	145.63
NOVACARE O&P	32.86
OLYMPIA ORTHOPAEDIC ASSOC	1,128.13
PARRINO MD, TREMONT V	150.96
POUW MD, T HIAN	142.08
PROVIDENCE PHYS THERAPY	758.13
RANIER SURGICAL, INC.	180.26
RX CLAIMS VENDOR	467.98
SCHOLES MD, GARY N	299.93
SOURI MD, MAHADEV K	1,260.96
ST PETER HOSPITAL	518.59
TAHOE EMERGENCY PHYSICIAN	39.96
URGENT CARE OF OLYMPIA	7,176.70
Sub-Total	16,208.78

Direct to Individuals	
ALICE APPLE	518.41
CANDICE CRY	378.74
DEB DILLION	312.76
Sub-Total	1,209.91
Report Total	17,418.69

Employer Paid Claims include the Administrator's Claim Fee.

Section 3

PAID CLAIMS – BY TYPE OF SERVICE BY LOCATION
(paid claims include both the employer and specific reimbursements)

Employer: ABC COMPANY, INC.
Policy Number: S409999
Policy Year: 01/01/2009
12/31/2009

Location: 0001
Location Name: ABC COMPANY, INC.

Type of Service	Amount	Percent of Total
IMMUNIZATION (S)	955.76	5.49%
LABORATORY SERVICES	839.16	4.82%
MEDICAL SERVICES	1,743.01	10.01%
MISCELLANEOUS SERVICE	4,193.73	24.08%
PHYSICAL THERAPY	438.67	2.52%
PHYSICIAN OFFICE VISIT	150.96	0.87%
PHYSICIAN VISIT	1,526.37	8.76%
PRESCRIPTION DRUGS	2,900.35	16.65%
RADIOLOGY SERVICES	1,124.22	6.45%
SURGERY	2,501.51	14.36%
WELLNESS / PREVENTATIVE	1,044.95	5.99%

Report Total	17,418.69	100.00%

Employer Paid Claims include the Administrator's Claim Fee.

Section 4

AGGREGATE EXCESS LOSS

Employer: ABC COMPANY, INC. Reporting Period: 12/31/2009
Policy Number: S409999
Policy Year: 01/01/2009
12/31/2009
Specific Deductible: 20000
Specific Basis: 12/18
Aggregate Basis 12/18
Current Funding Method: Minimum

Aggregate Attachment Factors:

	Medical	Dental	Vision	Total
Employee Only	175.56	0.00	0.00	175.56
Employee/Spouse	473.88	0.00	0.00	473.88
Employee/Children	473.88	0.00	0.00	473.88
Employee/Family	473.88	0.00	0.00	473.88

If the calculated attachment point, based on census*, is less than this amount, the minimum is substituted. This is compared on a monthly basis as well as an annual basis.

Minimum Monthly Attachment Point: 3,917.75
*Minimum Annual Attachment Point: 47,013.00

These claims apply to the aggregate – See aggregate advance on next page.

Month/ Year	# of EE Only	# of EE SPS	# of EE Chrn	# of EE Fam	Monthly Attachment Point	Yr-to-date Attachment Point (1)	Total Monthly Paid Claims (2)	Insurance Company Specific Reimbs. (3)	Claims Not Applied To Aggregate (4)	Yr-to-Date Net Paid Claims (5)	Ratio (5)/(1)	Month/ Year
01/2009	6	2	0	5	4,370.52	4,370.52	375.95	0.00	0.00	375.95	0.09	01/2009
02/2009	6	3	0	5	4,844.40	9,214.92	2,163.42	0.00	725.39	1,813.98	0.20	02/2009
03/2009	6	3	0	4	4,370.52	13,585.44	4,042.95	0.00	0.00	5,856.93	0.43	03/2009
04/2009	3	2	0	4	3,369.96	16,955.40	335.85	0.00	230.37	5,962.41	0.35	04/2009
05/2009	3	2	0	4	3,369.96	20,325.36	3,040.64	0.00	0.00	9,003.05	0.44	05/2009
06/2009	3	2	0	4	3,369.96	23,695.32	1,505.43	0.00	0.00	10,508.48	0.44	06/2009
07/2009	3	2	0	4	3,369.96	27,065.28	1,934.45	0.00	0.00	12,442.93	0.46	07/2009
08/2009	3	2	0	4	3,369.96	30,435.24	334.41	0.00	0.00	12,777.34	0.42	08/2009
09/2009	3	2	0	4	3,369.96	33,805.20	354.29	0.00	0.00	13,131.63	0.39	09/2009
10/2009	3	2	0	4	3,369.96	37,175.16	34.55	0.00	0.00	13,166.18	0.35	10/2009
11/2009	3	2	0	4	3,369.96	40,545.12	1,311.61	0.00	0.00	14,477.79	0.36	11/2009
12/2009	3	2	0	4	3,369.96	43,915.08	1,985.14	0.00	0.00	16,462.93	0.37	12/2009
Total	45	26	0	50	43,915.08	47,013.00*	17,418.69	0.00	955.76^	16,642.93	0.35	

Employer Paid Claims include the Administrator's Claim Fee. Section 5.1

AGGREGATE ADVANCE

Employer: ABC COMPANY, INC.
Policy Number: S409999
Policy Year: 01/01/2009
12/31/2009
Specific Deductible: 20000
Specific Basis: 12/18
Aggregate Basis 12/18
Current Funding Method: Minimum

Reporting Period: 12/31/2009

Aggregate Attachment Factors:

	Medical	Dental	Vision	Total
Employee Only	175.56	0.00	0.00	175.56
Employee/Spouse	473.88	0.00	0.00	473.88
Employee/Children	473.88	0.00	0.00	473.88
Employee/Family	473.88	0.00	0.00	473.88

Minimum Monthly Attachment Point: 3,917.75
*Minimum Annual Attachment Point: 47,013.00

Month/ Year	# of EE Only	# of EE SPS	# of EE Chrn	# of EE Fam	Monthly Attachment Point	Yr-to-date Attachment Point (1)	Monthly Net Paid Claims	Yr-to-Date Net Paid Claims (2)	Yr-to-Date Over/ -Under (2-1)	Monthly Advances Paid	Monthly Advances Repaid	Yr-to-Date Advance Balance
01/2009	6	2	0	5	4,370.52	4,370.52	375.95	375.95	-3,994.57	0.00	0.00	0.00
02/2009	6	3	0	5	4,844.40	9,214.92	1,438.03	1,813.98	-7,400.94	0.00	0.00	0.00
03/2009	6	3	0	4	4,370.52	13,585.44	4,042.95	5,856.93	-7,728.51	0.00	0.00	0.00
04/2009	3	2	0	4	3,369.96	16,955.40	105.48	5,962.41	-10,992.99	0.00	0.00	0.00
05/2009	3	2	0	4	3,369.96	20,325.36	3,040.64	9,003.05	-11,322.31	0.00	0.00	0.00
06/2009	3	2	0	4	3,369.96	23,695.32	1,505.43	10,508.48	-13,186.84	0.00	0.00	0.00
07/2009	3	2	0	4	3,369.96	27,065.28	1,934.45	12,442.93	-14,622.35	0.00	0.00	0.00
08/2009	3	2	0	4	3,369.96	30,435.24	334.41	12,777.34	-17,657.90	0.00	0.00	0.00
09/2009	3	2	0	4	3,369.96	33,805.20	354.29	13,131.63	-20,673.57	0.00	0.00	0.00
10/2009	3	2	0	4	3,369.96	37,175.16	34.55	13,166.18	-24,008.98	0.00	0.00	0.00
11/2009	3	2	0	4	3,369.96	40,545.12	1,311.61	14,477.79	-26,067.33	0.00	0.00	0.00
12/2009	3	2	0	4	3,369.96	43,915.08	1,985.14	16,462.93	-27,452.15	0.00	0.00	0.00
Total	45	26	0	50	43,915.08	47,013.00*	16,462.93	16,462.93	-30,550.07	0.00	0.00	0.00

Aggregate Advance Summary:

Year to Date Advance Balance	$0.00
Less Year to Date Over	$0.00
Equals Amount Due and Payable Upon Receipt	$0.00

Claims not applied to aggregate: $955.76

Employer Paid Claims include the Administrator's Claim Fee. Section 5.2

CLAIMS NOT APPLIED TO AGGREGATE

Employer: ABC COMPANY, INC. Reporting Period: 12/31/2009
Policy Number: S409999
Policy Year: 01/01/2009
12/31/2009

