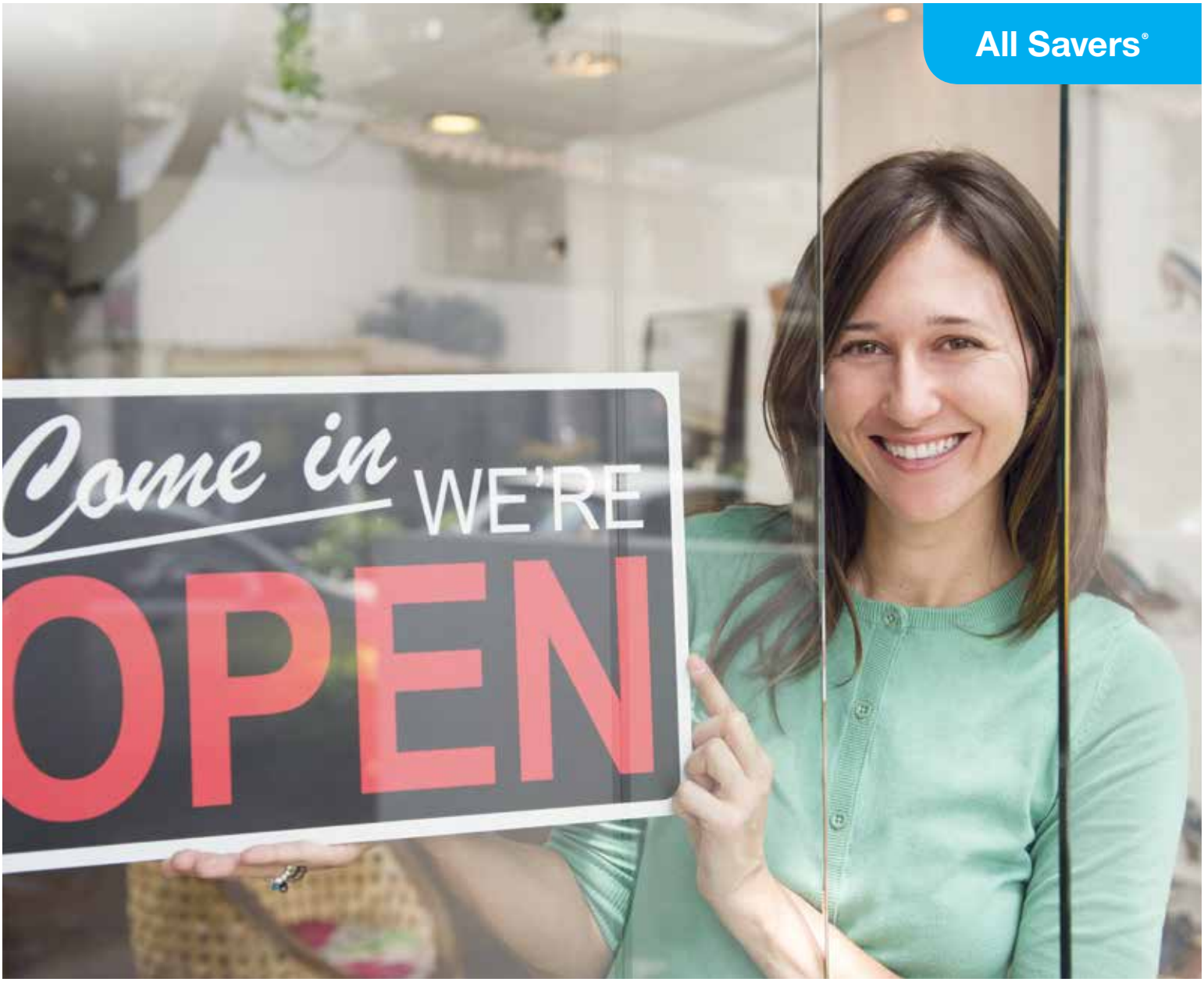
All Savers®



All Savers Alternate Funding

Explore new options to build the health of your business.

