LifeMap Assurance Company®
P.O. Box 1271, M/S E8L
Portland, OR 97207-1271
(800) 794-5390

Group Policy Administration Guide

This Group Policy Administration Guide ("Guide") is provided to assist the Group Administrator with the administration of the Policyholder's/Employer's benefits with LifeMap Assurance Company (LifeMap). It provides detailed information about group coverages, eligibility, enrollment, monthly billing and claims submission. The Guide is intended to be used for informational purposes and does not constitute legal advice.

This Guide contains information regarding LifeMap's standard administrative processes and standard plan provisions and is applicable to all of LifeMap's lines of coverage. At all times, coverage is governed by the terms of the group's policy through LifeMap for plan benefits and provisions. Refer to the Group Policy and Certificate of Coverage for specific information pertaining to the group.

Information in this Guide is subject to change without notice. The most current version of this Guide is available on LifeMap's web page at www.lifemapco.com. The Group Administrator is encouraged to review the online guide as a matter of course. No part of the Guide may be reproduced or transmitted in any form or by any means, electronic or mechanical, for any purpose, without the express written permission of LifeMap.

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Welcome

Thank you for selecting LifeMap Assurance Company for your Group's insurance needs. Please review this guide carefully to answer any questions you may have. You may also find helpful resources on LifeMapCo.com/employers. If you need additional assistance contact your LifeMap Account Executive.

Communicating with LifeMap

LifeMap office hours are from 8 a.m. to 5 p.m. Pacific Time, Monday through Friday, excluding major holidays. For prompt assistance, call our office at 1(800) 794-5390.

When communicating with LifeMap via email, ensure any correspondence containing Personally Identifiable Information (PII) or Personal Health Information (PHI) is sent securely. If you do not have a secure method of sending PII or PHI, contact the LifeMap department you are working with for assistance to determine the best way to send all information securely. Be sure to reference your Group Name and Number in all verbal and written correspondence.

Privacy
If you or your employees have any questions about privacy or how we handle member information, you can review our Privacy Policy online at LifeMapCo.com/privacy-policy.

Phone Interpreters
LifeMap provides members with language interpretation services when they call our office phone lines. The member will need to ask for an interpreter and provide the language needed to begin the process. It may take a few minutes while our team gets an interpreter on the line.

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Contact and Mailing Information

The most frequently used contact numbers and addresses for LifeMap benefits are listed below.

General Inquiries:

www.LifeMapCo.com
1 (800) 794-5390
LifeMap Assurance Company
PO Box 1271, M/S E8L
Portland, OR 97207-1271

Contact Information		
Eligibility – enrollment, changes and adjustments		
All Lines of Coverage	1 (888) 777-9368 Billing@LifeMapCo.com	Online Account Management LifeMapCo.com/employers
Portability	1 (888) 777-9368 LifeMapPort_Convert@LifeMapCo.com	
Conversion for Life	1 (888) 777-9368 LifeMapPort_Convert@LifeMapCo.com	Initial Enrollment: LifeMapCo.com/convert
Premium Payments		
Life, AD&D, STD, LTD, Critical Illness, Accident and Vision	1 (888) 777-9368 AccountsReceivable@LifeMapCo.com	LifeMap Assurance Company PO BOX 6840 Portland, OR 97228 Available online: LifeMapCo.com/employers
Dental	1 (888) 777-9368 AccountsReceivable@LifeMapCo.com	Refer to current Billing Statement for Premium Payment Address Available online: LifeMapCo.com/employers
Conversion for Life	(888) 999-4767 Conversions@HRMP.Com	HRMP Life Conversion Facility 300 Rosewood Drive, Suite 250 Danvers, MA 01923
Portability Initial premium payment (check with application)	1 (888) 777-9368	LifeMap Assurance Company Attn: Enrollment Dept. PO Box 1271 M/S E8L Portland, OR 97207
Portability Ongoing premium payments	1 (888) 777-9368	LifeMap Assurance Company PO Box 6840 Portland, OR 97228

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Contact Information, cont'd		
Claims and Appeals		
Life, AD&D, STD, Critical Illness, Accident, Conversion, and Portability	1 (800) 286-1129 Claims@LifeMapCo.com	LifeMap Assurance Company Attn: Life and Disability Claims Department PO Box 1271, M/S E8L Portland, OR 97207-1271 Fax (855) 733-4615
Dental	1 (800) 286-1129	Dental Claims: LifeMap Assurance Company PO Box 783 Milwaukee, WI 53201 Dental Appeals: LifeMap Assurance Company PO Box 1334 Milwaukee, WI 53201
Long Term Disability and Life Waiver	1 (877) 254-0085 Claims@DisabilityRMS.com	LifeMap Claims 300 Southborough Drive Suite 200 South Portland, ME 04106-6914 Fax 1 (207) 766-3448
Vision	Claims 1 (800) 877-7195	Vision Service Plan Attn: Claims Services PO Box 385018 Birmingham, AL 35238-5018
	Grievances 1 (800) 877-7195	VSP Complaints and Grievances PO Box 2350 Sacramento, CA 95741
	Appeals 1 (800) 286-1129	LifeMap Assurance Company Attn: Appeals P.O. Box 1271 E-8L Portland, OR 97207-1271
Travel Assistance Services through AXA for Life Policies		
Inquiries and Assistance	Within the U.S.: 1 (800) 230-5170 Outside the U.S.: +1 (630) 766-7772	
Evidence of Insurability (EOI) Status and Questions		
Enrollment Department	1 (800) 794-5390 Billing@LifeMapCo.com	LifeMap Assurance Company Attn: Enrollment PO Box 1271 M/S E8L Portland, OR 97207-1271

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Contact Information, cont'd		
FMLA and Leave Management for Short Term Disability Policies (If services purchased)		
Inquiries & Assistance	1 (877) 462-3652 FMLACenter@FMLASource.com	FMLASource/ComPsych 455 N City Front Plaza Drive 10th Floor Chicago, IL 60611 Fax: 1 (877) 309-0218 www.FMLASource.com
Employers with New York and New Jersey Residents with STD and PFL (If services purchased)		
Customer Service	1 (800) 927-8846 www.RenaissanceFamily.com	Renaissance Life & Health Insurance Company of New York 2 Court Street Suite 102 Binghamton, NY 13901
Claims Coordination	1 (800) 927-8846 GroupClaims@RenaissanceFamily.com	Group Fax: (607) 722-5622 Administration Fax: (607) 723-8665
1099 Information		
All Lines of Coverage	(503) 220-6172 1099s@CambiaHealth.com	
W2 Information		
Claims Dept.	1 (800) 794-5390 Claims@LifeMapCo.com	
FICA Information		
FICA Reporting Dept.	1 (800) 794-5390 FICA@LifeMapCo.com	
Report Fraud		
To report fraud, call our 24-hour Hotline at 1 (877) 664-2466 or submit a form online: www.LifeMapCo.com/contact-us/report-fraud		
Privacy Policy		
Privacy Policy and Contact	1 (800) 794-5390 www.lifemapco.com/privacy-policy	LifeMap Privacy Official P.O. Box 1271, Mailstop E12P Portland, OR 97207

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Group Administrator Responsibilities

The Group Administrator is a general term used throughout this guide to define the person or persons responsible for managing the Policyholder's* or Employer's administrative duties for the policy(ies). Administrator responsibilities vary between List Billed Groups and Summary Billed Groups.

The below provides a **common** list of the responsibilities of a Group Administrator but **is not all inclusive. Please refer to the following sections of this guide for more detailed information regarding specific responsibilities.**

1. Must keep all necessary paperwork on file including, but not limited to, enrollment forms and beneficiary designation forms. <u>Beneficiary designation forms should not be sent to LifeMap</u>, as we are not responsible for retaining beneficiary information.

2. Maintain the group's census information and submit to LifeMap in a timely manner. This includes, but is not limited to, adding and terming employees, employee eligibility, employee benefit selections, Evidence of Insurability submissions, and dependent enrollments.

3. Submit accurate premiums to LifeMap on a timely basis. Set up payroll deductions for voluntary benefits upon employee (and dependent) approval of voluntary coverage.

4. Notify LifeMap when a new Group Administrator will be managing the LifeMap benefits. Having the most current contact information for the Group Administrator ensures timely communication from LifeMap and the best possible customer experience.

5. When an employee is terminated or loses Life Insurance coverage for other reasons, the Group Administrator is responsible for distributing Conversion and Portability paperwork, as well as forms for Extension of Life Insurance, as applicable to the employee.

LifeMap will provide the following contracts:

Policies
The Policy is a legal document containing the detailed and controlling provisions of the Group's coverage with us. It includes a copy of the application and any amendments to the plan. An overview of the group-specific benefits and eligibility requirements are addressed in the Coverage Outline. A separate policy may be provided for each line of coverage.

Certificates of Coverage
The Certificate of Coverage contains information regarding the benefits and provisions provided to the employees and must be distributed to eligible employees when they enroll for benefits.

It is the Group Administrator's responsibility to provide each insured individual with the appropriate Certificate(s) of Coverage either via paper, electronically or using an intranet site.

**Policyholder means the person, individual firm, trust, or other organization named in the application for the group's policy and to whom the Group Policy has been issued.*

Applicable Forms

Many of the forms needed to administer the group's insurance plan(s) can be obtained from our website at LifeMapCo.com/forms. Use the dropdown menus to select the appropriate category and state for the forms you need. If the form you need is not available on our website, or if you have difficulty obtaining forms via our website, please call us toll free at 1 (800) 794-5390 or contact your LifeMap Account Executive. The types of forms you will likely need to be familiar with include:

- Billing FAQ
- Domestic Partnership Affidavits
- Claim Forms
- Conversion and Portability Applications
- Beneficiary Designation Form
- Evidence of Insurability Form
- Dental and Vision Waiver Forms
- Notice of Privacy Practices – for Vision and Dental
- Privacy Notice
- Affidavit of Qualified Disabled Dependent
- Employer Admin Center User Guide and FAQ

You can also request the following form through LifeMapCo.com/employer/manage-account/change-request.