ID Number	Individual	Relation	Reason	Claim No.	Incr Date	Paid Date	Type of Service	Amount
999999911	HANK HANNA	e	EXC	01855289 01	07/07/2009	08/15/2009	ADDITIONAL BENEFITS	955.76
							Subtotal:	955.76
Report Total:								955.76

EXC = Excluded Benefit: 955.76
POP = Paid Outside Aggregate Contract Period: 0.00
ASD = Additional Specific Deductible: 0.00
RLE = Run-in Limit Exceeded: 0.00
EXR = Excess Rebate Amount 0.00

Employer Paid Claims include the Administrator's Claim Fee. Section 5.3

FIXED COST

Employer: ABC COMPANY, INC.
Policy Number: S409999
Policy Year: 01/01/2009
12/31/2009
Specific Deductible: 20000
Specific Basis: 12/18
Aggregate Basis 12/18

Reporting Period: 12/31/2009

Fixed Cost :

	Medical	Dental	Vision	Total
Employee Only	171.32	0.00	0.00	171.32
Employee/Spouse	412.31	0.00	0.00	412.31
Employee/Children	412.31	0.00	0.00	412.31
Employee/Family	412.31	0.00	0.00	412.31

Month/ Year	# of EE Only	# of EE SPS	# of EE Chrn	# of EE Fam	Monthly Paid Specific Premium (1)	Monthly Paid Aggregate Premium (2)	Monthly Paid Other Fixed Cost (3)	Total Monthly Paid Fixed Cost (1+2+3)	Yr-to-Date Paid Fixed Cost
01/2009	6	2	0	5	2,816.93	792.87	304.29	3,914.09	3,914.09
02/2009	6	3	0	5	3,113.32	878.46	334.62	4,326.40	8,240.49
03/2009	6	3	0	4	2,816.93	792.87	304.29	3,914.09	12,154.58
04/2009	3	2	0	4	2,149.44	610.41	227.97	2,987.82	15,142.40
05/2009	3	2	0	4	2,149.44	610.41	227.97	2,987.82	18,130.22
06/2009	3	2	0	4	2,149.44	610.41	227.97	2,987.82	21,118.04
07/2009	3	2	0	4	2,149.44	610.41	227.97	2,987.82	24,105.86
08/2009	3	2	0	4	2,149.44	610.41	227.97	2,987.82	27,093.68
09/2009	3	2	0	4	2,149.44	610.41	227.97	2,987.82	30,081.50
10/2009	3	2	0	4	2,149.44	610.41	227.97	2,987.82	33,069.32
11/2009	3	2	0	4	2,149.44	610.41	227.97	2,987.82	36,057.14
12/2009	3	2	0	4	2,149.44	610.41	227.97	2,987.82	39,044.96
Total	45	26	0	50	28,092.14	7,957.89	2,994.93	39,044.96	39,044.96

Monthly Paid Other Fixed Cost includes medical conversion premium, utilization management fees and administrative service fees. It may also include managed care, COBRA, HIPAA, Form 5500 preparation, and terminal liability fees, if applicable.

SECTION V

CLAIMS

This section contains the following information:

- Claims Filing Information.
- Pre-certification requirements.
- Customer service.
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Claims Filing Information

The following section describes how to file medical, prescription drug, dental, life, and weekly disability claims. **This manual is for informational and instructional purposes only. The Master Contracts and the Plan Document determine your rights and coverages.**

1. **Instructions For Filing Medical Claims**:

If you utilize a Preferred Provider, they will file your claim for you. If a non-preferred provider is utilized, a standard HCFA medical form or UB-92 medical form (or their successor forms) should be utilized. Your Plan reserves the right to require that additional information be submitted at any time depending on the circumstance of a particular situation.

- **Medical claims from non-preferred providers should be mailed to the following address:**

American Trust Administrators, Inc.
Attn: Claims Department
7223 West 95th Street, Suite 301
Overland Park, Kansas 66212-2291

- Instructions for filing **Proof of Loss**[1] (itemized medical bills) are contained on the back of your Member Identification Card.

2. **Instructions For Filing Prescription Drug Claims**:

This section applies if your plan includes coverage for Outpatient Prescription Drugs.

- Instructions For Prescription Drug **Co-pay** Plans:
  - As long as members utilize a network pharmacy, the cost to the member for covered drugs is the applicable brand/generic co-pay. These amounts do not accumulate towards your deductible and out-of-pocket due to coinsurance.
  - If members under this plan purchase prescription drugs outside of the network, they must pay the entire cost of the pharmacy retail price. In this case, members should submit the prescription receipt to the Claims Department at: **7223 West 95th Street, Suite 301, Overland Park, Kansas 66212-2291.** Members filing prescription drug claims using this method are responsible for the difference between the contracted rate and the retail rate, in addition to any co-pays.

- Instructions For Prescription Drug **Deductible** Plans:
  - Under this plan, members have the ability to obtain discounts by utilizing a network pharmacy. Members present their prescription drug card to the participating pharmacy and are responsible for paying the pharmacy's retail cost less any discounts. The pharmacy will automatically file the claim with the Claims Department. Members under this plan should not file their paper copy of their prescription drug. However, they should retain a copy for their records in order to ascertain that the Claims Department adjudicated the claim.

- Instructions For Plans **Without Prescription Drug Cards**:
  - If your plan does not provide prescription benefits through the use of a pharmacy network, you must purchase all prescriptions from the pharmacy, and then mail the prescription receipt for claims processing to the Claims Department at**: 7223 West 95th Street, Suite 301, Overland Park, Kansas 66212-2291.**

3. **Instructions For Filing Dental Claims**:

This section applies if your plan includes dental benefits:

- **Step #1** : All dental claims must be filed to the following address:

  American Trust Administrators, Inc. (ATA)
  7223 West 95th Street, Suite 301,
  Overland Park, Kansas 66212-2291

- **Step #2**: Charges for Type III Major Procedures should be pre-determined by the dentist rendering the dental services. Prior to beginning an extensive treatment plan, the dentist should determine the charges for Type III Major Procedures and submit his claim determination to the address provided above.

  The Claims Department will determine the benefits payable and return the information to the dentist. This lets the employee know in advance the portion of the expenses for which he or his covered dependent will be responsible. The employee, patient, and the dentist can then make arrangements for the payment of the expenses which are not covered by the employee's dental plan and may discuss alternative plans of treatment, if necessary.

- **Step #3:** After the employee, patient, and the dentist have agreed upon a treatment plan, the employee's signature (or signature on file) must be included in the claim submission. This is generally provided via a standard dental claim form provided and submitted by the dentist. This acknowledges that the covered employee (and his covered dependent, if such dependent is the patient) has reviewed the treatment plan. This part also assigns payment of the employee's benefits to the dentist.

- **Step #4:** Once the treatment plan has been completed, the dentist should submit the claim to American Trust Administrators, Inc. at the address provided above. Payment of the benefits will then be made to the dentist.
  **** Important: If the claim form is not completed in its entirety, the payment of claims will be delayed. All areas that require signatures must be signed and every question must be answered.**

Pre-Certification and Pre-Treatment Review Requirements

Your medical benefit requires pre-treatment review of all hospital admissions, confinements, and most surgical procedures, including MRI's. Specific information regarding this provision and information pertaining to the toll-free hotline is found on the front of your medical identification card.

Failure to comply with these requirements may affect the benefits payable under the plan. Refer to your Plan Document and ID cards for specific details and instructions regarding your pre-treatment review requirements.

Customer Service

If you have questions regarding claims status, procedures, etc., please contact ATA's Customer Service Department at 800-843-4121.

Appendix A

Definitions Section

***Important: The following definitions are based upon the provisions of our standard plans. Your plan document may have been altered to incorporate a definition that is specific to your plan. In the event there is conflict between this manual and your plan document, the provisions of Section 1 of your plan document will control. Definitions of words in policies of insurance you have purchased may differ. Please refer to those policies for appropriate definitions.**

Section 1. Definitions

1. **Accidental injury** means accidental bodily injury sustained by the covered person which is the direct result of an unforeseen and unexpected event; is independent of disease or bodily infirmity; and, which occurs while coverage is in force.
2. **Active work, actively working, actively at work** means the continuous actual performance of the customary duties designated by the company.
3. **All days** shall be considered to begin at 12:01 a.m., and to end immediately prior to 12:01 a.m. standard time at the residence of the employee, as stated in his application/request for coverage under the plan; or if none is stated, at the address of the company.
4. **Ambulatory surgical center** means a permanent facility that operates for the purpose of performing surgical procedures. While such facility must have a staff of physicians, proper medical equipment, continuous physician services, and registered professional nursing services whenever a patient is in the facility, it shall not provide overnight accommodations.
5. **Calendar year** means a period beginning at 12:01 a.m. on January 1 of one year, and ending immediately prior to 12:01 a.m. on January 1 of the next year.
6. **Company** means the plan sponsor designated on the cover.
7. **Company's prior benefit plan** means the company's plan of benefits which were replaced by similar benefits under this plan, and were in effect up to the day before the effective date of this plan.
8. **Company's prior dental benefit plan** means the dental benefits under the company's prior benefit plan.
9. **Company's prior medical benefit plan** means the medical benefits under the company's prior benefit plan.