Employer Guide

UnitedHealthcare®

Important Contact Information

General Correspondence
United HealthCare Services, Inc.
P.O. Box 19032
Green Bay, WI 54307-9032
Fax: (920) 661-9959
Phone: 1-800-291-2634

Appeals
United HealthCare Services, Inc.
Appeals
P.O. Box 13597
Green Bay, WI 54307-3597

Regular Payments
United HealthCare Services, Inc.
P.O. Box 88106
Chicago, IL 60680-1106

Overnight Payments
United HealthCare Services, Inc.
Attn: Lockbox #88106
4900 W. 95th St.
Oak Lawn, IL 60453

Website
www.myallsavers.com

Table of Contents

Thank you for choosing All Savers Alternate Funding.

This guide was developed to help you understand how an All Savers Alternate Funding plan works. These plans are self-funded plans tailored for small businesses.

All Savers Alternate Funding plans have three parts:
1. The small business' medical plan
2. A third-party administration agreement
3. A stop-loss insurance policy

The **medical plan** is the set of benefits you establish to cover certain medical expenses of your employees and their dependents. All Savers Alternate Funding plans offer you, the employer, the ability to choose between several pre-built plan designs to make choosing the benefits easier. Once you have chosen a plan design for your employees, your employees can choose their own copayment and deductible options without affecting the cost. The Summary Plan Description has a full explanation of the plan benefits, exclusions, and limitations.

The **third-party administration agreement** is the contract you enter into for claim administration services. Under the All Savers Alternate Funding plan, these services include claims processing, billing, reporting, enrollment, membership changes, materials fulfillment, customer service, etc. These services are provided by United HealthCare Services, Inc. The Administrative Services Agreement describes the contract with United HealthCare Services, Inc.

The **stop-loss insurance policy** (also known as an excess loss insurance policy) protects you from large, catastrophic claims incurred by a single covered member, and provides overall protection in the event that all of the claim payments made under your medical plan exceed a certain dollar limit. The Stop-Loss Insurance Policy describes the stop-loss coverage and is issued by All Savers Insurance Company.

Administrative service fees, the monthly maximum claim liability, and the stop-loss premium will all be billed together to you, the employer, on a monthly basis.

How does Alternate Funding work?

With All Savers Alternate Funding plans, you, the employer, set up a medical plan that pays for employees' medical benefits directly, and employers just have to cover the monthly bill. Part of the risk for medical expenses is taken on by the medical plan rather than by an insurance company. The rest of the risk for medical expenses is covered by stop-loss insurance, underwritten by All Savers Insurance Company.

Stop-loss insurance puts a cap on the plan's medical claims payment risk. This cap is based on the amount the plan must pay for an individual's medical claims (called the "specific deductible"), as well as the combined amount of all eligible medical claims the plan must pay in a given period (called the "aggregate attachment point"). With stop-loss insurance, the plan is protected from high individual medical claims and high overall claims expenses.

Specific stop-loss coverage protects the plan from unexpected large medical claims incurred by covered individuals in the group.

Specific stop-loss deductible is the amount of eligible medical claims the plan pays for any individual member before the stop-loss insurance begins to reimburse the plan (within the contract year). For example, if an Alternate Funding plan had a specific deductible of $15,000 per member, and a member has medical claims of $22,000, then the plan covers $15,000 of those expenses and the stop-loss insurance covers the rest.

Aggregate stop-loss coverage provides protection by limiting the medical plan's risk for the sum of the group's total eligible medical claims.

Aggregate attachment point is the total amount of eligible medical claims in the contract year that the medical plan pays before stop-loss insurance begins to reimburse the plan. If the eligible medical claims exceed the plan's maximum claims liability for that contract period, stop-loss insurance reimburses the plan. Although stop-loss insurance is purchased for the entire year, the policy provides immediate reimbursement to employers throughout the year.

For example, if an Alternate Funding plan has an aggregate attachment point of $4,000 per month and the number of members does not change, the aggregate accumulates each month to an annual aggregate deductible of $48,000 ($4,000 x 12 months).