- Request Enrollment Change

Managing Eligibility Online – Employer Admin Center (EAC)

LifeMap allows Group Administrators to manage the group's eligibility and benefits enrollment online through a simple process. The LifeMap Assurance Company Employer Admin Center allows you to easily administer your coverage(s):

- Life and AD&D;
- Short Term Disability;
- Long Term Disability;
- Critical Illness;
- Accident Only;
- Vision; and
- Dental

What can a Group Administrator do in the EAC?

- Manage personal and employment information for new employees, as well as their dependents
- Enroll new employees in basic and voluntary lines of coverage up to the Guarantee Issue limits
- Enroll new employees' dependents in lines of coverage up to the Guarantee Issue limits
- Make changes to enrollment due to a qualifying life event
- Rehire/Re-enrollment of prior employees
- Export, view, sort and filter a roster of employees
- Download and/or print policies and certificates
- View, export or print and pay billing statement online

The site is available 24 hours, 7 days per week. Changes are processed nightly Monday through Friday.

How does a Group Administrator get access to the EAC?

New online administration access is by invitation only. Once a new group has been set up in the system and the initial bill is generated, the Group Administrator is invited to register for the EAC.

If you are an existing group interested in using the EAC, speak with your LifeMap Account Executive about getting started or visit LifeMapCo.com/employers and click on the Login to Accounts link in the right navigation > Request Admin Access.

Navigating the EAC?

You can view and download the EAC User Guide from the LifeMap website for information on Registering, Managing User, Employee and Billing, Benefit forms and Reporting at https://www.lifemapco.com/employer/manage-account/faq and click on the eac_user_guide file.

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Enrollment Via 834 EDI File Feeds

If you are using an enrollment platform for your eligibility updates and would like to send us full ANSI X12 5010 834 files that are HIPAA compliant, we can set up an EDI file feed to update your group membership. With this format you will not be sending us manual changes via forms, applications or make changes via the EAC. All additions, terminations or changes in enrollment will be sent to LifeMap via the file feed.

Establishing a file feed is subject to LifeMap review and approval. The process for setting up the file feed is comprehensive and typically takes about 13 weeks to implement but may be longer depending on all parties meeting required deadlines. For list billed coverages, the 834 file feed should include benefit enrollment and maintenance for ancillary coverage, such as Life and Disability, if your account has these lines of coverage in addition to LifeMap Dental and/or Vision.

If a full ANSI X12 5010 834 file is not available, LifeMap can receive a Change-Only spreadsheet for processing.

If you have questions you can email us at EDI@LifeMapCo.com.

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LifeMap Key Terms

Eligible Dependents

Who is an eligible dependent?

- Spouse (person to whom the employee is legally married)
- Domestic Partner
  - State registered/certified, as defined by state of residence
  - Non-state registered/certified, if elected by your group (see Group Policy)
- Employee's child, spouse's child or domestic partner's child who is under age 26, unmarried, not in a domestic partnership and meets the following criteria:
  - Natural child, step child, adopted child or legally placed for adoption, or
  - A child for whom the court has appointed legal guardianship, or
  - A child for whom legal Qualified Medical Child Support Order (QMSCO) has been issued.

Disabled Dependent Child

We may allow coverage to continue for a Disabled Dependent Child past the limiting age of 26 for the following lines of coverage: Life and AD&D, Dental, Vision, Critical Illness and Accident Only. Refer to the Group Policy to determine if this provision is included.

What is required to continue coverage for a disabled dependent child after age 26?

The **Affidavit of Qualified Disabled Dependent** (Affidavit) packet can be found on LifeMapCo.com. For assistance in submitting the Affidavit, you may contact a Claims Representative at 1(800) 286-1129.

How are the Affidavit forms completed and submitted?

The **Affidavit** is downloadable for printing from the Forms tab on LifeMapCo.com. The form includes separate sections for the employee and attending physician. To avoid a delay in the processing of the request, all sections should be completed in full and signed.

1. The employee must complete and sign the **Insured's Statement** section of the form.
2. The dependent child's attending physician must complete and sign the **Attending Physician's Statement** section of the form.

All pages of the form (original copy is not required) and any supporting documentation should be sent to LifeMap Claims. Refer to Claims and Appeals in the **Contact and Mailing Information** section at the beginning of this guide or the Disabled Dependent Application Instructions sheet for email, fax and mailing address.

The request for continuance of coverage must be sent to LifeMap within 31 days of the later of: the child's 26th birthday; or the employee's effective date. Once the review has been completed, the approval or denial notification will be sent to the employee and a copy will be sent to the Employer.

Note: Once an employee drops coverage for a disabled dependent child for any reason, the child is not eligible to be added back on as the employee's dependent.

Benefit Reduction Schedule

What is the benefit reduction schedule?

The benefit reduction schedule may be shown as BENEFIT REDUCTIONS in a group's Life and AD&D policy or may be referred to as an age reduction schedule. It will indicate when a benefit amount will be reduced based on an Employee's age. You will find this schedule in Basic and/or Voluntary Life and/or AD&D policies. The reduction for Spouse Voluntary Life and/or AD&D, may be based on the Spouse's age.

When does the reduction happen and how does it affect the premium?

If you have a group policy that includes a benefit reduction schedule, reductions will be based on the employee's or spouse's birthdate but will not be reflected until the group's anniversary date following that age change. Any change in premium will take place on the group's anniversary date, unless a different process was requested at initial implementation.

How does the benefit reduction affect a claim?

If a claim should occur between the insured's change in age and the group's anniversary date, any eligible benefit paid would be based on the actual age of the insured at time the claim was incurred, regardless of what is being billed.

Age Rated Premium

What is age rated premium?

Age rated premium is a table of rates that are separated by age bracketing, normally in 5 year increments. These are standardly the rates provided for small group and/or voluntary coverages. The tables will be shown in the group's proposal and may be reflected in the application and/or policy for that line of coverage.

When is an age rated premium applied?

If you have a group policy that includes age-rated premiums, the rates will change as an insured ages, based on their birthdate. The change in rate will be reflected on the group's anniversary date, unless a different process was requested at initial implementation. Watch for these premium changes (increases/decreases) on your renewal month billing.

See Premium Calculation Examples section for more information on how to calculate age rated premium.

Evidence of Insurability

What is evidence of insurability?

Evidence of insurability (EOI) means a statement or proof of a person's medical history which LifeMap will use to determine if the person is approved for insurance. The form to provide evidence of insurability is the **Evidence of Insurability Form (EOI) with HIPAA Authorization** and can be found on LifeMapCo.com.

When is evidence of insurability required?

Employees or dependents need to provide evidence of insurability when:

1. An employee wants to apply for coverage in excess of the **Guarantee Issue** amount for self or dependents.
2. An employee wants to increase insurance for self or dependents within the **Guarantee Issue** amount, except as specifically provided under the Voluntary Life Guarantee Issue of Increased Benefit provision (Step-Up Guarantee™).

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3. An employee is enrolling self or dependents after the initial enrollment period and they are considered late enrollees.
4. An eligible dependent applies for insurance after initially declining coverage.

Guarantee Issue

What is guarantee issue amount?

The guarantee issue (GI) amount is the maximum amount of insurance LifeMap will allow without requiring evidence of insurability. This amount is based on the class of insurance for which the person is eligible according to the Group Policy. Any coverage amounts applied for in excess of the guarantee issue amount will not be considered in force without approval of evidence of insurability by LifeMap Medical Underwriting, regardless of premium payment to LifeMap.

Annual Enrollment

What is Annual Enrollment?

Annual enrollment is a period of time as determined by the Employer and LifeMap, when employees and dependents may enroll for coverage if enrollment was not made when initially eligible. Annual enrollment is only available if provided specifically by your LifeMap policy. Evidence of Insurability may be required when enrolling during this period; for more information refer to the specific coverage sections of this guide.

Open Enrollment

What is a one-time Open Enrollment?

A one-time Open Enrollment (OE) may apply to Voluntary coverages, such as Life and Short Term Disability, when offered to a new or existing group. It is a period of time (standardly a month) that is approved in advance by LifeMap, to allow a group to provide a one-time enrollment for their employees, in order to meet and/or increase participation and requirements for a Guarantee Issue Amount. EOI is not required during an Open Enrollment for elections up to the GI, even if the enrollee did not enroll when initially eligible (late entrant). Open Enrollment is **not** an Annual Enrollment. Elections previously declined will remain declined.

Confirmation Statement

What is a Confirmation Statement?

The confirmation statement is a document that provides a description of the type of coverage, amount(s) approved and the coverage effective date for each employee and/or dependent when voluntary coverage is elected at initial enrollment and/or when Evidence of Insurability is required and approved for requested coverage, whether coverage is voluntary or employer paid, whether coverage is voluntary or employer paid.

When a group is maintained under the Summary Billed Group Administration, confirmation statements are provided for approved coverages when an application is sent directly to the LifeMap Medical Underwriting department.

When a confirmation statement is provided to the employee, a notification of approval is also provided to the Group Administrator for documentation.

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List Billed Group Administration

A List Billed Group is a type of administration where LifeMap produces a monthly invoice based on the enrollment and eligibility provided by the Group Administrator. The invoice contains the billing detail for each covered member for each line of coverage. All elections and changes are submitted to LifeMap or through the EAC for processing on a monthly basis.

Enrollment Checklist

The preferred method of processing enrollments and/or changes is online through the EAC if you are currently registered; or refer to the section titled **Managing Eligibility Online - Employer Admin Center** for more information or to request access.

If not using the EAC, the following is a checklist of common group enrollment administrative requirements but is not considered all inclusive. Refer to each section of the guide for more detailed procedures and/or requirements.