10. **Company's prior orthodontic benefit plan** means the orthodontic benefits under the company's prior benefit plan.

11. **Complications of pregnancy** means conditions resulting from surgical procedures for extrauterine pregnancy; or complications requiring intra-abdominal surgery after termination of pregnancy; or pernicious vomiting when confined in the hospital on an inpatient basis. Complications of pregnancy shall not mean normal childbirth, miscarriage or cesarean section, or treatment rendered in connection with or resulting from normal childbirth, miscarriage, or cesarean section.

12. **Copayment** means the payment a covered person makes to the provider for each visit, procedure or confinement. It is a portion of the charge for which no benefits are available under this plan.

13. **Coverage** means the benefits under this plan in reference to which the term is used, which compensate for loss as provided in the Plan Document. When used without reference to a particular benefit, coverage means any benefit under the plan which compensates for loss as provided in the Plan Document.

14. **Coverage restriction** means a period of time, as stated in the plan document, that a person must actually be covered under a given coverage of the plan before benefits will be payable. A coverage restriction shall not be confused with a waiting period. (See definition of "waiting period").

15. **Covered dependent** means a dependent of an employee for whom coverage under the plan has commenced and has not terminated.

16. **Covered employee** means an employee of the company for whom coverage under the plan has commenced and has not terminated.

17. **Covered percent** or **percentage** means the percent of eligible expenses which according to the Plan Document is the benefit payable by the plan.

18. **Covered person** means a covered employee and/or covered dependent.

19. **Critically ill** means a medical condition(s) which may directly result in life-threatening complications; or predispose the patient to life-threatening complications.

20. **Custodial care** means any type of care designed primarily to assist a person in meeting or accomplishing his activities of daily living, regardless of the name by which it is called or the place where performed. Custodial care does not seek a cure and may be provided between periods of acute care. Custodial care includes any skilled or non-skilled health services or personal comfort and convenience services which provide general maintenance, supportive, preventive and/or protective care. This includes (but is not limited to) assistance with, performance of, or supervision of:
    A. walking, transferring or positioning in bed and range of motion exercises;
    B. self-administered medications;
    C. meal preparation and feeding, by utensil, tube or gastronomy;
    D. oral hygiene, skin and nail care, toilet use, routine enemas;

E. nasal oxygen applications, dressing changes, maintenance of indwelling bladder catheters, general maintenance of colostomy, ileostomy, gastronomy, tracheostomy and casts.

21. **Deductible** means the amount of medical, dental, or orthodontic charges which must be incurred and paid by each covered person during the period designated by the plan before benefits will be payable for eligible expenses incurred during the remainder of such period. The medical deductible amount, the dental deductible amount (if applicable), and the orthodontic deductible amount (if applicable), are each separate deductible amounts.

22. **Dental charges** means only the dental charges described in Section 9, Subsection A, Part 4. (The plan will not have a Section 9 unless dental benefits are available under the plan.)

23. **Dependent** means an employee's opposite-sexed spouse who is not legally separated from the employee and each of the employee's children. For the purpose of this paragraph only, "child or children" means only natural children, step-children or legally adopted children who have been born, and who are less than 26 years of age.

24. **Dependent coverage** means a covered employee's coverage under the Plan Document with respect to his dependents.

25. **Durable therapeutic equipment** means devices for the treatment of a specific sickness or injury, as prescribed by a physician, but in no event means common household items or exercise or gym equipment or such items that would be beneficial to persons without a specific sickness or injury, nor shall it mean any equipment used to purify air or water.

26. **Effective date**, when referenced to personal or dependent coverage or a given part thereof (medical, or if applicable, dental coverage), means the date on which the plan will become obligated to pay benefits for covered charges incurred on or after that date.

27. **Election Period** means the period of time during the plan year that an employee may request coverage or change coverage for himself and/or his dependents as allowed by the plan.

28. **Eligible expense** means the medical, dental, or orthodontic charges (whichever is applicable) which are in excess of the applicable deductible amount for each covered person and for the medical charges which are in excess of the applicable copayment.

29. **Emergency**, when referenced to inpatient admission, confinement, surgical procedures, and conditions, means that the cause of such admission, confinement, surgery, or condition, if not treated at once, would jeopardize the covered person's life, or cause serious impairment to the covered person's body functions.

30. **Employee** means any person who is at least 18 years of age, and who is actively working full-time for the company for a salary or wage, and for whom

the company is withholding and matching social security, and who is subject to the control of the company, not only as to the result to be accomplished, but also as to the details and means by which the result is accomplished. If a person has an ownership interest in the company, he shall be deemed to be an employee only if he is actively working full-time for the company, and is earning a salary or wage due to such active work.

31. **Employer** is the employer and plan sponsor designated on the cover.

32. **Experimental, Investigational or Unproven** means a service or supply, such as medication, that meets any of the following criteria:
    A. For a service or supply that is subject to Food and Drug Administration (FDA) approval:
        1. it does not have FDA approval; or
        2. it has FDA approval, but is being used for an indication or at a dosage that is not an accepted off-label use.

    B. An accepted off-label use is a use that is:
        1. established based on reliable evidence as defined in this provision; or
        2. is included and favorably recognized for treatment of the indication in at least one of the following publications: DrugDex, Drug Facts and Comparisons, Clinical Pharmacology or other established reference compendia as designated by Medical Management, and the data are sufficiently conclusive as to efficacy to allow recognition of the off-label use; or
        3. Is being provided pursuant to phase I, II, III or IV clinical trials; or
        4. Is being provided pursuant to a written protocol that describes among its primary objectives determination of maximum tolerated dosage, safety, toxicity, effectiveness, or effectiveness compared to conventional alternatives; or
        5. Is being provided pursuant to a written informed consent used by the treating provider that refers to the service or supply as experimental, investigational, unproven or for research; or
        6. Is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the Department of Health & Human Services (HHS) and the FDA; or
        7. Based upon review and analysis of the published peer-review medical or dental literature, the weight of the evidence demonstrates that it is the predominant opinion of independent experts that the service or supply:
            a. is substantially confined to use in research settings; or
            b. is subject to further research studies or clinical trials, in order to determine maximum tolerated dosage, safety, toxicity, effectiveness, or effectiveness compared to conventional alternatives;
            c. is experimental, investigational, unproven; or

8. Is not a covered service or supply as defined under Medicare because it is considered investigational or experimental as determined by HHS/Centers for Medicare & Medicaid Services (CMS); or
9. Is not currently the subject of active investigation because prior investigations and/or studies have failed to establish proven efficacy and/or safety.

For the purposes of this definition, "reliable evidence" means evidence of all of the following:

A. There are at least two articles in peer-reviewed U.S. scientific medical or pharmaceutical publications supporting use of the service or supply outside the investigational setting; and
B. The published articles evidence a well-designed investigation that has been reproduced by non-affiliated authoritative sources with measurable, clinically meaningful results; and
C. The investigation evidences that the probable benefits of using the service or supply in the unique circumstances in the particular case in question outweigh the risks associated with such use in situations where conventional alternatives have no or would not be efficacious.

33. **Family unit** means the covered employee and his covered dependents.

34. **Full-time** means actively working for the company at least 30 hours per week during a normal work week or at least 120 hours per month, not including regularly scheduled vacations or days off.

35. **He, his,** and **him** apply to persons of either gender unless the context indicates otherwise.

36. **Hospital** means an institution which is licensed by the appropriate governing body in which it is located for the care and treatment of sick or injured persons and which is accredited as a hospital by the joint commission on accreditation of hospitals.

    A hospital is not:

    A. Primarily a clinic, a place for rest, a place for the aged, or a nursing or convalescent home; or

    B. A hospital owned or operated by the United States government or any agency thereof (unless the covered person is legally required to pay for services) or any hospital which makes no charge that the covered person is legally required to pay.

    If medical charges are incurred for authorized treatment of a medical condition or an authorized surgical procedure while confined in a facility authorized by the pretreatment review unit, hospital shall also mean such facility. (See Subsection A of Section 8.)

37. **Illness** means a disease, sickness, bodily infirmity, hernia of any kind, or bacterial infection other than that occurring with, and as a result of an injury.