The aggregate stop-loss coverage pays for high aggregate claims expenses throughout the year. So if claims total $40,000 by month four, the plan will have paid up to the aggregate attachment point of $16,000 ($4,000 x 4 months) and the stop-loss insurance will have covered the remaining $24,000.

If, at the end of the contract period, eligible claims under

the medical plan exceed the plan's aggregate stop-loss deductible, the stop-loss insurance will reimburse the medical plan for the amounts over the aggregate stop-loss deductible.

If total eligible claims are less than the aggregate stop-loss deductible, a portion of the surplus claims dollars will be refunded to the plan. Where required by law, the entire surplus will be refunded to the plan.

Incurred but not reported (IBNR) refers to health care claims that will come in after the end of the plan year. It's commonly called "runout" or "runoff."

Deficit carry-forward is something All Savers Alternate Funding plans do not have, but you might hear about it from others. If a group had a really bad year (say $1 million in actual claims), the stop-loss insurance would cover it. But the insurance company might decide to hold back all renewal refunds until that huge sum is paid back. In other words, the insurance company could carry the deficit from the one bad year forward to future years.

Again, All Savers plans do not have a deficit carry-forward. All Savers Alternate Funding plans are designed to be free from hidden costs or fees. No matter what the previous claims are, your company's tally starts each year at zero.

Claim funding.

ERISA places a fiduciary responsibility on you, as plan sponsor, to ensure the plan is adequately funded. If you fail to fund the monthly maximum liability, then United HealthCare Services, Inc. has a right to terminate the administrative services agreement.

Maximum funding.

The maximum claim liability must be remitted each month.

If your claims exceed the maximum cumulative monthly claim liability, the plan will reimburse eligible claims, even if your company hasn't met the aggregate stop-loss limit for the policy or plan year; this is called "accommodation." If your company's claims exceed the aggregate stop-loss limit at any point in the policy or plan year, the stop-loss insurance will pay for additional eligible claims.

Also, if an individual employee meets the individual stop-loss limit, any additional eligible claims for that employee will be paid for by the stop-loss insurance.

Claims and provider information.

Notification for medical procedures.

Notification must be given to United HealthCare Services, Inc. before a person receives certain covered health services, such as a transplant evaluation or participation in a clinical trial. The notification must be submitted within five business days, or as soon as possible before, a scheduled service or treatment occurs. Notification must also be given of an inpatient stay on the day of admission and emergency inpatient admissions as soon as reasonably possible. Emergency health services do not require notification. If notification is not given as required, benefits can be reduced by up to 60 percent of eligible expenses, not to exceed $1,000 per occurrence. Members are encouraged to contact United HealthCare Services, Inc. to confirm that the services they plan to receive are covered health services.

Submitting claims.

Network providers are obligated under their provider contracts to submit claims for processing on behalf of enrolled members. Employees are encouraged to call Member Services if they have questions about the benefits and how best to utilize the plan.

All enrolled members receive ID cards. When seeking care, they simply present their card to the provider.

This card indicates the following to the employees and the provider:

- The member's name
- The network of health care providers
- Amount of copayment, types of benefits and effective date of the current plan
- The number to call for customer service, provider verification and benefit information
- Where to send claims

Explanation of benefits.

United HealthCare Services, Inc. provides an Explanation of Benefits (EOB) to the employee and provider of services whenever a claim is submitted and processed. The EOB form outlines the charge for each procedure. It also explains if the procedure is an eligible expense and, if so, at what percentage the charge was paid. Deductibles accumulated throughout the calendar or plan year, based on their plan, are totaled and indicated on the EOB. If a claim is denied, then the EOB explains the member's appeal rights.

Prior-carrier deductible.

If, prior to the implementation of the All Savers Alternate Funding arrangement, your group medical plan was underwritten or administered by another carrier or administrator, then employees who enroll in the All Savers Alternate Funding plan will receive credit for the calendar year deductible with the amount of deductible satisfied under the prior plan for each employee. (Only applies to Calendar Year Deductible plans).