1. When using the **Employee Enrollment Change Form** and/or **Voluntary Benefits Employee Enrollment and Change Form:**
   - Review the form(s) for legible, complete, and accurate information prior to forwarding to LifeMap
   - Be sure the employee has signed and dated their enrollment form
2. If using a census:
   - Check that all necessary information has been provided
3. Necessary information on the enrollment form and census include, but are not limited to:
   - Employee's full name
   - Date of birth
   - Gender
   - Social Security Number or alternate ID number
   - Employee's full home address
   - Date of full-time employment or rehire date
   - Annual Salary
   - Employee occupation / job title
   - Initial effective date of coverage and any change dates
   - Employee class
   - Division name
   - Spouse name, date of birth, gender and Social Security number or alternate ID number, if applying
   - Dependent child(ren) names, dates of birth and gender, if covered
   - Current coverage elections and volume amounts
4. Have employee(s) complete a **Beneficiary Designation Form** to be retained by the employer (do not send this form to LifeMap). Incomplete forms are not valid, confirm the form has been signed and dated by the employee.

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Enrollment of New Hires

When are employees eligible for coverage?

Non-contributory (employer-paid) coverage
Employees are eligible for coverage after completing the eligibility waiting period indicated in the Group Policy.

Contributory and/or Voluntary (employee-paid) coverage
Employees have up to 31 days from the end of their eligibility waiting period to enroll for coverage (this is the initial enrollment period).

Refer to the Group Policy for specifics regarding eligibility waiting periods, effective dates of coverage and guarantee issue amounts.

What are the guidelines for non-contributory insurance?

If the employer pays the full cost of insurance, 100% of all eligible employees must be enrolled. Eligible employees cannot waive non-contributory coverage, except as follows:

- Special circumstances allowing waiver of life coverage (example: religious reasons)
- Dental and Vision coverage if also covered through another carrier

What is contributory and voluntary insurance?

If the employee pays <u>any portion</u> of the cost of insurance, coverage is considered contributory. If the employee pays <u>the full cost</u> of insurance, coverage is considered voluntary.

During the employee's initial enrollment period, the employer should offer the employee the option to enroll for coverage.

How are new employees enrolled?

1. The preferred method of processing enrollments is online through the EAC. Refer to the user guide for utilizing the EAC if you are registered; or refer to the section titled **Managing Eligibility Online – Employer Admin Center** for more information.
2. When not utilizing the EAC, complete an **Employee Enrollment Change Form** (found on LifeMapCo.com/employer/manage-account/change-request) to enroll new employees.
3. The following applies if coverage is contributory or voluntary:
    - If evidence of insurability is not required, the **Voluntary Benefits Employee Enrollment and Change Form** should be completed by the employee and/or dependents.
    - If evidence of insurability is required, the **Evidence of Insurability Form** should be completed in addition to the **Voluntary Benefits Employee Enrollment and Change Form** by the employee and/or dependents.
4. Review the form(s) to ensure they are filled out completely and send to LifeMap immediately upon completion. LifeMap may return incomplete forms. **LifeMap does not accept enrollment additions or changes noted on your billing statement.**
5. The Group Administrator should maintain a copy of the **Employee Enrollment Change Form** and **Voluntary Benefits Employee Enrollment and Change Form**, if applicable, on file as a permanent record for proof of enrollment. The employee's signature on the form serves as the payroll deduction authorization.
6. **<u>EMAIL</u>** completed forms to <u>Billing@LifeMapCo.com</u>. All forms must be received no later than 31 days after the employee's eligibility date.

    <u>DO NOT MAIL</u> enrollment forms with premium payment.

    <u>DO NOT MAIL</u> the originals to LifeMap.

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Prompt submission of documents facilitates efficient processing of the application.

Enrollment paperwork should be immediately sent to LifeMap upon completion. Eligible employees will be reflected on the bill following the later of: completion of the employee's eligibility waiting period; or our receipt of the completed enrollment form.

Guarantee issue amounts of coverage applied for when initially eligible, will be added to the first monthly bill following the later of: completion of the employee's eligibility waiting period; or our receipt of the completed enrollment form.

If evidence of insurability is required and coverage is approved by LifeMap, the employee will be added to the monthly bill following LifeMap approval. There will be no mid-month premium proration.

Do not begin payroll deductions for coverage amounts requiring approval of Evidence of Insurability until written notice of approval is received from LifeMap. Payment of premium without approval by LifeMap does not constitute coverage.

Enrollment of Current Employee After Loss of Coverage

When are employees who have lost coverage eligible again for coverage?

Non-contributory (employer-paid) coverage
Employees who had a loss of coverage due to hours, classification, job description or other reason not stated and later meet the requirements of a defined eligible class, are eligible for coverage after completing the eligibility waiting period indicated in the Group Policy.

Contributory and/or Voluntary (employee-paid) coverage
Employees who had a loss of coverage due to hours, classification, job description or other reason not stated (except for voluntary termination of coverage) and later meet the requirements of a defined eligible class, have up to 31 days from the end of their new eligibility waiting period to enroll for coverage (this is considered the initial enrollment period).

Refer to the Group Policy for specifics regarding eligibility waiting periods, effective dates of coverage and guarantee issue amounts.

What are the guidelines for non-contributory insurance?

If the employer pays the full cost of insurance, 100% of all eligible employees must be enrolled. Eligible employees cannot waive non-contributory coverage, except as follows:

- Special circumstances allowing waiver of life coverage (example: religious reasons)
- Dental and Vision coverage if also covered through another carrier

What is contributory and voluntary insurance?

If the employee pays any portion of the cost of insurance, coverage is considered contributory. If the employee pays the full cost of insurance, coverage is considered voluntary.

During the employee's initial enrollment period, the employer should offer the employee the option to enroll for coverage.

How are eligible employees enrolled?

Refer to the instructions for Enrollment of New Employees on the previous pages.

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Enrollment of Rehired Employees

Who is a rehired employee?

Any employee who returns to work following a layoff or termination of employment for any reason is considered a rehired employee.

See the Group Policy for more information regarding your reenrollment provision following a layoff or termination of employment.

How is a rehired employee enrolled?

1. The preferred method of processing rehire enrollments is online through the EAC. Refer to the user guide for utilizing the EAC if you are registered; or refer to the section titled **Managing Eligibility Online – Employer Admin Center** for more information.
2. When not utilizing the EAC an **Employee Enrollment and Change Form** should be completed immediately after an employee is rehired and should include the rehire date* (see below) and current information. Review the form to ensure it is filled out completely and send to LifeMap. LifeMap may return incomplete forms. **LifeMap does not accept enrollment additions or changes noted on your billing statement.**
3. The following applies if coverage is contributory or voluntary:
   - If evidence of insurability is not required, the **Voluntary Benefits Employee Enrollment and Change Form** should be completed by the employee and/or dependents and should include the rehire date.
   - If evidence of insurability is required, the **Evidence of Insurability Form** should be completed in addition to the **Voluntary Benefits Employee Enrollment and Change Form** by the employee and/or dependents and should include the rehire date.
4. Review the form(s) to ensure they are filled out completely and send to LifeMap immediately upon completion. LifeMap may return incomplete forms. **LifeMap does not accept enrollment additions or changes noted on your billing statement.**
5. The Group Administrator should maintain a copy of the **Employee Enrollment Change Form** and **Voluntary Benefits Employee Enrollment and Change Form**, if applicable, on file as a permanent record for proof of enrollment.
6. **EMAIL** completed forms to: Billing@LifeMapCo.com. All forms must be received no later than 31 days after the employee's rehire date.

   DO NOT MAIL enrollment changes with premium payment.

   DO NOT MAIL the originals to LifeMap.

*Why is the rehire date important?

The rehire date will be used to determine eligibility, unless otherwise noted in the Group Policy. If the former employee is rehired within a specific period of time following their termination or layoff date, previous employment may apply toward the eligibility waiting period to determine the employee's eligibility date.

Rehired employees may still be considered to be late enrollees if they apply for insurance after their initial enrollment period following rehire (See Enrollment of Late Enrollees section).

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Enrollment of Late Enrollees

Who is considered a late enrollee?

Any employee who applies for insurance after their initial enrollment period is considered a late enrollee.

What are the guidelines and enrollment requirements for late enrollees?

1. **For Non-Contributory Insurance (employer-paid)**
   - 100% of all eligible employees must be enrolled on or before their eligibility date
   - In the event an administrative error occurs, and an employee is not enrolled for coverage during their initial enrollment period, insurance for the late enrollee will be made effective on the employee's original effective date.
   - An **Employee Enrollment Change Form** should be completed immediately upon discovering the error. The employer must pay all back premiums.
2. **For Contributory or Voluntary Insurance (employee paid coverage)**
   - Any guarantee issue amount is only available during the initial enrollment period and evidence of insurability is required for all coverages, except; Accident, Voluntary AD&D, Dental or Vision.
   - the **Voluntary Benefits Employee Enrollment and Change Form** and **Evidence of Insurability Form** are required to be completed by the employee, including late enrollments due to qualifying events. Evidence of insurability may also be required if application for dependent coverage is made after the initial enrollment period.
3. Review the form(s) to ensure they are filled out completely and send to LifeMap immediately upon completion. LifeMap may return incomplete forms. **LifeMap does not accept enrollment additions or changes noted on your billing statement.**
4. The Group Administrator should maintain a copy of the **Employee Enrollment Change Form** and **Voluntary Benefits Employee Enrollment and Change Form**, if applicable, on file as a permanent record for proof of enrollment.
5. **EMAIL** completed forms to Billing@LifeMapCo.com

   DO NOT MAIL enrollment forms with premium payment.

   DO NOT MAIL the originals to LifeMap.

If evidence of insurability is required and coverage is approved by LifeMap, the employee will be added to the monthly bill following LifeMap approval. There will be no mid-month premium proration.

Do not begin payroll deductions for coverage amounts requiring approval of Evidence of Insurability until written notice of approval is received from LifeMap. Payment of premium without approval by LifeMap does not constitute coverage.

What are the guidelines and enrollment requirements for late enrollees of Dental or Vision?

1. **Dental / Vision Insurance**
   - An employee may enroll in dental or vision insurance after their initial enrollment period *if* one of the following apply:
     - The employee has experienced a qualifying life event (See Qualifying Life Event section)
     - The policy contract contains a late enrollment provision
     - During annual enrollment if your plan is operating under the IRS Section 125 rules
   - A Dental / Vision Application must be completed by the employee or an **Employee Enrollment Change Form** by the Employer and sent to LifeMap.