38. **Incur or Incurred** means the date that the services, treatment, supply, or facility is provided.

39. **Individual** means an employee of the company and/or the dependents of such employee.

40. **Injury** means sudden and instant damage to the body, which is unintended and undesigned by the individual and which results directly from and independently of all other causes of loss covered by the plan.

41. **Inpatient** means assignment to a bed (other than a bed in an outpatient department) of a medical treatment facility.

42. **Intensive care unit** means a section, ward, single room, or coronary care unit within the hospital, which (a) is operated exclusively for the purpose of providing care and treatment for the most critically ill patients; and (b) has special supplies and equipment necessary for such care and treatment available on a stand-by basis for immediate use; and (c) provides room and board and constant supervision and care by registered professional nurses or other highly trained hospital persons. Intensive care unit shall in no event, however, include hospital facilities used for the purpose of intermediate or normal operative recovery treatment or service or for any service not provided to the most critically ill patients or in a coronary care unit. .

43. **Lifetime**, when used in reference to the dental or orthodontic deductible amount, means the total period of time that a person has coverage under the dental and/or orthodontic benefits of the plan without interruption.

    Lifetime, when used in reference to the benefits payable under the plan, or to maximum benefits or benefit limits, means the total period of time that a person has coverage under the plan, including any one or more interrupted periods of coverage.

    The term "lifetime" shall not be construed to provide coverage for any given benefit during any period of time that the person is not covered under such benefit of the plan.

44. **Medical charges** means only the medical charges described in Part 4 of Subsection B of Section 8.

45. **Medically Necessary/Medical Necessity/Necessary Medical Care** means health care services and supplies, such as medication, that a Physician, exercising prudent clinical judgment, provides or orders to be provided to a Covered person for the purpose of preventing, evaluating, diagnosing or treating an Illness or Injury of a covered person, and which are:
    A. In accordance with generally accepted standards of medical or dental practice; and
    B. Clinically appropriate, in terms of type, frequency, level, extent, site and duration, and considered effective for the Covered person’s Illness, Injury or disease; and
    C. Not deemed to be cosmetic or Experimental, Investigational or Unproven as defined in the Plan; and

D. Specifically allowed by the licensing statutes which apply to the Physician or Dentist who provides the service or supply; and
E. At least as medically effective as any standard care and treatment; and
F. Not primarily for the convenience, psychological support, education or vocational training of the covered person, Physician, Dentist or other health care provider; and
G. Not more costly than an alternative service, supply or sequence of services or supplies which such alternative care is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Covered person's Illness, Injury or disease.

For the purposes, "generally accepted standards of medical or dental practice" mean the:

A. Standards that are based on credible scientific evidence published in peer-reviewed medical and dental literature generally recognized by the relevant medical and dental community;
B. Recommendations of an American Medical Association-recognized Physician specialty society or of an American Dental Association-recognized Dentist specialty society; or
C. Prevalent practices of Physicians or Dentists in the relevant clinical area.

46. **Medical treatment facility** means any facility which provides care and/or medical treatment to any person for any reason, including but not limited to a hospital, hospice, clinic, nursing home, rest home, asylum, diagnostic center and a residential treatment program.

47. **Orthodontic charges** means only the orthodontic charges described in Section 9, Subsection B, Part 4. (The plan will not have a Subsection B of Section 9 unless orthodontic benefits are available under the plan.)

48. **Out-of-pocket maximum** means the maximum amount of eligible expenses payable in a plan year by the covered person due to the uncovered percent.

49. **Personal**, when used in reference to an employee's coverage or eligibility, means the employee's coverage or eligibility with respect to himself, but not his dependents.

50. **Physician** means a person who is licensed to practice as a doctor of medicine, doctor of osteopathy, doctor of podiatry, doctor of dental surgery, doctor of dental medicine, doctor of chiropractic, doctor of optometry, or a psychologist. Physician shall also mean a person who is licensed to practice as a certified nurse practitioner (CNP) or a physician's assistant (PA), or anyone with a license from a state to provide psychiatric care, who is acting within the scope of his or her license and supervised by an appropriate medical professional as required by the person's license. Physician shall mean no other type of practitioner.

51. **Plan administrator** is the company.

52. **Plan Document** means the Plan Document written on the forms labeled "S4", which includes an adoption agreement written on form S4-D that is executed by the company (the employer identified on the cover of the Plan Document and Summary Plan Description, who is the administrator and sponsor of the plan), and which may be amended from time to time by the company. The term "plan document," as used in the Summary Plan Description, means the provisions of the Plan Document as they pertain to employees of the company and dependents of such employees, but shall not be construed to imply: (a) that any individual or entity other than the named plan sponsor holds a Plan Document or is the owner of the plan document; (b) that any covered person or eligible person has any rights under the Plan Document other than the rights specifically given to such person as stated in the Summary Plan Description; (c) that the Summary Plan Description is the plan document; (d) that any personal or dependent coverage will commence in any manner other than as stated in Section 2 of the Plan Document and Summary Plan Description; or (e) that any personal or dependent coverage will cease or terminate in any manner other than as described in Sections 3 and 4 of the Plan Document and Summary Plan Description.

53. **Plan sponsor** is the employer and plan sponsor designated on the cover.

54. **Plan year** is indicated in the schedule of benefits.

55. **Preventive care** means immunizations, vaccinations, physician exams and diagnostic services not related to the treatment of a specific diagnosisas indicated by the following guidelines:

    (1) Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force;

    (2) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the covered person;

    (3) With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

    (4) With respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration; or

    (5) The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention.

(6) Contraception and contraceptive counseling. All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. These recommendations do not include abortifacient drugs.

(7) Breastfeeding support, supplies and counseling. Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.

(8) Well-women visits. Annual well-women visit for adult women to obtain the recommended preventative services that are age and developmentally appropriate, including preconception and prenatal care.

(9)

56. **Reasonable and customary** means the general level of charges as determined in accordance with the reasonable and customary guidelines and data customarily used by the service organization.

57. **Service organization** means American Trust Administrators, Inc., or its successors. The plan administrator has contracted the service organization to provide limited services pursuant to a written agreement. The service organization is not a plan fiduciary by virtue of performing administrative functions pursuant to the terms of its contract with the plan administrator or the terms of the plan document.

58. **Sickness** means a disease, illness, bodily infirmity, hernia of any kind, or bacterial infection other than that occurring with and as a result of an injury.

59. **Subsidiary** or **Affiliate** means any entity named in Part 1 of the Plan Specifications that is a member of a controlled group of corporations, a member of a group of trades or businesses under common control (whether or not incorporated), or a member of an affiliated service group, as those terms are defined in the Internal Revenue Code, of which the plan sponsor is a member.

60. **Summary Plan Description** means a written description of the content of the Plan Document which is distributed to covered employees of the company. A Summary Plan Description is not a plan document.

61. **The plan** and **this plan** mean the plan document.

62. **Uncovered percent** means the percent which is the difference between 100% and the covered percent. It is the portion of each dollar of eligible expenses incurred by a covered person that is to be paid by the covered employee or covered person.

63. **Urgent Care Center** is a treatment facility which meets established ambulatory care criteria and provides medical care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent

Care Centers are staffed by medical doctors, registered nurse practitioners and physician assistants primarily for the purpose of treating patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room.

64 The **Waiting period** for: 1) a person not subject to the penalties provided in Part 6 of Section 2 is the period of time an employee must be continuously actively working full-time for the company immediately prior to the employee's effective date; 2) a person subject to the penalties provided in Part 6 of Section 2 shall be equal to the period of time described in Part 6 of Section 2 that such a person must remain continuously actively working full-time or remain an eligible dependent before that person's coverage will become effective. This period of time will commence on the date the service organization receives that person's application for coverage.

Appendix B

Eligibility, Enrollment, & Effective Dates Section

***Important: The following section is based upon the provisions of our standard plans. Your plan document may have been altered to incorporate a provision that is specific to your plan. In the event that there would be a conflict between this manual and your plan document, the provisions of Section 2 of your plan document will control.**

- All employee's and/ or dependents who are aliens, legally residing in the U.S.A., must submit a copy of their resident alien card, work visa, approval notice for a nonimmigrant worker, or a copy of their temporary social security card.

Section 2. Eligibility, Enrollment, & Effective Dates

1. **Employee Eligibility**: All actively working full-time employees in an eligible class (see plan specifications) and are resident citizens of the U.S.A. or aliens legally residing in the U.S.A. will become eligible for personal coverage on the later of:

   A. The Plan Document Effective Date; or

   B. The date such employee completes the minimum waiting period applicable to him, as described in the plan specifications (or if there is no minimum waiting period applicable to him, the date such employee's full-time active work for the company commences).