To administer the deductible credit, United HealthCare Services, Inc. must be provided with proof of the amount of expenses under the prior plan that were counted towards that plan's deductible. Acceptable proof would include:

- Copies of any EOB forms from the prior carrier or administrator that show charges applied to the deductible for the applicable calendar or plan year
- Verification letter from the prior administrator/carrier

The employee ID number and group number from the ID card, with dependent's name when appropriate, must be included on any document. It should be emailed to **claimsrequests@UnitedHealthOne.com**.

Provider information.

Employees can access a list of participating providers at www.myallsavers.com or by calling the toll-free number on their ID cards. They can also call to request a provider directory be sent to them.

Providers are subject to change. Therefore employees:

- Should call to verify that a provider is contracted with the network each time they call for an appointment and immediately prior to the appointment
- Should remember that a directory listing for a provider doesn't guarantee benefits
- Are encouraged to review their ID cards and Summary Plan Descriptions for detailed benefit information and requirements
- Are encouraged to call using the toll-free number on their ID cards if they have questions about their benefits and how to best use them

Appeals.

Employees or their authorized representatives have a right to appeal any adverse benefit determination within 180 calendar days from the date of notification of an adverse benefit determination.

The appeal may include:

- Written comments, documents, records, and other information relating to the claim; and
- The ID numbers on the employee's insurance ID card

The written request may be sent directly to the Claims Administrator at the following address:

United HealthCare Services, Inc. – Appeals
P.O. Box 13597
Green Bay, WI 54307-3597

The period of time for benefit determination on review begins when an appeal is received, regardless of whether all the information necessary to make a benefit determination accompanies the appeal.

Group participation and contribution requirements.

Group participation requirements.

Retirees are not eligible for coverage under the All Savers health plans.

Note: New business participation/eligibility is verified according to the group's most recent wage and tax quarterly filing. Payroll records alone are not acceptable documents for determining eligibility/participation. Employee Participation is 50% of eligible employees.

Contribution requirements.

Employers are required to contribute a minimum of 50 percent of the employee-only cost for the lowest-cost medical plan sponsored by the employer.

Employee enrollment and changes.

Whenever you submit an Employee Enrollment Form, please ensure that the employee has completed the entire form, including his or her signature, date, ID number and group number.

Send all employee enrollment correspondence to:

United HealthCare Services, Inc.
P.O. Box 19032
Green Bay, WI 54307-9032
Fax: (920) 661-9959
Email: AdminAllSavers@unitedhealthone.com

Employee and dependent eligibility.

An eligible employee is a regular full-time employee who is scheduled to work at least 30 hours per week.

Eligible dependents include the employee's spouse, employee's child or employee's spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom employee or employee's spouse are the legal guardian; or an unmarried child age 26 or over who is or becomes disabled and dependent upon employee.

Note: Dependents may not enroll in the plan unless an employee is also enrolled. If an employee and his or her spouse are both covered under the medical plan, each may be enrolled as a participant or be covered as a dependent of the other person, but not both. In addition, if an employee and his or her spouse are both covered under your group's benefit plan, only one parent may enroll a child as a dependent.

Employee Enrollment Form.

- An Employee Enrollment Form must be submitted for the following events:
- Adding an employee to your plan.
- Adding a spouse or child to an employee's coverage.
- Adding an employee who lost eligibility and once again is eligible for benefits.
- Open enrollment 60 days prior to and 31 days after an anniversary renewal date.
- Requesting a benefit change for an employee, whether the request is for an increase or decrease in benefits. Benefits may be changed in the 30 days prior to renewal.

Authorization to Release Medical Information. Please make sure the employee reads and understands the information described in this section. The employee's signature indicates that the employee has:

- Supplied true and correct information.
- Acknowledged that benefits are not effective until approved by us.
- Authorized the release of medical information.

After reading this section, the employee must sign and date the form.

Waiver of Medical Benefits. Employees and their dependents may waive group medical benefits. The waiver section must be completed on the Employee Enrollment Form.

Adding employees or dependents.

United HealthCare Services, Inc. must receive an enrollment form from a new employee within 31 days of his or her eligibility date. The employee's spouse and dependents can also enroll during this time. Eligibility dates are based on the employee's date of hire and the waiting period selected on the Employer Group Application.