- An employee and/or dependent enrolling due to a qualifying life event will not be subject to the late enrollment penalty described in the policy.
- If the policy has benefit waiting periods for late enrollment, those will only apply to enrollments made during annual enrollment if your plan is **not** operating under the IRS Section 125 rules.
- If your policy contains a 24-month late enrollment penalty for voluntary termination, that will only apply if your policy is **not** operating under the IRS Section 125 rules.

2. **EMAIL** completed forms to: Billing@LifeMapCo.com

DO NOT MAIL enrollment changes with premium payment.

DO NOT MAIL the originals to LifeMap.

Reporting Adjustments and Changes

How are changes and adjustments reported?

1. The preferred method of processing changes and adjustments is online through the EAC. Refer to the user guide for utilizing the EAC if you are registered; or refer to the section titled **Managing Eligibility Online – Employer Admin Center** for more information. The changes listed under #2 can be processed through the EAC as they occur.
2. When not utilizing the EAC, use the **Request Form for Enrollment Changes** to report any of the following changes as they occur or as noted:
   - Terminations of employment
   - Loss of eligibility for coverage (i.e., work hours drop below the eligibility requirement)
   - Occupational class changes
   - Division (location) transfers
   - Salary changes on an annual basis (hourly rates must include the number of regularly scheduled hours per week per employee).
   - Name changes
   - Address Changes
   - Dependent eligibility or election changes
3. Complete and submit a **Request Form for Enrollment Changes** immediately. This form can be found on our website at: https://www.lifemapco.com/employer/manage-account/change-request
4. The Group Administrator should keep a copy for the employer's records.
5. **EMAIL** completed forms to: Billing@LifeMapCo.com
6. Enrollment forms must be received by the 1st of the month to be included in the following month's billing statement.
7. All forms must be received no later than 31 days after the employee's eligibility date.

   DO NOT MAIL enrollment forms with premium payment.

   DO NOT MAIL the originals if enrollments have been emailed.

How do salary changes affect premium?

Premium will be adjusted based on reported salary changes for salary and increment based coverages. Report salary changes as they occur on all employees whose insurance is determined according to their earnings, but no more frequently than once per year.

If at claim time an employee's salary differs from what has been reported to LifeMap, we will pay claims based on the latest salary and the premium will be adjusted on the next billing statement retroactively to the effective date of the salary change.

What happens when a salary fluctuates?

Increase in Salary
When an employee's salary increases, the benefit amount tied to the salary increments will not automatically increase. To increase the benefit, an employee will be required to apply and submit any required evidence of insurability.

Decrease in Salary
When an employee's salary decreases, any benefit amount tied to the salary increments will automatically reduce to match the new benefit maximum.

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How do additions and terminations affect premium?

1. If an employee is effective for coverage on the 1st of the month, premiums are due for the entire month.
2. If additions and terminations are received after the processing cutoff date described above, the adjustments for prior month charges and credits will appear on the next month's billing statement.
3. LifeMap does not prorate premium.

Is there a time limit to adding or terminating employees from the bill?

Retroactive Enrollment of Employees and/or Dependents
Subject to the eligibility provisions of the Group Policy and payment of all applicable premium, the Group Administrator may request an employee or dependent be retroactively enrolled up to 12 months prior to the date we receive the request, please refer to the Group Policy for contract provisions.

Retroactive Termination of Employees and/or Dependents
The Group Administrator may request that an employee and/or dependent be retroactively terminated up to 3 months from the date we receive the request for termination, subject to any claim payments. Termination of an employee will result in termination of all enrolled dependents.

If claims are incurred for an employee and/or dependent after the requested termination date, the employee and/or dependent will be terminated at the end of the month for which the last claim was incurred and paid, and premium must be received for that monthly billing period.

Premium adjustments involving the return of unearned premium, due to retroactive terminations, are limited to the 3 month billing period immediately prior to the date we receive the request that such an adjustment should be made.

To eliminate possible billing errors, each monthly bill should be checked for accuracy, to ensure employees and/or dependents have been added or removed as needed.

Billing Statements and Premium Payment Methods

LifeMap provides two methods for billing payments. Each employer should choose the method that works best for their operations.

1. Pay as Billed (Preferred method and the only method available through the EAC)
2. Pay as Reconciled

What is the Pay as Billed method?

Pay as Billed means paying the amount listed next to "**Total Amount Due**" on the billing statement and allowing LifeMap to calculate the amounts due, or debits for additions and credits for terminations. The debits and termination credits will be reflected on a future billing statement. Paying as billed is the easiest option for most employers and avoids the risk of cancellation of coverage due to insufficient payment.

What is the Pay as Reconciled method?

Reconciled means that the Group Administrator calculates the amounts due for additions and credits owed for terminations and makes the dollar adjustment to (or reconciles) the total amount billed to determine the amount to be paid. The Group Administrator must provide payment support reflecting all adjustments at the member level. Payment support can be submitted with your payment, but it is preferred that it be emailed in an Excel spreadsheet to AccountsReceivable@LifeMapCo.com. If there is a discrepancy between the adjusted amount paid and the amount due after submitted eligibility changes are processed, it will be reflected on the next billing statement.

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All eligibility changes must be submitted through our Employer Admin Center or on the **Employee Enrollment Change Form** available to download at https://lifemapco.com/employer/manage-account/change-request. Once the form is completed it must be emailed to Billing@LifeMapCo.com by the 1st of the month, in order for LifeMap to reflect the changes on the next billing statement. It is the responsibility of the Group Administrator to reconcile deductions and additions taken to credits and debit adjustments on the next billing statement.

Please note: Eligibility changes submitted with payment support will NOT be processed. The payment support is used by LifeMap to ensure the balances on the billing statements are collectible.

What does the billing statement include?

Clients who have list billing will receive statements that include:

- Billing Period (date range of coverage being billed)
- Group Number (your Policy or Group number)
- Invoice Number (number generated for this billing period)
- Print Date (date invoice generated)
- Invoice Due Date (date premium is due for this billing period)
- Previous Balance (total amount due from previous invoice)
- Payments (sum of all payments to date applied to this billing statement)
- Current Premium Due (premium due for the stated billing period)
- Discretionary Billing Items (any discretionary debit or credit applied to the account)
- Credit Amounts (any overpaid amounts on the account)
- Adjustments (total net of all prior adds/terms/changes which were not reflected on last billing;
- Write-Offs (any amount written off the account)
- Total Amount Due: (total amount of premium due by invoice due date)
- List of each insured employee under the plan with coverage volumes and monthly premium
- A report of adjustments made from the previous month's statement, including a summary page
- A payment coupon that reflects the group number, balance due, invoice #, invoice due date and payment mailing details. This coupon should be submitted with your payment.

Check the statement carefully to ensure all eligible employees are included on the statement and that the benefits listed are correct.

Billing Payments and Delinquency FAQs

When will my billing statement generate?

Generally, billing statements are generated two weeks before the due date.

When is my payment due?

Your payment is always due on the first of the month for the coverage period billed. i.e. premium for June coverage is due on June 1st.

What forms of payment are accepted? Where should they be sent?

- Online Bill Pay
- Automated Clearing House (ACH) push
- Wire transfer
- e-Check payments at www.LifeMapCo.com/employers then click the Make a Payment link
- e-Check payments in the Employer Admin Center (paid in full only)
- Check mailed to one of the Premium Payment locations listed in the Contact and Mailing Information section at the beginning of this guide. Please note, location may vary by line of coverage.

Checks should include the policy number and payment period, along with the payment coupon.

When payment is made by Online Bill Pay or e-Check, a copy of the payment coupon or billing statement must be submitted to AccountsReceivable@LifeMapCo.com for each monthly payment.

When payment is made by ACH or wire transfer, a copy of the LifeMap ACH or wire template must be submitted along with a copy of the payment coupon or billing statement to: AccountsReceivable@LifeMapCo.com for each monthly payment.

There is no mid-month proration of premium for additions or terminations.

NOTE: Sending check payments without a payment coupon or sending a dental payment to an address other than the one listed on the billing statement, could result in a delay or misapplication of your payment, putting the Group Policy at risk for termination due to non-payment.

What happens if you don't receive my payment by the 1st?

- During the grace period, you may receive a payment reminder notice and/or courtesy call from LifeMap.
- **Cancellation of coverage** will occur if payment is not received by the end of your grace period (see your policy for details on grace period). A notice of termination along with the final invoice will be mailed.

Payments must cover at least 80% (tolerance level) of billed premium. Any account that is not paid within the tolerance level may be subject to termination for insufficient payment.

What happens to claims if payment is received after the first day of the month?

If premium payment is not received and posted by the first of the month, new claims will continue to be paid until the last day of the grace period. For coverage to continue beyond the grace period, we must receive full payment prior to the end of the grace period. Any claim payments made after a group termination is processed may be considered overpayments and repayment may be requested.

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What if our policy cancels for nonpayment of premium?

If the policy is terminated for nonpayment of premium, the termination will occur at the end of the grace period. LifeMap shall be entitled to collect premium for the period between the last date premium was paid and the policy termination date.

If the Group Policy is cancelled for nonpayment, the Group Administrator can request reinstatement of coverage within four weeks of policy termination by completing the following:

1. Submitting a written reinstatement request to AccountsReceivable@LifeMapCo.com explaining the reason for the delinquency and how delinquency will be avoided in the future;
2. Provide further documentation, if requested, by LifeMap; and
3. Paying the policy to current based on the estimate calculated by LifeMap. **LifeMap will not generate any invoices before the estimated amount due is paid in full by the Group.**

The request must be approved by LifeMap Assurance Company to be reinstated. A group will not be considered for more than one reinstatement within a 12-month period.

Bankruptcy

In the event of a bankruptcy filing, notify LifeMap by email at AccountsReceivable@LifeMapCo.com and provide the file number and date of filing.