   Such employee will cease to be eligible for personal coverage on the date his full-time active work for the company ceases. In addition, if the employee voluntarily fails to submit the required enrollment/refusal card described below refusing coverage under the plan for himself and his eligible dependents, the employee and all dependents of the employee will no longer be eligible for coverage under the plan. As used hereinafter, "eligible employee" shall mean an employee who is eligible for personal coverage under the plan.

2. **Dependent Eligibility**: An eligible employee will become eligible for dependent coverage on:

   A. The date he becomes eligible for personal coverage, if he has any dependents on that date; or

   B. The date he acquires his first dependent, if he acquires his first dependent after he becomes an eligible employee;

   provided such dependent is a resident citizen of the U.S.A. or an alien legally residing in the U.S.A.

An employee's adopted child will be considered acquired on the date the legal adoption document declares the adoption to be final, or on the date such child is placed for adoption in the employee's home, whichever occurs first.

An employee will cease to be eligible for dependent coverage on the date he ceases to be an eligible employee or he ceases to have any dependents, whichever occurs earlier. In addition, any eligible dependent for whom the employee voluntarily fails to submit the required enrollment/refusal card described below refusing coverage under the plan for such dependent, will no longer be eligible for coverage under the plan.

3. **General Procedures**: An employee must complete an enrollment/refusal card on which he must request or refuse coverage available for himself and each of his dependents, if any, when he becomes eligible for personal and, if applicable, dependent coverage; or when the company adds dental or vision benefits under this existing plan.

   An employee must use a change form when he has already submitted an enrollment card and subsequently acquires a new dependent (including newborns) for whom he is requesting or refusing any coverage; or he elects to change his personal or dependent coverage in any other manner.

4. **Effective Date of Personal Coverage**: Personal coverage requested by an eligible employee will become effective as follows, subject to the exceptions in Subpart C below and except as stated in Parts 6, 7 and 11 of this Section.

   A. **Timely Request**: The enrollment/refusal form requesting personal coverage for an eligible employee must be signed by the employee within 30 days of first becoming eligible for coverage. Such enrollment/refusal form must be received by the service organization within 52 days from the date the employee first became eligible for coverage. If the enrollment/refusal form is signed and received as described above, then such employee's personal coverage will become effective on the later of:

      1. The Plan Document Effective Date; or

      2. The first day of the month coinciding with or next following the date such employee completes the minimum waiting period applicable to him, as described in the plan specifications (or, if there is no minimum waiting period applicable to him, the first day of the month coinciding with or next following the date such employee's full-time active work commences).

   B. **Late request**: All requests to add eligible employees and/or dependents must be done within the time frames allowed or the individual will be considered a Late Entrant and will be subject to a 6-month waiting period. Plans with Limited Open Enrollment or Open Enrollment require that the employee must wait until the next open enrollment period to request coverage. No coverage will be provided during the waiting period and the individual will not have to make any contributions.

   C. **Exceptions**: Exceptions to the effective date provisions are as follows:

1. **Failure to make contribution**: No coverage under this plan will become effective with respect to an eligible employee if such employee fails to make the required contribution, if any, to the cost of such coverage in a timely manner.

2. **Not actively at work for other than a health related reason**: Following completion of the minimum waiting period, if an eligible employee is not actively working full time on the date coverage would otherwise commence for a reason that is not related to the employee's health, (i.e. sickness, illness, disability), then such employee will cease to be eligible for coverage and must complete another minimum waiting period before coverage will become effective.

D. **Dependent Special Enrollment Period (Personal Coverage)**:

1. In addition to the provisions of Subpart A of this Part 4, an eligible employee who has completed the minimum waiting period, as described in the plan specifications, will be eligible to enroll for coverage, provided a Change Form is signed within 30 days of the date of the event and received by the Service Organization within 52 days, on the date one of these dependent special enrollment events occurs:

   A. The employee's marriage (a marriage certificate may be requested);

   B. A living dependent child is born to the employee***** (a birth certificate may be requested); or

   C. The adoption of a child by, or the placement for adoption of a child with, the employee (a copy of the executed court documents will be required).

2. Coverage for an eligible employee qualifying for coverage under this Subpart D will become effective as follows:

   A. In the case of marriage, as of the first day of the month next following the date the enrollment/refusal form is received by the service organization;

   B. In the case of a dependent's birth, as of the date of such birth; or

   C. In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

   *** Please note, newborns are not added automatically, a change form must be received before the newborn will be added.**

E. **Employee and/or Dependent Special Enrollment Period :**

1. In addition to the provisions of Subpart A of this Part 4, an eligible employee who has completed the minimum waiting period, as

described in the plan specifications, and originally refused coverage due to other coverage, will be eligible to enroll for coverage, provided an enrollment/refusal form or change form is signed within 30 days and received within 52 days from the loss of prior health coverage*. The loss of prior health coverage must pertain to the following special enrollment provisions:

A. Termination of Employment;

B. Reduction of employer contribution;

C. Employee and/or Dependent is no longer eligible under the previous groups' plan;

D. The Divorce or Legal Seperation of the employee;

E. Exhaustion of COBRA

2. Coverage for an eligible employee and/or dependent qualifying for coverage under this Subpart E will become effective on the first day following the occurrence of the event.

***Important: Loss of coverage under Medicare, Medicaid, or an individual policy cannot be used as the basis for a special enrollment**

5. **Effective Dates of Dependent Coverage**: Subject to the exceptions in Subpart E below, and except as stated in Parts 6 and 7 of this Section, dependent coverage requested by an employee who is eligible for dependent coverage will become effective as follows:

   A. **Dependents on Employee's Effective Date**: If an employee has dependents on the date his personal coverage becomes effective, coverage for those dependents shall also become effective on the date such employee's personal coverage becomes effective, but only with respect to those dependents for whom the employee has specifically requested dependent coverage on the enrollment/refusal form, provided the form is signed and received by the service organization within the time specified in Subpart 4(A) of Section 2.

   B. **Dependents Acquired or Becoming Eligible After Employee's Effective Date:** If a covered employee acquires a dependent after the date he becomes eligible for personal coverage, an enrollment/refusal form must be signed within 30 days of the date such dependent was acquired. Such enrollment/refusal form must be received by the service organization within 52 days from the date the dependent first became eligible for coverage. Provided the enrollment/refusal form is received as stated above, such dependent's coverage will become effective:

      1. In the case of marriage, as of the first day of the month next following the date the enrollment/refusal form is received by the service organization (a copy of the marriage certificate may be requested);

2. In the case of a dependent's birth, as of the date of such birth (a birth certificate may be requested);
3. In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption (a copy of the executed court documents will be required); or
4. In the case of a dependent who was acquired prior to the employee's effective date, who was ineligible for coverage under this plan on that date, and who subsequently becomes eligible, the first day of the month next following the date the enrollment/refusal form is received by the service organization.

C. **Dependent Special Enrollment Period (Spousal Coverage)**:

1. In addition to the provisions of Subparts A and B of this Part 5, an eligible dependent spouse of an eligible employee who has completed the minimum waiting period, as described in the plan specifications, will be eligible to enroll for coverage, provided an enrollment/refusal form is signed and received by the service organization within the time specified in Subpart B of this Part 5, on the date one of these dependent special enrollment events occurs:

   A. The employee or employee's dependent spouse gives birth to a living child; or

   B. The adoption of a child by, or the placement of a child with, the employee.

2. Coverage for a dependent spouse qualifying for coverage under this Subpart C will become effective as follows:

   A. In such case of a dependent's birth, as of the date of such birth; or

   B. In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

D. **Late Requests**: If an employee's request for dependent coverage is not received by the service organization within the time allowed, the dependent will be considered a Late Entrant and will be subject to a 6-month waiting period. Plans with Limited Open Enrollment or Open Enrollment require that the employee must wait until the next open enrollment period to request coverage. No coverage will be provided during the waiting period and the employee will not be charged the dependent premium until the effective date.

E. **Exceptions**: Exceptions to the dependent effective date provisions are as follows:

1. **Employee must be covered**: A dependent's coverage cannot become effective prior to the date the eligible employee's coverage for similar benefits is effective.

2. **Failure to make contribution**: No coverage under this plan will become effective with respect to an eligible dependent if the employee fails to make the required contribution, if any, to the cost of such coverage in a timely manner.

3. **Employer Administrative Exception Requests**: If an officer of the company would like to request an Administrative Exception to their plan for an Employee and/or a dependent's effective date, the officer must submit a written request on company letterhead to the Eligibility Department for further review.