If an enrollment form is not received within 31 days after the eligibility date, the employee is a late enrollee and coverage will be postponed until the renewal date.

For a new spouse to be covered as of the date of the marriage, United HealthCare Services, Inc. must receive an enrollment form within 31 days of the date of marriage. If an enrollment form is not received within 31 days after the eligibility date, the spouse is a late enrollee and coverage will be postponed until the renewal date.

United HealthCare Services, Inc. must receive an enrollment form within 31 days of the birth or adoption for coverage to be effective as of the date of birth or adoption. If an enrollment form is not received within 31 days after the eligibility date, the dependent is a late enrollee and coverage will be postponed until the renewal date.

An employee and/or dependents may enroll within 31 days of an employee's major life change event, such as marriage, the birth or adoption of a child, or the involuntary loss of other health coverage. This is true whether or not the employee was previously covered under another plan.

Unless the employee experiences a change in employee status (see at right), an employee who waives medical coverage will not be able to enroll in the medical plan until the next renewal date.

If the employee has not experienced a major life change event, he or she will not be able to enroll until the plan's renewal date.

Late enrollees.

If an enrollment form is received later than 31 days from the date an employee or dependent is first eligible to enroll, coverage will be postponed until the benefit plan's next anniversary renewal date.

Terminations of coverage.

An employee's coverage under the medical plan shall end at the earliest of the following events:

- The employee's employment is terminated.
- The employee is no longer in an eligible class
- The employee retires.
- The employee requests termination of benefits and signs the request.
- The employee stops making the required contributions.

Coverage for a spouse or dependent of an employee shall end at the earliest of the following:

- The date the employee's coverage terminates
- The date the spouse is no longer the employee's lawful spouse due to divorce, annulment or legal separation
- The date the dependent marries or attains age 26

To terminate an employee's benefits, a written request from you, the employer (not your agent), is required. You must notify us within 31 days or indicate the termination on your current billing statement, noting the last date the employee worked full time.

The employee's or dependent's benefits will terminate on the last day of the month in which the termination is requested. Payment is due for that month.

Change in employee status.

Please notify us within 31 days of any of the following:

- An employee marries, divorces, is legally separated or has a marriage annulled.
- An employee dies while family benefits are in force.
- An employee loses eligibility for group benefits due to termination of employment, temporary layoff, seasonal layoff, leave of absence or temporary reduction in work hours.
- An employee's child dies, turns 26, or is no longer eligible as a dependent.
- An employee has a newborn baby, adopts a child, or places a child for adoption or legal guardianship.

Note: We require immediate notification from the company contact if an employee uses the Family Medical Leave Act.

Family Medical Leave Act (FMLA).

FMLA is a federal law. Employers with 50 or more workers, all located within a 75-mile radius, must comply with FMLA. Eligible employees may qualify for at least 12 weeks of leave for any of the following:

- The birth or adoption of a child, or the placement of a foster child with the employee.
- Serious illness of the employee's spouse, child or parent.
- The employee's own disabling illness. (determined by the employer with the employee and the employee's physician)

Because FMLA is an employer-directed law, you should consult your attorney for information about FMLA.

You must provide the same coverage to those on leave as you provide to your active employees. The employee's coverage does not change. However, you must notify United HealthCare Services, Inc. when employees exercise their rights under FMLA.

Disability.

Please notify United HealthCare Services, Inc. within 31 days of the onset of the disability and include the name of the employee, the date disability began and the date last worked. We'll record the change and determine whether any further steps are necessary.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law applicable to employers that requires some employers to allow qualified individuals to continue group health coverage that would normally be lost due to certain qualifying events.

Regulations exempt some employers from COBRA. If you are an employer with 20 or more employees (for at least 50 percent of typical business days during the prior calendar year), you may be subject to COBRA. If you are unsure whether your plan is subject to COBRA, please consult your attorney or tax adviser.

You, as the employer, are responsible for compliance with any applicable COBRA requirements and may be subject to fines if compliance with the law isn't maintained.