Note: Include specific information on Chapter 7 and Chapter 11 processes.

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COBRA Billing Administration

Billing Statements and Premium Payment Methods

LifeMap provides two methods for billing payments. Each Group or COBRA Administrator should choose the method that works best for their operations.

3. Pay as Billed (Preferred method and only method available through the EAC)
4. Pay as Reconciled

What is the Pay as Billed method?

Pay as Billed means paying the amount listed next to “Total Amount Due” on the billing statement and allowing LifeMap to calculate the amounts due, or debits for additions and credits for terminations. Those addition debits and termination credits will show up on the next billing statement and would not be paid until that time. Paying as billed is the easiest option for most Group and COBRA Administrators and avoids the risk of cancellation of COBRA coverage for insufficient payment.

What is the Pay as Reconciled method?

Reconciled means that the Group or COBRA Administrator calculates the amounts due for additions and credits owed for terminations and makes the dollar adjustment to (or reconciles) the total amount billed to determine the amount to be paid. The Group or COBRA Administrator must provide payment support reflecting all adjustments at the member level. Payment support can be submitted with the payment, but it is preferred that it be emailed in an Excel spreadsheet to Accountsreceivable@LifeMapCo.com. If there is a discrepancy between the adjusted amount paid and the amount due after submitted eligibility changes are processed, it will be reflected on the next billing statement. It is the responsibility of the Group or COBRA Administrator to reconcile deductions and additions taken to credits and debit adjustments on the next billing statement.

All eligibility changes must be submitted through our Employer Admin Center or on the **Enrollment Change Request Form** available to download at: https://lifemapco.com/employer/manage-account/change-request. Once the form is completed it must be emailed to Billing@LifeMapCo.com by the 1st of the month, in order for LifeMap to reflect the changes on the next billing statement. It is the responsibility of the Group or COBRA Administrator to reconcile deductions and additions taken to credits and debit adjustments on the next billing statement.

Please note: Eligibility changes submitted with payment support will NOT be processed. The payment support is used by LifeMap to ensure the balances on the billing statements are collectible.

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Summary Billed Group Administration

A Summary Billed Group is a type of administration where the Group Administrator manages enrollment and eligibility and is responsible for completing a summary bill template by line of coverage, that does not include member level information. The summary bill is submitted along with the monthly premium payment to LifeMap.

Enrollment Checklist

All summary billed groups must sign a **Summary Bill Agreement** with LifeMap.

NOTE: Dental and Vision coverage are not eligible for summary billing.

The following is a checklist of common group enrollment administrative requirements but is not considered all-inclusive. Refer to each section of the guide for more detailed procedures and/or requirements.

1. Maintain an accurate enrollment record with employee eligibility and information. The Policyholder enrollment record must include all necessary employee information including, but not limited to:
   - Employee's full name
   - Date of birth
   - Gender
   - Social Security Number or alternate ID number
   - Full home/mailing address
   - Date of full-time employment or rehire date
   - Annual Salary
   - Occupation / job title
   - Initial effective date of coverage and any change dates
   - Class
   - Division name
   - Spouse name, date of birth, gender and Social Security number or alternate ID number, if covered
   - Dependent child(ren) names, dates of birth and gender, if covered
   - Current coverage elections and volume amounts
2. A copy of the enrollment record must be submitted to LifeMap on an annual basis or upon request and must include:
   - Employee initial enrollment date and any change dates
   - Current census
   - Current participation numbers per coverage
   - Payroll deductions/premium amount
   - Current Group Administrator name and phone number
3. For contributory/voluntary benefits, the completed enrollment form should be kept on file as a record of the employee's enrollment. Please do not fax or mail forms to LifeMap unless enrollment is for a contributory/voluntary line of coverage that requires medical underwriting.
4. Have employee(s) complete a **Beneficiary Designation Form** to be retained with the employee's records. (do not send this form to LifeMap). Incomplete forms are not valid, confirm the form has been signed and dated by the employee.

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5. Proof of coverage should be provided to an employee upon request. Proof of coverage should reflect any increases including amounts and/or coverage(s) that required Evidence of Insurability and were previously approved by LifeMap, as well as decreases in amounts and/or terminations of coverage(s) that have occurred from initial enrollment up to the time of the request.
6. When a claim is filed, in addition to a completed claim form, the following employee related documentation may be required:
    - Payroll records
    - Enrollment forms and/or electronic enrollment validation
    - Current **Beneficiary Designation Form**

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Enrollment of New Hires

When are employees eligible for coverage?

Non-contributory (employer-paid) coverage
Employees are eligible for coverage after completing the eligibility waiting period as indicated in the Group Policy.

Contributory and/or Voluntary (employee-paid) coverage
Employees have up to 31 days from the end of their eligibility waiting period to enroll for coverage (this is the initial enrollment period).

Refer to the Group Policy for specifics regarding eligibility waiting periods, effective dates of coverage and guarantee issue amounts.

What are the guidelines for non-contributory insurance?

If the employer pays the full cost of insurance, 100% of all eligible employees must enroll in the Employer's online enrollment platform immediately after being hired. Eligible employees cannot waive non-contributory coverage, except as follows:

- Special circumstances allowing waiver of life coverage (example: religious reasons)
- Dental and Vision coverage if also covered through another carrier

What is contributory and voluntary insurance?

If the employee pays any portion of the cost of insurance, coverage is considered contributory. If the employee pays the full cost of insurance, coverage is considered voluntary.

During the employee's initial enrollment period, the employer should offer the employee the option to enroll for coverage.

How are new employees enrolled?

1. Enrollment into the Employer's enrollment platform, should be completed immediately after a new employee is hired, including enrollment for guarantee issue amounts of coverage.
2. The following applies if coverage is contributory or voluntary:
   - If evidence of insurability is not required, enrollment through the Employer's enrollment platform should be completed by the employee and/or dependents.
   - If evidence of insurability is required, the **Evidence of Insurability Form** should be completed in addition to the **Voluntary Benefits Application** and enrollment into the Employer's enrollment platform by the employee and/or dependents.
3. **EMAIL** the **Voluntary Benefits Application, Evidence of Insurability Form** and census to medical.uw@lifemapco.com immediately upon completion by the employee and/or dependents. Prompt submission of documents facilitates efficient processing of the request.
4. Review the completed form(s) or online enrollment record(s) to ensure they are filled out completely and retain on file as a permanent record for proof of enrollment. The employee's signature on the form(s) or electronic signature serves as the payroll deduction authorization. Do not send any forms to LifeMap, except as required in #3 above.

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5. Add the new employee(s) and/or dependents to the Number of Covered Lives and Volume of each applicable Coverage on the first monthly summary bill, following completion of their eligibility waiting period. Guarantee issue amounts of coverage, applied for when initially eligible, must be added to the Number of Covered Lives and Volume of each Coverage, on the first monthly summary bill, following completion of the eligibility waiting period.

If evidence of insurability is required and coverage is approved, LifeMap will send a written notice of approval of coverage, including the effective date, and the employee and/or dependents should be added to the Number of Covered Lives and Volume of each applicable Coverage on the summary bill, upon receipt of notice of approval.

Do not begin payroll deductions for coverage amounts requiring approval of Evidence of Insurability until written notice of approval is received from LifeMap. Payment of premium without approval by LifeMap does not constitute coverage.

If enrollment is completed using the Employer's enrollment platform, and a claim is filed, the employer must be able to provide a screen print of the employee's enrollment information. The documentation provided must also reflect the electronic time stamp showing when the election was made for that member.

Enrollment of Current Employee After Loss of Coverage

When are employees who have lost coverage eligible again for coverage?

Non-contributory (employer-paid) coverage
Employees who had a loss of coverage due to hours, classification, job description or other reason not stated and later meet the requirements of a defined eligible class, are eligible for coverage after completing the eligibility waiting period indicated in the Group Policy.

Contributory and/or Voluntary (employee-paid) coverage
Employees who had a loss of coverage due to hours, classification, job description or other reason not stated (except for voluntary termination of coverage) and later meet the requirements of a defined eligible class, have up to 31 days from the end of their new eligibility waiting period to enroll for coverage (this is considered the initial enrollment period).

Refer to the Group Policy for specifics regarding eligibility waiting periods, effective dates of coverage and guarantee issue amounts.

What are the guidelines for non-contributory insurance?

If the employer pays the full cost of insurance, 100% of all eligible employees must be enrolled. Eligible employees cannot waive non-contributory coverage, except as follows:

- Special circumstances allowing waiver of life coverage (example: religious reasons)
- Dental and Vision coverage if also covered through another carrier

What is contributory and voluntary insurance?

If the employee pays any portion of the cost of insurance, coverage is considered contributory. If the employee pays the full cost of insurance, coverage is considered voluntary.

During the employee's initial enrollment period, the employer should offer the employee the option to enroll for coverage.

How are eligible employees enrolled?

Refer to the instructions for Enrollment of New Hires on the previous pages.

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Enrollment of Rehired Employees

Who is a rehired employee?

Any employee who returns to work following a layoff or termination of employment for any reason is considered a rehired employee.

See the Group Policy for more information regarding your reenrollment provision following a layoff or termination of employment.

How is a rehired employee enrolled?

1. Online enrollment through the Employer's enrollment platform, should be completed immediately after an employee is rehired and should include the rehire* date and current information.
2. The following applies if coverage is contributory or voluntary:
   - If evidence of insurability is not required, enrollment through the Employer's enrollment platform should be completed by the employee and/or dependents and should include the rehire date.
   - If evidence of insurability is required, the **Evidence of Insurability Form** should be completed in addition to the **Voluntary Benefits Application** and enrollment through the Employer's enrollment platform by the employee and/or dependents and should include the rehire date.
3. **EMAIL** the **Voluntary Benefits Application, Evidence of Insurability Form** and census to medical.uw@lifemapco.com immediately upon completion by the employee and/or dependents. Prompt submission of documents facilitates efficient processing of the request.
4. Review the completed form(s) or online enrollment record(s) to ensure they are filled out completely and retain on file as a permanent record for proof of enrollment. Do not send any forms to LifeMap, except as required in #3 above.
5. Add the rehired employee and dependents, if applicable to the Number of Covered Lives and Volume of each applicable Coverage on the first monthly summary bill, as of the employee's rehire date or following completion of any eligibility waiting period required.