6. **Penalties**: If the service organization receives a late request for coverage as described in Parts 4 or 5 of this Section, the coverage (medical and/or dental, if applicable) for the eligible person(s) with respect to whom the late request was made will be subject to the penalties below. The penalties also apply when coverage is requested for a person who has previously been denied coverage under the plan, and when the request for coverage is made after the time limitation described in Part 7 of this Section.

   A. With respect to medical benefits – coverage shall become effective as follows:

      1. If the request for coverage is received by the service organization on the first day of the month, then coverage shall become effective 6 months after the request is received by the service organization;

      2. If the request for coverage is received on any other day of the month, coverage shall become effective on the first day of the month next following 5 months after the date the service organization received the request for coverage.

      3. For plans with Limited Open Enrollment or Open Enrollment the requested coverage will be effective on the next Plan Anniversary.

   B. With respect to dental benefits (if applicable), subject to the continuous coverage requirements of Subpart B of Part 7 of Section 9,- such person's coverage will become effective as follows:

      1. If the request for coverage is received by the service organization on the first day of the month, then coverage shall become effective 6 months after the request is received by the service organization;

      2. If the request for coverage is received on any other day of the month, coverage shall become effective on the first day of the month next

following 5 months after the date the service organization received the request for coverage.

7. **Dual Coverage**: A person cannot be covered under this plan simultaneously as an employee and a dependent, nor can a person be covered under this plan simultaneously as a dependent of more than one employee.

   Notwithstanding any provisions to the contrary, if an employee who is eligible for personal and, if applicable, dependent coverage, refuses such coverage because he and any eligible dependents are covered as dependents of another employee and if such employee and any of his eligible dependents subsequently cease to qualify as dependents of the "other" employee while remaining eligible for coverage under the plan, he shall be entitled to request personal and, if applicable, dependent coverage without such request being considered a late request if the change form requesting such coverage is received by the service organization within 30 days immediately following the date such employee and any dependents ceased to qualify as dependents of the "other" employee.

   Notwithstanding any provisions to the contrary, if an employee who is eligible for personal and dependent coverage, refuses dependent coverage because he has personal coverage and he subsequently ceases to qualify for personal coverage while remaining eligible for dependent coverage under the plan, he shall be entitled to request dependent coverage without such request being considered a late request if the change form requesting dependent coverage is received by the service organization within 30 days immediately following the date such employee ceased to qualify for personal coverage.

8. **Medicare**: This plan is secondary to Medicare whenever by law it may be secondary. The following are the basic rules: 1. If the employer employs more than 20 full-time and part-time employees for 20 or more weeks in either the current or preceding calendar year then this plan is primary to Medicare (unless the Medicare beneficiary is covered by reason of having End Stage Renal Disease (ESRD)). 2. If the Medicare beneficiary is receiving Medicare due to disability (other than ESRD), then this plan will be primary as long as the employer had over 100 full-time and part-time employees on 50% or more of its business days during the preceding calendar year. 3. If the Medicare beneficiary is receiving Medicare due to ESRD then Medicare is secondary for the first 30 months after commencement of the statutory waiting period.

   In order for Medicare to be primary under either paragraph 1 or 2 above, the Medicare recipient must have coverage under this plan by virtue of the employee's current employment status. In determining whether the 20 or 100 person tests have been met, there are special aggregation rules set forth in the Internal Revenue Code.

   Groups with between 17 and 23 total employees may be required to submit Quarterly Wage Reports for the preceding calendar year’s four quarters in

order for ATA UW to determine how this plan coordinates with Medicare. This may be required to properly establish individual specific deductible amounts.

Unless prohibited by law, an employee or dependent eligible for Medicare must be enrolled in Medicare Part B (physician) to be eligible under this plan.

9. **Family Medical Leave Act/COBRA**: If the company is subject to the provisions of the Family Medical Leave Act of 1993, ("FMLA"), as amended, or the Consolidated Omnibus Reconciliation Act of 1985, ("COBRA"), as amended, and if an employee is eligible for coverage under the FMLA or COBRA, then, the requirement that an employee be actively working full-time to remain eligible shall not apply to any employee who is on qualifying leave under FMLA or COBRA on the date his coverage under the plan would otherwise become effective.

   However, if that employee's coverage under the minimum requirements of FMLA expires or otherwise ends, and the employee has not returned to full-time active work, the employee must submit an enrollment/refusal card to apply for coverage as a new employee and meet the minimum waiting period in order to be covered as an active employee under the plan. Likewise, if a COBRA participant's coverage expires or otherwise ends pursuant to the minimum requirements of COBRA, and the person is not eligible as a dependent or as a new employee having resumed full-time active work for the duration required to meet the minimum waiting period, then, in order for the participant to become covered under the plan, the person must meet the definition of an eligible employee or dependent and otherwise meet the requirements of this Section.

10. **Qualified medical child support order**: A "Qualified medical child support order" means a medical child support order issued by a court having jurisdiction to issue the same and which creates or recognizes the existence of the employee's child's right to, or assigns to such child the right to receive benefits for which an employee is eligible under this plan, provided such order clearly specifies:

    A. The name and last known mailing address (if any) of the employee;

    B. The name and mailing address of each child covered by the order;

    C. A reasonable description of the type of coverage to be provided by the plan to each such child, or the manner in which such type of coverage is to be determined;

    D. The period to which such order applies.

    The company shall notify the employee and each child designated in the court order within forty-five (45) days of receipt of a medical child support order.

The notification shall contain information which permits the child to designate a representative for receipt of copies of notices that are sent to the child with respect to a medical child support order.

Upon determination of whether a medical child support order is or is not qualified, the company will send a written copy of the determination to the employee and each child.

If it is determined that the medical child support order is qualified, an employee or the child's guardian must complete a change form and provide additional information if required by the service organization. Such change form must be received by the service organization within forty-five (45) days immediately following the date the determination was made that the order was a qualified medical child support order. Unless the qualified medical child support order provides otherwise, the employee shall be responsible to make the required contribution, if any, to the cost of such coverage.

If it is determined the medical child support order is not qualified, the written determination will include the reasons why the order is not qualified. An employee, the child or the child's legal guardian may appeal the determination to the company. Any request for review of a determination must be filed with the company within sixty (60) days after the date the original determination is made.

Notwithstanding the effective date and termination provisions to the contrary, coverage for a child who is the subject of a qualified medical child support order shall become and remain effective only to the minimum extent required under applicable law.

11. **Special effective date rule for certain employees and dependents losing other coverage**:

A. An employee who has completed the minimum waiting period applicable to him but has not enrolled for coverage under this plan, and a dependent of any employee who has completed the minimum waiting period under this plan but who has not enrolled for coverage under this plan, shall become covered under this plan on the day immediately following the date their previous health coverage terminated if all of the following conditions are met:

1. The employee and dependent losing other coverage had health coverage at the time coverage was offered to the employee under this plan;

2. The employee stated in writing by completing the enrollment/refusal form that the reason for refusing personal and/or dependent coverage was that the employee and/or the dependent had other health coverage at that time;

3. The other health coverage was under a COBRA continuation provision and such coverage was exhausted due to the expiration of the maximum coverage period under COBRA, or was not under COBRA and the coverage was either terminated as a result of loss of eligibility for coverage (including legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions toward the cost of such other coverage were terminated;

4. The employee signs the enrollment/refusal form within 30 days of the date coverage terminated as described in Subpart 3 above, and such enrollment/refusal form is received by the service organization within 52 days of the date such other health coverage terminated.

B. **Late Requests**: If an employee's request for employee and/or dependent coverage is not signed and received within the applicable time limitations imposed in Paragraph 4 of Subpart A of this Part 11, the applicable penalty or penalties described in Part 6 of this Section 2 will apply with respect to such dependent and his coverage which is requested late.

C. As used in this Part 11, "Health Coverage" means an employee welfare benefit plan if the plan provides medical care to employees or their dependents directly or through insurance reimbursement or otherwise. "Health Coverage" also means benefits consisting of medical care (whether provided directly, through insurance, or reimbursement or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract issued by a health maintenance organizaiton or a licensed insurance company.

D. “Medical Care”, as used above, means:

1. Amounts paid for the diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;
2. Amounts paid for transportation primarily for and essential to medical care referred to in Paragraph 1 above; and
3. Amounts paid for insurance covering medical care referred to in Paragraphs 1 and 2 above.