You may contract with another party to assist with COBRA administration.

State continuation laws.

State fully insured continuation laws do not apply to self-funded plans covered by ERISA.

Group changes and termination.

Group changes.

If your company moves or changes its name or contact information, submit a letter or send an e-mail to adminallsavers@UnitedHealthOne.com as soon as possible. It is important that this information be kept current.

If your company's ownership changes, new ownership must complete a new stop-loss insurance application in order to issue a new Stop-Loss Insurance Policy, and enter into a new Administrative Services Agreement.

Changes to benefits under the medical plan, including waiting period changes, may be made only at your group's anniversary renewal date. A new Employer Group Application may be needed. Depending on your request, your employees may be required to complete new employee enrollment forms. Consult your agent for details. Before making any change to the benefits under your plan, you may want to contact your broker or call United HealthCare Services, Inc. to discuss all of your options.

Group termination.

The Stop-Loss Insurance Policy will terminate if you fail to make a monthly payment within the grace period, your business stops operating, the administrative services agreement is terminated or you give written notice to terminate the Stop-Loss Insurance Policy. See the Stop-Loss Insurance Policy for full details.

The Administrative Services Agreement will terminate if you miss a payment, the stop-loss policy is terminated, you don't meet the minimum contribution requirements or you give written notice to terminate the agreement.

The Administrative Services Agreement may also terminate if your company has fewer than 10 enrolled employees for two months in a row. See the Administrative Services Agreement for full details.

Any termination request must be made directly to United HealthCare Services, Inc. by you. Broker requests for terminations are not accepted. You are responsible for notifying your employees that your administrative services have been terminated.

Claims processing after early termination.

If the Administrative Services Agreement and Stop-Loss Insurance Policy terminate before the end of the plan year, run-out services will be provided. This means that all eligible claims incurred prior to the group termination will be paid. You will be billed for maximum claim liability up to your termination date (see Claim Funding on Page 5).

Billing options and payments.

The monthly bill will consist of amounts for administration fees, the stop-loss premium and their monthly maximum claim liability.

For your convenience, there are many ways to make required monthly payments.

Billing and payment options.

All Savers offers two payment options: Electronic Funds Transfer (EFT) and direct billing.

You may choose the payment method most convenient for you. No administration fee is charged for EFT. Direct billing may include an additional monthly fee.

If you choose to pay by EFT, your payment will be automatically withdrawn from your account on or around the first of each month.

If you choose to be billed directly, you'll receive a monthly statement. Payments are due by the first of the month for that month's coverage. For example, the payment for February's coverage would be due February 1. You may change your payment method at any time by calling 1-800-291-2634.

Payments are due on the first of each month. Businesses that choose direct billing will receive a monthly statement. If you choose to pay by EFT, you may request a monthly statement by calling 1-800-291-2634. When you receive a statement, please do the following:

- Check to be sure the statement is accurate. If you see any errors, please call. The number to call is printed on your statement.
- If any of your participants no longer qualify for coverage, document that information.
- Make your check or money order payable to United HealthCare Service, Inc. and put your group number on the check. Send it in the envelope provided, along with the perforated billing coupon and documentation, to one of the addresses below.

Payment mailing address.

The first month's payment must be submitted with the Employer Group Application to:

United HealthCare Services, Inc.
P.O. Box 19032
Green Bay, WI 54307-9032

Subsequent payments should be sent to the following address:

Regular mail
United HealthCare Services, Inc.
P.O. Box 88106
Chicago, IL 60680-1106

Overnight
United HealthCare Services, Inc.
Attn: Lockbox #88106
4900 W. 95th St.
Oak Lawn, IL 60453

Nonpayment.

You have a grace period to make the monthly payment. Covered persons' claims will not be paid during the grace period until your payment is made. If payment is not received by the end of your grace period, your Stop-Loss Insurance Policy and Administrative Services Agreement will terminate as of the due date of your monthly payment.

If payment by check or Electronic Funds Transfer is declined or returned, a service fee may be applied.

All Savers

The smart choice – for you, for your employees, for better health.

UnitedHealthcare®