If evidence of insurability is required and coverage is approved, LifeMap will send a written notice of approval of coverage, including the effective date, and the employee and/or dependents should be added to the Number of Covered Lives and Volume of each applicable Coverage on the summary bill, upon receipt of notice of approval.

Do not begin payroll deductions for coverage amounts requiring approval of Evidence of Insurability until written notice of approval is received from LifeMap. Payment of premium without approval by LifeMap does not constitute coverage.

*Why is the rehire date important?

The rehire date will be used to determine eligibility, standardly 6 months, unless otherwise noted in the Group Policy. If the former employee is rehired within the specified period of time following their layoff or termination date, previous employment may apply toward the eligibility waiting period to determine the employee's eligibility date. Rehired employees may still be considered to be late enrollees if they apply for insurance after their initial enrollment period following rehire (See Enrollment of Late Enrollees section).

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Enrollment of Late Enrollees

Who is considered to be a late enrollee?

Any employee who applies for insurance after their initial eligibility date is considered a late enrollee.

What are the guidelines and enrollment requirements for late enrollees?

1. **For Non-Contributory Insurance (employer-paid)**
   - 100% of all eligible employees must be enrolled on or before their eligibility date
   - In the event an administrative error occurs and an employee is not enrolled for coverage during their initial enrollment period, insurance for the late enrollee will be made effective on the employee's original effective date. The employer must add the employee and/or dependents to the Number of Covered Lives and Volume of each applicable Coverage on the next monthly summary bill and pay all back premiums
2. **For Contributory and Voluntary Insurance (employee paid coverage)**
   - Any guarantee issue amount is only available during the initial enrollment period and evidence of insurability is required for all coverages, except; Accident, Voluntary AD&D, Dental or Vision.
   - The **Voluntary Benefits Application** and enrollment through the Employer's enrollment platform and the **Evidence of Insurability Form** are required to be completed by the employee, including late enrollments due to qualifying events. Evidence of insurability may also be required if application for dependent coverage is made after their initial enrollment period.
3. **EMAIL** the **Voluntary Benefits Application, Evidence of Insurability Form** and census to medical.uw@lifemapco.com immediately upon completion by the employee and/or dependents. Prompt submission of documents facilitates efficient processing of the request.
4. Review the completed form(s) or online enrollment record(s) to ensure they are filled out completely and retain on file as a permanent record for proof of enrollment. Do not send any forms to LifeMap, except as required in #3 above.

If evidence of insurability is required and coverage is approved, LifeMap will send a written notice of approval of coverage, including the effective date, and the employee and/or dependents should be added to the Number of Covered Lives and Volume of each applicable Coverage on the summary bill, upon receipt of notice of approval. The employee and/or dependents coverage(s) may only be added to the summary bill after written approval is received from LifeMap.

Do not begin payroll deductions for coverage amounts requiring approval of Evidence of Insurability until written notice of approval is received from LifeMap. Payment of premium without approval by LifeMap does not constitute coverage.

The employee's signature on the form(s) or electronic signature serves as the payroll deduction authorization.

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Adjustments and Changes

How are changes and adjustments maintained?

As a summary billed group, you are responsible for maintaining accurate adjustment and change records for your group.

The Employer's enrollment platform must be completed and/or updated to keep record of any of the following changes as they occur:

- Terminations of employment
- Loss of eligibility for coverage (i.e., work hours drop below the eligibility requirement)
- Occupational class changes
- Division (location) transfers
- Salary changes (hourly rates must include the number of regularly scheduled hours per week per employee)
- Name changes
- Address Changes
- Dependent insurance Changes

How do salary changes affect premium?

Premium should be adjusted based on salary changes. Salary changes should be recorded as they occur on all employees whose insurance is determined according to their earnings, but no more frequently than once per year.

If at claim time, an employee's salary differs from what has been reported to LifeMap, we will pay claims based on the latest salary information provided to LifeMap. The premium should be adjusted on the next summary bill retroactively to the effective date of the salary change.

What happens when a salary fluctuates?

Increase in Salary
When an employee's salary increases, the benefit amount tied to the salary increments should not be automatically increased. To increase the benefit, an employee will be required to apply and submit any required evidence of insurability.

Decrease in Salary
When an employee's salary decreases, any benefit amount tied to the salary increments should be automatically reduced to match the new benefit maximum.

How do additions and terminations affect premium?

1. If an employee is effective for coverage on the 1st of the month, premiums are due for the entire month.
2. If additions and terminations are received after the processing cutoff date described above, the adjustments for prior month charges and credits should be included on the next month's summary bill.
3. LifeMap does not prorate premium.

Is there a time limit to adding or terminating employees from the bill?

Retroactive Enrollment of Employees and/or Dependents

Subject to the eligibility provisions of the Group Policy and payment of all applicable premium, the Group Administrator may request an employee or dependent be retroactively enrolled up to 12 months prior to the date we receive the request, please refer to the Group Policy for contract provisions.

Retroactive Termination of Employees and/or Dependents

The Group Administrator may request that an employee and/or dependent be retroactively terminated up to 3 months from the date we receive the request for termination, subject to any claim payments. Termination of an employee will result in termination of all enrolled dependents.

If claims are incurred for an employee and/or dependent after the requested termination date, the employee and/or dependent will be terminated at the end of the month for which the last claim was incurred and paid, and premium must be received for that monthly billing period.

Premium adjustments involving the return of unearned premium, due to retroactive terminations, are limited to the 3 month billing period immediately prior to the date we receive the request that such an adjustment should be made.

To eliminate possible billing errors, each summary bill should be checked for accuracy, to ensure the Number of Covered Lives and Volume by Coverage have been updated as needed.

Summary Bill Statements

What are the responsibilities of the Group Administrator?

1. Monthly updating and reporting of information for each line of insurance at the subgroup level (if applicable), including:
    - Number of Covered Lives
    - Volume
    - Premium
    - Age-Banded Products: Number of Covered Lives, Volumes and Premiums, if applicable
2. Submitting the following:
    - LifeMap Summary Bill
    - Form of Payment

How is the summary bill completed?

1. A Summary Bill template will be provided by LifeMap. The template should be completed for each division, by Coverage, Rate, Number of Covered Lives, Volume and Monthly Premium and sent with the corresponding premium payments that are due on the 1st of each month.
2. There is no mid-month proration of premium for additions or terminations.

For assistance in calculating premium, refer to the Premium Calculation Examples section of this guide.

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Billing Payments and Delinquency FAQs

When will my summary bill generate?

LifeMap does not produce and mail a monthly summary bill. We provide the initial Summary Bill Template that the Group Administrator is required to proactively complete and send to LifeMap on a monthly basis.

When is my payment due?

Your payment is always due on the first of the month for which you are paying for coverage. i.e. premium for June coverage is due on June 1st.

What forms of payment are accepted? Where should they be sent?

- Online Bill Pay
- Automated Clearing House (ACH) push
- Wire transfer
- e-Check and immediate payments at www.LifeMapCo.com/employers then click the Make a Payment link
- Check mailed to one of the Premium Payment locations listed in the Contact and Mailing Information section at the beginning of this guide. Please note, location may vary line of coverage.

Checks should include the policy number and payment period, along with the completed summary bill statement.

When payment is made by Online Bill Pay or e-Check, a copy of the summary bill statement must be submitted to AccountsReceivable@LifeMapCo.com for each monthly payment.

When payment is made by ACH or wire transfer, a copy of the LifeMap ACH or wire template must be submitted along with a copy of the summary bill statement to: AccountsReceivable@LifeMapCo.com for each monthly payment.

There is no mid-month proration of premium for additions or terminations.

NOTE: Sending payments without a summary bill statement could result in a delay or misapplication of your payment leading to termination of the Group Policy due to non-payment.

What happens if you don't receive my payment by the 1st?

- During the grace period, you may receive a payment reminder notice or courtesy call from LifeMap.
- **Cancellation of coverage** will occur if payment is not received by the end of your grace period (see your policy for details on grace period). A notice of termination will be mailed to you.

To avoid termination, payment is required prior to the end of the contracted grace period.

What happens to claims if payment is received after the first day of the month?

If premium payment is not received and posted by the first of the month, new claims will continue to be paid until the last day of the grace period. For coverage to continue beyond the grace period, we must receive full payment prior to the end of the grace period. Any claim payments made after a group termination is processed may be considered overpayments and refund may be requested.

What if our policy cancels for nonpayment of premium?

If any portion of the premium is not paid during the grace period, the policy will terminate at the end of the grace period and LifeMap shall be entitled to collect premium for the period between the last date premium was paid and the policy termination date.

If the Group Policy is cancelled for nonpayment, the Group Administrator can request reinstatement of coverage within four weeks of policy termination by completing the following:

1. Submitting a written reinstatement request to AccountsReceivable@LifeMapCo.com explaining the reason for the delinquency and how delinquency will be avoided in the future;
2. Provide further documentation, if requested, by LifeMap.
3. Paying the policy to current based on the estimate calculated by LifeMap.

The request must be approved by LifeMap Assurance Company to be reinstated. A group will not be considered for more than one reinstatement within a 12-month period.

Bankruptcy

In the event of a bankruptcy filing, notify LifeMap by email at AccountsReceivable@LifeMapCo.com and provide the file number and date of filing.

Note: Include specific information on Chapter 7 and Chapter 11 processes.

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Qualifying Life Events

Due to the tax advantages offered by cafeteria plans, the Internal Revenue Service (IRS) allows members to change their benefits between annual enrollment periods only if they have a qualified change in status (a Qualified Life Event), such as the following examples defined by Section 125 of the IRS Code:

- A loss of eligibility under other coverage, Medicaid/CHIP
- Birth of a child
- Marriage of an employee
- Adoption (or placement for adoption) of a child with the employee
- Gain of eligibility for Medicaid/CHIP premium assistance

For additional examples and more information on Qualified Life Events under Section 125 of the IRS code, you can refer to the IRS.Gov. website.