12. **Special effective date rules related to Medicaid and CHIP previous coverage:**

A. An Employee who is eligible, but not enrolled, for coverage under the terms of the Plan (or dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if either of the following conditions is met:

1. Termination of Medicaid or CHIP coverage: The Employee or Dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage of the Employee or Dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the Employee requests coverage under the Plan not later than 60 days after the date of termination of such coverage.
2. Eligibility for employment assistance under Medicaid or CHIP: The Employee or Dependent becomes eligible for assistance, with respect to coverage under the Plan, under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the Employee requests coverage under the Plan not later than 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

Appendix C

Termination Section

***Important: The following section is based upon the provisions of our standard plans. Your plan document may have been altered to incorporate a provision that is specific to your plan. In the event that there would be a conflict between this manual and your plan document, the provisions of Section 3 of your plan document will prevail.**

Section 3. Termination

1. **Termination of Plan Document:** The Plan Document may be terminated at any time, for any reason, including failure to maintain the participation requirements as required by Part 1 of Section 7 of the Plan Document. The Plan Document will automatically terminate on the date the company's coverage under the excess loss policy ceases or on the date the company's contract with the service organization terminates.
2. **Termination of Employee's Coverage:** Subject to any applicable provisions of Section 4, an employee's coverage under this plan will terminate at the end of the month during which the earliest of the following occurs:
3. The Plan Document is terminated;
4. The employee ceases to be an eligible employee who is actively working full-time;
5. A Subsidiary or Affiliate ceases to be a Subsidiary or Affiliate as defined in Section 1, if the employee works for such Subsidiary or Affiliate listed in Part 1 of the Plan Specifications.
6. The employee fails to make the required contribution for his personal coverage, if any;*
7. The service organization receives the employee's written request to terminate his personal coverage;*
8. The employee allows someone, other than a covered dependent to use his identification card, or the employee and/or his dependents file a fraudulent claim with the plan.
9. **Termination of Dependent Coverage:** Subject to any applicable provisions of Section 4, a dependent's coverage under this plan will terminate at the end of the month during which the earliest of the following occurs:

10. Personal coverage terminates for the employee through whom the dependent is covered (such dependent's medical coverage will terminate at the same time the employee's medical coverage terminates, if any, and such dependent's dental coverage will terminate at the same time the employee's dental coverage terminates, if any);

11. The dependent ceases to be a dependent as defined in Section 1 of the Plan Document, (Legally seperated and divorced spouses are not eligible, children other than the natural children, stepchildren or legally adopted children who have been born are not eligible, children who do not rely on the employee for at least half of their support and maintenance and/or are over the age of 19 and not a full-time student, or are full-time students over the age of 23/25 years of age, depending on the plan, are not eligible);

12. The employee fails to make the required contribution for the dependent's coverage, if any;*

    D. The service organization receives the employee's written request to terminate his dependent's coverage;*

* This provision applies separately with respect to medical and dental coverage, if any. The Service Organization will require a copy of the executed court documentation, on all retroactive termination requests for divorced or legally separated spouses.

    E. The dependent enters the armed forces of any country or international organization.

13. **Rescission Due To Misrepresentation:** If it is discovered that the employee has supplied incomplete and/or incorrect material or statements regarding himself or his dependent(s), on documents submitted to the company or service organization, personal and dependent coverage under the plan (including such coverage under any continuation provisions) may be rescinded retroactively to the employee's effective date of coverage, upon written notice to the employee.

Appendix E

COBRA Administration Section

The purpose of this section is to assist you in providing answers to common questions regarding COBRA Administration. Federal COBRA laws require certain employers to offer continuation of health coverage to certain individuals upon the occurrence of qualifying events.

Is Your Plan Subject To COBRA?

Small employer plans are not subject to COBRA. To determine if a Plan is subject to COBRA, the employer must determine the number of employees normally employed during the previous calendar year.

Please refer to the following example:

ABC Company is trying to determine if their plan is subject to Cobra for their plan year beginning October 1, 2012. To determine whether ABC Company's plan was subject to COBRA for qualifying events occurring in 2012, they must count the number of employees employed in 2011. If they employed fewer than 20 employees, (part-time employees are counted as a fraction of their working hours divided by the number of hours the employer considers full-time), on at least 50% of their working days during the preceding calendar year, they are not subject to COBRA. If they employed 20 or more employees, (part-time employees are counted as a fraction of their working hours divided by the number of hours the employer considers full-time), on at least 50% of their working days during the preceding calendar year, they are subject to COBRA.

If you are not currently subject to COBRA, you may become subject to it in the future if the number of your employees increases to 20 or more for at least 50% of your working days during a calendar year. If this happens, you will be subject to COBRA on January 1, immediately following the year the number of employees increased to 20 or more on at least 50% of your working days. **If you later become subject to COBRA, you must notify ATA within 30 days of the date your plan becomes subject to COBRA.**

INSTRUCTIONS AND FORMS:

All groups subject to COBRA must follow ATA's administrative instructions and use ATA's COBRA forms. The following forms are included in **Appendix F**:

- ❑ Notification to employees regarding their right to continue group health coverage under COBRA (Form COBRAForm1.doc);
- ❑ Notice to ATA regarding a qualifying event (Form COBFormA.doc);
- ❑ COBRA Change Form;
- ❑ COBRA Election Notice.

EMPLOYER RESPONSIBILITY:

COBRA is a federal law which applies to employers (not to insurance companies or their service organizations). Penalties for failure to comply with COBRA are imposed on the employer. If you are an employer who is subject to COBRA, you should make sure you are complying with the law. This memo is not legal advice, but rather is to merely advise you of the existence of COBRA and its possible effects on your group health plan as the law and regulations exist on this date. Therefore, should you have questions about the applicability of COBRA to your particular business, you should seek legal counsel.

American Trust Administrators, Inc. will assist you in providing COBRA continuation coverage only if: (1) we receive a COBRA Form A timely from you; (2) you are subject to the COBRA law; and (3) you comply with American Trust Administrators' administrative instructions. Your Excess Loss Policy will not provide coverage for COBRA continuation under your plan if the request is not received or if you are not subject to the law, or if you fail to comply with the administrative instructions.

ATA COBRA NOTIFICATION SERVICE:

American Trust Administrators, Inc. will provide COBRA notification services to your employees (and their dependents) on your behalf, pursuant to the federal law and regulations. You must notify ATA of the COBRA qualifying event (Using Form COBFormA.doc) and provide the last known address for persons eligible for COBRA. ATA will then send the required COBRA notices and election forms within the required time frames to persons entitled to such notice. ATA will also keep a record of all statutory time requirements. In addition, you will be given notice of all persons who properly elect COBRA. The service charge for this service is included in the administration fee listed on your billing statement**.**

ATA COBRA SERVICE

ADMINISTRATIVE INSTRUCTIONS FOR COBRA SERVICES PERFORMED BY ATA

ATA will provide specified COBRA continuation services on your behalf only if you comply with all of these instructions. These instructions only apply to ATA's COBRA Service.

ATA's obligations and responsibilities are limited to those items specified in the Service Agreement, and will be performed only if all instructions and requirements are satisfied, and only for groups that are subject to COBRA.

If required by ATA, the employer group must complete and return an Annual COBRA Verification form that will be mailed each December, telling us whether they are subject to Federal COBRA for the next calendar year.

SUMMARY OF INSTRUCTIONS

1. Initial notification of COBRA rights.
2. Notice Form
3. Responsibilities when there is a qualifying event.
4. Electing COBRA continuation.
5. Responsibilities for billing and premium collection.
6. Termination of COBRA continuation.
7. General provisions.

1. INITIAL NOTIFICATION OF COBRA RIGHTS

- **NEW EMPLOYEES**
- **NEW OR ADDED SPOUSES OF COVERED EMPLOYEES**

Initial notification of COBRA rights must be sent once an employer group health plan becomes subject to COBRA. Both the employee and his/her covered dependent spouse must be notified of their COBRA rights. Groups subject to COBRA prior to their effective date with ATA should have provided this notice to all employees who were effective on or before the plan's effective date. If your group has not yet provided the initial COBRA notice to employees hired on or before your effective date with ATA, you should do so immediately. After a group is subject to COBRA, each new employee (and the employee's spouse – including a spouse who is added to the plan after the employee is already covered) who becomes covered by the plan, must be notified of their COBRA rights. ATA will provide the Initial Notice for employees and spouses who become covered after the group effective date. ATA will send, by regular mail, a notice addressed to the employee and spouse.

2. NOTICE FORM

The employer must notify ATA of all individuals in their COBRA election period on, or within 60 days before, the plan effective date who elect COBRA continuation coverage by completing a Notice of COBRA Election form. The completed form must be sent to ATA by certified mail along with a copy of the COBRA notice that was provided to the beneficiary and a copy of the signed COBRA election form within 14 days of the employer receiving it.