Note: Qualified Event is a defined term used for those insurance products covered by Section 125 of the IRS code. This IRS code does not apply to Life, Disability or non-health products.

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Life and AD&D Insurance Administration Guidelines

The Accidental Death & Dismemberment (AD&D) benefit is not included with all Basic Life insurance policies and may be issued as a separate Voluntary Insurance policy. See the Group Policy(ies) to determine whether this benefit is available to your group.

Enrollment and Eligibility

When are employees and dependents eligible?

Employees are eligible for coverage after completing the eligibility waiting period indicated in the policy.

Non-contributory (employer-paid) coverage
Eligible employees will be effective first of the month following completion of the new employee waiting period. Eligible dependents will be effective on the same day as the employee.

Contributory and/or Voluntary (employee-paid) coverage
Employees have up to 31 days from the end of their eligibility waiting period to enroll themselves and any eligible dependents for coverage (this is the initial enrollment period).

- If coverage does not require approval of evidence of insurability, eligible employees will be effective first of the month following completion of the new employee waiting period.
- If evidence of insurability is required and coverage is approved by LifeMap, the employee and/or dependents will be effective the first of the month on the later of: completion of the new employee waiting period; or approval by LifeMap. There will be no mid-month effective dates.

Refer to the Enrollment sections within this guide for the enrollment requirements, and the Group Policy for specifics regarding the eligibility waiting period and effective date of coverage.

When do employees or dependents need to submit evidence of insurability?

Evidence of insurability will need to be provided for an employee or dependent as outlined in the Evidence of Insurability section of your group's policy and this guide. Some common reasons include, but are not limited to:

- The amount applied for is over any guarantee issue amount
- An employee wants to increase coverage for self or dependents
- The applicant is a late enrollee

Is there an annual enrollment period?

Annual enrollment is only available if provided specifically by your LifeMap policy. If provided by your policy, annual enrollment is a period of time as determined by the employer and LifeMap, when employees and dependents may enroll for voluntary coverage if enrollment was not made when initially eligible. Evidence of insurability is required for Voluntary Life Coverage when enrolling during the annual enrollment period, except as provided for in the Voluntary Life Guarantee Issue of Increased Benefit (Step-Up Guarantee™). AD&D does not require EOI at any time.

What is the Voluntary Life Guarantee Issue of Increased Benefit aka Step-Up Guarantee™?

If available to your group, the Voluntary Life Guarantee Issue of Increased Benefit; also referred to as the Step-Up Guarantee™, would be found in the Voluntary Life policy. This means, if employees enroll for a specified amount when initially eligible or at group effective date, they may increase their benefit amount during the annual enrollment period(s) up to the guarantee issue amount shown in the Group Policy, without providing evidence of insurability. This is not available to dependents.

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Claim Submission

Life Insurance and Accidental Dismemberment Claim forms can be found on LifeMapCo.com. For assistance in submitting Life and/or AD&D claims, you may contact a Claims Representative at 1(800) 286-1129.

What form is used and how is it completed for submission of a death claim?

The **Life Insurance Claim Form** is downloadable for printing from the Forms tab on LifeMapCo.com. The form includes separate sections for the beneficiary, Employer and Policyholder, if applicable. To avoid a delay in the processing of a claim, all sections should be completed in full and signed.

1. The beneficiary/claimant is responsible for completing the **Beneficiary's Statement** section of the form.
2. The Employer or Group Administrator is responsible for completing the **Employer's and/or Administrator's Statement** section of the form.
3. If the Policyholder is not the employer (as is the case with Trust or Associations), then the Policyholder is responsible for completing the **Policyholder's Statement** section of the form. Policyholder means the entity named on the group master application which is part of the group master policy.

What documentation should be submitted for a death claim?

1. **For Life Insurance:**
    - **Life Insurance Claim Form** fully completed by all parties
    - Certified original death certificate stating the cause and manner of death (the original certificate will be returned)
    - Current **Beneficiary Designation Form**
2. **For Accidental Death**, all documents indicated above; plus:
    - Coroner's report
    - Investigating agency's report or police records
    - Employer's Workers' Compensation report of claim, if applicable
    - Media report(s), if available
    - Toxicology report(s), if applicable

The claim form and all supporting documentation should be sent to LifeMap Claims. Refer to Claims and Appeals in the **Contact and Mailing Information** section at the beginning of this guide or the Claim Filing Instruction sheet for email, fax and mailing address.

What form is used and how is it completed for submission of a dismemberment claim?

The **Accidental Dismemberment Claim Form** is downloadable for printing from the Forms tab on LifeMapCo.com. The form includes separate portions for the employee, Employer and Policyholder, if applicable. To avoid a delay in the processing of a claim, all sections should be completed in full and signed.

1. The employee/claimant (or their legal representative) is responsible for completing the **Employee's Statement** section of the form.
2. The Employer or Group Administrator is responsible for completing the **Employer or Administrator's Statement** section of the form.
3. If the Policyholder is not the employer (as is the case with Trust or Associations), then the Policyholder is responsible for completing the **Policyholder's Statement** section of the form. Policyholder means the person, individual firm, trust, or other organization named in the application for the group's policy and to whom the Group Policy has been issued.

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What documentation should be submitted for a dismemberment claim?

- **Accidental Dismemberment Claim Form**, fully completed by all parties
- Medical records pertaining to the loss
- Copy of Accident Report related to the loss

The claim form and all supporting documentation should be sent to LifeMap Claims. Refer to Claims and Appeals in the **Contact and Mailing Information** section at the beginning of this guide or the Claim Filing Instruction sheet for email, fax and mailing address.

Benefit Determination

To whom are Life Insurance proceeds paid?

Benefits paid due to the death of the employee are paid to their beneficiary(ies). Benefits paid due to the death of a spouse or dependent child(ren) are paid to the employee.

To whom are Accidental Dismemberment insurance proceeds paid?

Benefits paid for an employee's covered dismemberment are paid to the employee. Refer to the Group Policy for additional benefits provided due to a covered loss under the Accidental Death and Dismemberment provision.

How can a denied claim be appealed?

For Life claims - The claimant (or legal representative) has 60 days after receiving a life claim denial to appeal the decision. The appeal must be submitted in writing and must provide specific information outlining why the claimant disagrees with LifeMap's decision, along with any additional documentation that was not previously submitted. Additional information to support the appeal may include medical records, test results, or payroll records.

If the denial was due to a waiting period or effective date issue, proof is required to support the employee's eligibility. Appropriate proof may include an enrollment form or copies of payroll deductions.

The written appeal and all supporting documentation should be sent to LifeMap Claims. Refer to Claims and Appeals in the **Contact and Mailing Information** section at the beginning of this guide.

LifeMap will provide a written response within 60 days from receipt of the appeal to advise the claimant if additional information is needed or if a decision has been reached. If additional time is required the claimant will receive a letter outlining the reason for the delay. The appeal determination will not take longer than 120 days provided all documentation is received in a timely manner.

For Dismemberment claims - The claimant (or legal representative) has 180 days after receiving a denial to appeal. The appeal must be submitted in writing and must provide specific information outlining why the claimant disagrees with LifeMap's decision, along with any additional documentation that was not previously submitted. Additional information to support the appeal may include medical records, test results, or payroll records.

If the denial was due to a waiting period or effective date issue, proof is required to support the employee's eligibility. Appropriate proof may include an enrollment form or copies of payroll deductions.

The written appeal and all supporting documentation should be sent to LifeMap Claims. Refer to Claims and Appeals in the **Contact and Mailing Information** section at the beginning of this guide.

LifeMap will provide a written response within 45 days from receipt of the appeal to advise the claimant if additional information is needed or if a decision has been reached. If additional time is required the employee will receive a letter outlining the reason for the delay. The appeal determination will not take longer than 90 days provided all documentation is received in a timely manner.

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Beneficiary Information

Who is the employee's beneficiary?

The beneficiary is named on the employee's **Beneficiary Designation Form**. The employee may have more than one primary beneficiary and more than one contingent beneficiary.

NOTE: LifeMap does not retain employee Beneficiary Designation Forms; these should be retained by the group.

What is the Beneficiary Designation Form?

This form is the written instrument in which beneficiaries are named or changed. If the LifeMap Group Policy replaces insurance provided by an earlier Group Policy, a beneficiary designation under the earlier Group Policy may be accepted in place of the LifeMap **Beneficiary Designation Form**. The most current beneficiary form must be signed and dated and should be submitted with the claim. Incomplete forms are not valid.

What if the primary beneficiary is deceased?

If the primary beneficiary is deceased and a second primary beneficiary was not designated, proceeds will be paid to the contingent beneficiary.

What if there is no beneficiary?

If there is no surviving beneficiary, or a beneficiary has not been designated, proceeds will be paid according to the highest ranking surviving relative(s) per the Facility of Payment provision of the Group Policy. In order to determine Facility of Payment, the claimant must complete an Affidavit of Survivorship, which will be provided by LifeMap.

What if the beneficiary is a minor?

In compliance with the Uniform Transfers to Minors Act (UTMA) there is a limited benefit amount that can be paid to a guardian of a minor as determined by each state. Upon receiving proof of guardianship, if the benefit amount is less than or equal to the UTMA limit for the minor's state of residency, LifeMap will pay the benefits to the guardian. The guardian must complete a UTMA affidavit, which will be provided by LifeMap.

Benefit amounts in excess of UTMA can only be released to the person who has obtained legal conservatorship over the estate of the minor. If LifeMap does not receive legal documentation for conservatorship at the time a life claim is approved for payment of the benefit, a Supplemental Contract will be issued to the minor. A Supplemental Contract is an agreement in which LifeMap holds the Life Insurance proceeds until one of the below occurs:

1. Proof of legal conservatorship over the estate of the minor is provided; or
2. The minor reaches the age of majority in the state in which they reside and requests payment of proceeds.

Does LifeMap provide any beneficiary services?