The employer must notify ATA of all individuals who were enrolled for COBRA continuation coverage under the prior plan who are to be enrolled under this plan by completing the Notice of COBRA Beneficiaries on Plan Effective Date form within 10 days of the Plan effective date. We cannot provide COBRA Service for these individuals until we receive this notice.

3. RESPONSIBILITIES WHEN THERE IS A QUALIFYING EVENT

Once a Qualifying Event occurs, specific notice requirements must be met within a specified amount of time.

A. Employer Responsibilities: If a covered person (employee or dependent) would lose coverage under the plan due solely to one of the following Qualifying Events which occurs on or after the Plan effective date:

   1. voluntary or involuntary termination (except when due to "gross misconduct")
   2. reduction in hours
   3. employee's death
   4. employee's entitlement to Medicare

   the employer must notify ATA within 30 days after the date of the Qualifying Event. The employer must send such notification to ATA by certified mail on COBRA Form A, "Notice of Qualifying Event", within 30 days of the date of the Qualifying Event.

B. ATA SERVICES: After ATA receives COBRA Form A and is properly notified of a Qualifying Event (within 30 days of the event), ATA will notify the Qualified Beneficiaries entitled to such notice of their COBRA election rights.

   1. Such "Renotification of COBRA Rights" will be sent via U.S. mail within 14 days after the date ATA receives COBRA Form A, "Notice of Qualifying Event", provided the COBRA Form A was sent within the referenced time period.
   2. A COBRA Election Form will be sent with each Notice.
   3. A Notice and Election Form will be sent to all qualified beneficiaries entitled to receive notice and election forms at the address(es) provided on COBRA Form A.
   4. ATA will monitor the Qualified Beneficiary's 60-day election period.

5. ATA will review and process all Election Forms submitted by Qualified Beneficiaries.
6. ATA will add persons who properly elect COBRA to employer's plan and employer's billing.
7. ATA will send confirmation of COBRA coverage to persons who properly elect COBRA and send a copy of the confirmation to employer.
8. ATA will notify persons who fail to properly elect COBRA and advise the employer.

SOCIAL SECURITY BENEFITS / SECOND QUALIFYING EVENTS:

If a qualified employee, or qualified dependent, is determined by the Social Security Administration to be totally disabled at the time, or within 60 days, of a qualifying event that is termination of employment or reduction in work hours, the qualified employee and any qualified dependents are eligible to extend their COBRA continuation coverage for an additional 11 months (or a total of 29 months from the date of the initial qualifying event) provided such person provides notice to the employer of the Social Security Administration disability determination within 60 days of such determination and prior to the end of the 18th month of continuation coverage. The employer must notify ATA of the event by providing a COBRA Change Form to ATA within 7 days of receipt of such notice.

If a dependent, who has continuation coverage for 18 months due to the termination of the covered employee's employment or reduction in the covered employee's work hours (or who has continuation extended due to total disability), experiences an additional qualifying event that is the death of a covered employee, divorce or legal separation from the covered employee, the covered employee's enrolling in Medicare, or a dependent child's ceasing to be eligible for coverage as a dependent under the plan, such dependent shall be entitled to elect continuation coverage for an additional 18 months (or the balance thereof, not to exceed a total of 36 months from the date of the first qualifying event), if he notifies the employer in writing of the occurrence of the second qualifying event prior to the date the initial 18 month continuation would otherwise terminate. The employer must notify ATA of the event by providing a COBRA Change Form to ATA within 7 days of receipt of such notice.

4. ELECTING COBRA CONTINUATION COVERAGE

Qualified beneficiaries must elect COBRA continuation coverage within 60 days of the later of: (1) the date the person's coverage would terminate due to the qualifying event or; (2) the date that the person is sent notice of his/her right to elect COBRA continuation coverage. An election is considered to be made on the date the election form is sent by the Qualified Beneficiary to ATA.

The Excess Loss Carrier will provide coverage for those on COBRA under your health plan only if all notices and elections are made within the statutory time periods and the Administrative Instructions are followed.

5. RESPONSIBILITIES FOR BILLING AND PREMIUM COLLECTION

The employee is responsible for remitting the premiums for COBRA continuation coverage to AMERICAN TRUST ADMINISTRATORS, INC. on or before the first day of each month for which coverage is being provided. Persons who have properly elected COBRA will be listed on the employer's monthly statement and indicated as having COBRA coverage.

The COBRA premium will be equal to 102% (or 150% if disabled) of the applicable premium. ATA will calculate suggested applicable premiums and send these rates to new and renewal groups for approval. An officer of the group must complete the Suggested Monthly COBRA Rates form and mail it to American Trust Administrators, Inc., Attn: COBRA Compliance, 7223 West 95th Street, Suite 301, Overland Park, Kansas 66212-2291 or fax it back to the attention of the COBRA department at 913-378-9869 within one week of receiving it. ATA will retain 2% of the applicable premium as an administrative fee. COBRA continuees must pay their first COBRA premium payment within 45 days of the date they elected COBRA. ATA will bill COBRA continuees the COBRA premium directly to the most current address reported to ATA on the COBRA election form, or on a subsequent COBRA Change Form. The first payment shall be for the period of time between the date coverage would have terminated and the end of the period for which any current monthly premium has become due. The COBRA continuees will be provided with bills / coupons for making their payments for all subsequent months of coverage. COBRA continuees will be allowed a 30-day grace period for payment of COBRA premiums. These individuals will receive new coupons in the event the group's rates change during the continuation period.

The employer's bill will continue to reflect the full cost of coverage as if the person was an employee. The employer will be credited the entire amount of the collected COBRA premium (less the 2% administration fee). This amount will appear as a credit under the column headed "Total" on the monthly bill.

6. NOTICE OF TERMINATION OF COBRA CONTINUATION COVERAGE

Notice of termination of COBRA continuation coverage will be sent to COBRA beneficiaries at the last address in ATA's records upon the first of the following to occur:

A. When a COBRA continuee fails to timely pay the premium due;

B. When a COBRA continuee becomes covered (as an employee or otherwise) under any other group health plan, which does not contain any exclusion or limitation with respect to any pre-existing condition of the person continuing coverage;

C. When a COBRA continuee becomes entitled to Medicare benefits;

D. When the employer ceases to maintain a group health plan for all employees;

E. When the COBRA maximum coverage period ends (18/36 months depending on the qualifying event, or 29 months if the covered person is total disabled and meets the requirements for the extension of COBRA continuation coverage);

F. If continuation is provided to a COBRA continuee who has coverage under another group health plan which contains a pre-existing condition exclusion or limitation, when such person has satisfied, due to creditable coverage or otherwise, that plan's pre-existing condition time period;

G. If a COBRA continuee is entitled to up to 29 months continuation due to total disability, when such person ceases to be totally disabled after 18 months of continuation; or

COBRA continuation coverage and services provided by ATA will terminate on the date coverage for all actively working employees terminates. The employer must notify American Trust Administrators, Inc. on a COBRA Change Form within 7 days of the occurrence of one of the above events with respect to all COBRA continuees. ATA will send a letter to the COBRA continuee whose COBRA continuation coverage has terminated before the end of the maximum coverage period explaining the reason for termination within 14 days of receipt of the Change Form.

7. GENERAL PROVISIONS

A. If you have questions regarding COBRA, you should consult with an attorney.

B. Federal laws and regulations shall control administration of COBRA continuation. These administrative instructions are not to be considered legal advice. They are ATA's understanding of the COBRA laws and regulations as they exist at this date. These instructions may be changed without prior notice.

C. ATA will process material received by ATA which is not sent via registered or certified mail, however, ATA shall not be responsible or liable for the loss or failure to process any material not sent via registered or certified mail.

D. All responsibilities and obligations contained in these instructions shall terminate on the date the employer's group health plan serviced by ATA terminates.

E. ATA's COBRA Services do not include COBRA services for a Qualifying Event that involves the employer's bankruptcy proceedings.

F. ATA is not required to act upon a change of address notice until 14 days after receipt.

Appendix F

Forms

The following table lists the forms assessable to you. If you have any questions regarding the forms, please contact the Administration Department. If you need any of the forms listed below, please contact Rochelle Llamas.

	Form Number	Form Description
1.	ULSSD1B – EE Form	AmeriShare Employee Enrollment / Refusal Form
2.	A-01024FL	AmeriShare Employee Enrollment / Refusal Form (Florida Only)
3.	MCCF01	Employee Change Form
4.	COBFormA.doc	COBRA Form A - Notice of Qualifying Event (to ATA)
5.	COBRA Change Form	
6.	COBRA Election Notice	
7.	RX Mail In Form	