LifeMap provides a Beneficiary Assistance Program to beneficiaries at time of claim approval. The beneficiary will receive a brochure outlining the benefits available.

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Life Insurance Provisions

Accelerated Benefit for Terminal Illness

What is an Accelerated Benefit for Terminal Illness?

This benefit is an amount of Life Insurance that may be paid in advance of the insured's death if they are terminally ill. Refer to the Accelerated Benefit for Terminal Illness section of your Life Insurance Policy for the full benefit provision.

Note: The Accelerated Benefit may be taxable. The claimant should consult a tax professional with any questions regarding the taxability of the Accelerated Benefit.

Who qualifies to receive an Accelerated Benefit?

1. All employees insured for Life Insurance who meet the definition of Terminally Ill or Terminal Illness in the Accelerated Benefit for Terminal Illness section of the Group Policy may apply for an Accelerated Benefit.
2. If a spouse is covered under the group's Voluntary Life Insurance, and meets the above requirements, the spouse may apply for an Accelerated Benefit under the Voluntary Life Insurance Group Policy.

How does an insured individual apply to receive an Accelerated Benefit?

1. The Group Administrator or insured can contact LifeMap Claims at 1(800) 286-1129 and request a **Statement for Accelerated Benefit Claim Form.** (This form is not available on our website). The form includes the Claim Filing Instructions.
2. The Employer or Group Administrator is responsible for completing and signing the **Employer's or Administrator's Statement** section of the form. If the Policyholder is not the Employer (as is the case with Trust or Associations), then the Policyholder is responsible for completing the **Policyholder's Statement** section of the form. Policyholder means the entity named on the group master application which is part of the group master policy.
3. Upon receipt of the completed **Employer's or Administrator's Statement** and/or **Policyholder's Statement**, LifeMap Claims Department mails a **Statement for Accelerated Benefit Claim Form** to the insured individual (or legal representative) to complete.
4. The insured individual (or legal representative) may apply for the benefit by submitting satisfactory proof of terminal illness, and a completed **Statement for Accelerated Benefit Claim Form**. The insured individual (or legal representative) is responsible for completing and signing the **Employee's Statement** and **Authorization to Obtain and Release Information** sections of the form.
5. The insured's attending physician must complete and sign the **Attending Physician's Statement** section of the form.
6. The claim form and all supporting documentation should be sent to LifeMap Claims. Refer to Claims and Appeals in the Contact and Mailing Information section at the beginning of this guide or the Claims Filing Instruction sheet for email, fax and mailing address. To avoid a delay in processing, all sections should be completed in full and signed.

To whom is the Accelerated Benefit paid?

If approved, the Accelerated Benefit will be paid in one lump sum to the insured. Only one Accelerated Benefit may be paid during the insured's lifetime under the Group Policy.

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What affect does an Accelerated Benefit payment have on the remaining Life Insurance benefit amount?

The amount of Life Insurance remaining after payment of the Accelerated Benefit, is the amount in force prior to the payment of the Accelerated Benefit less the administration costs outlined in the policy (if any), and less the Accelerated Benefit amount paid to the insured. LifeMap will waive premium on the remaining amount of Life Insurance after payment of the Accelerated Benefit.

Extension of Life Insurance During Total Disability (Waiver of Premium)

What is Extension of Life Insurance During Total Disability?

This benefit allows waiver of Life Insurance premium when the insured individual becomes totally disabled per the terms of your Group's Policy, also known as waiver of premium. Refer to the Extension of Life Insurance During Total Disability section of your Life Insurance Policy(ies) for the full benefit provision.

Who qualifies for Extension of Life Insurance During Total Disability?

1. All employees insured for Life Insurance who meet the definition of total disability in the Extension of Life Insurance During Total Disability section of the Group Policy may apply for waiver of premium. If the employee is approved for waiver of premium under the Basic Life Insurance Group Policy, then premium for the employee's insured dependent children may also be waived. If approved, waiver of premium applies to the employee's basic and voluntary Life Insurance.
2. If a spouse is covered under the group's Voluntary Life Insurance, and meets the definition of total disability, they may apply for waiver of premium under the Voluntary Life Insurance Group Policy. In California the only insured individual eligible for this benefit is the employee.
3. The following requirements are LifeMap standards, however please refer to the Group Policy for specific requirements. The disabled individual must:
    - Become totally disabled while insured under the Group Policy.
    - Be totally disabled for at least 6 consecutive months.
    - Be under age 60 when the total disability begins.
    - Provide written proof to LifeMap of the continuous total disability within 12 months after the date the total disability began.
    - Continue to provide written proof of total disability as required by LifeMap.

How does an insured individual apply for Extension of Life Insurance During Total Disability?

The **Extended Life Insurance Claim Form** is downloadable for printing from the Forms tab on LifeMapCo.com. The form includes the Claim Filing Instructions.

1. Insured employees or spouses who wish to apply for extended Life Insurance must complete the **Extended Life Insurance Claim Form**. The insured employee or spouse is responsible for completing and signing the **Employee's Statement** and **Authorization to Obtain and Release Information** sections of the form.
2. The insured's attending physician must complete and sign the **Attending Physician's Statement** section of the form.
3. The Employer or Group Administrator is responsible for completing and signing the **Employer's or Administrator's Statement** section of the form.
4. The form can be emailed to Claims@disabilityrms.com, faxed or mailed to the address on the form. To avoid a delay in processing, all sections should be completed in full and signed.

What are the Group Administrators responsibilities during an employee's or spouse's disability?

LifeMap policies standardly provide a 6-month waiting period, please see the policy for the specific waiting period. The Employer should continue to pay premium during the 6-month waiting period. If the claim is approved, Life Insurance will continue without further payment of premium, subject to all requirements and limitations of the provision and LifeMap will refund premium that was paid after the date the insured individual became totally disabled.

What if the employee submitted a Long Term Disability (LTD) claim through LifeMap?

If the employee is covered under a LifeMap Long Term Disability Insurance Group Policy and has filed a claim for LTD benefits, it is not necessary to complete the **Statement for Extended Life Insurance** form in order to apply for this benefit. The LTD claim documentation will be reviewed to determine if the disability meets the requirements of the Life waiver of premium provision, and the employee will be notified of the determination.

Do insured individuals need to apply for Conversion?

Individuals who are completing the 6-month waiting period are not required to request conversion to an individual life policy. Conversion should be requested if the insured is not totally disabled or if the claim for extended Life Insurance is denied.

What happens if an insured individual applies for both Conversion and Extension of Life Insurance During Total Disability?

If a request for Conversion is received by HRMP, they will send a request to LifeMap to confirm if the insured individual currently has a waiver of premium request under review or is already on waiver of premium.

- If the insured individual does not have a waiver of premium request under review or has been denied waiver of premium, the conversion request will be reviewed and/or accepted by HRMP.
- If the insured individual has a waiver of premium request under review, the conversion request will be reviewed and/or accepted by HRMP.
- If the conversion request is accepted by HRMP and the waiver of premium request is later approved, the insured individual must notify HRMP and surrender the conversion policy without a claim. Upon notification to HRMP by the insured individual, the conversion policy will be terminated, and all premiums will be refunded.
- If the insured individual is currently on waiver of premium, HRMP will deny the conversion request.

What if the insured individual dies prior to the date proof of total disability is furnished?

If it is determined that the insured individual was totally disabled from the last day worked to the date of death, LifeMap will pay the benefit amount that would otherwise have been continued, provided:

- Total disability began while the insured individual was insured under the Group Policy; and
- The death occurred within 1 year after the date the total disability began; and
- We are given proof of the insured individual's continuous total disability within 1 year after the date of death; and
- We are given proof of the insured individual's death.

LifeMap will refund premium that was paid after the date the insured individual became totally disabled.

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Premium Adjustments

How are premiums adjusted upon approval of the Accelerated Benefit for Terminal Illness or Extension of Life Insurance?

1. **List Billed Groups** – LifeMap's Enrollment Department will make the necessary adjustments to the monthly billing statement. Any adjustments reflecting future premium waiver for the Accelerated Benefit will be shown after benefit is paid. Any adjustments for an approved Extended Life claim will reflect future premium waiver and/or refunds of Basic and/or Voluntary Life premium previously paid, back to the date of disability.
2. **Summary Billed Groups** – the Group Administrator should make the necessary adjustments to the Summary Bill and remitted premium. Any adjustments should reflect the premium waiver for the Accelerated Benefit based on benefit paid date. Any adjustments for an approved Extended Life claim should reflect future premium waiver and/or credits for Basic and/or Voluntary Life premium previously paid, back to the date of disability as indicated on the approval letter.

Note: The Accidental Death and Dismemberment (AD&D) premium is not eligible for waiver and will terminate on the first of the month following three months from the date of disability.

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Portability

Portability is not included with all Life insurance policies. Refer to your Group Life Insurance Policy(ies) to see if this provision is available.

What is Portability?

- It allows an insured to continue their Life Insurance under the Group Policy provided by LifeMap if coverage would otherwise end (except when the Group Policy terminates)
- It is term Life Insurance (there is no cash value)
- It does not include Extension of Life Insurance During Total Disability or Accelerated Benefit for Terminal Illness
- It is not provided to insured individuals who have converted their Life Insurance to an individual policy

NOTE: if the LifeMap Group Policy terminates, then any LifeMap ported policies also terminate on that same date.

Who is eligible to apply for Portability?

Insured employees who meet the portability eligibility requirements of the Group Policy are eligible to port coverage for themselves and their enrolled dependents if it will otherwise end under the Group Policy. Portability also allows spouses to port coverage for themselves and dependent children without the continuation of employee coverage, if the spouse is widowed, divorced, legally separated from the employee, or a domestic partnership is terminated. Please see your policy for specifics about eligibility.

How does an insured individual request Portability?

The Group Administrator initiates the process for the individual by contacting LifeMap for the **Request for Portability of Life Insurance** form. The Employer or Group Administrator must complete the section titled To be Completed by Employer prior to providing the application to the employee.

The insured completes all remaining sections of the form, including the calculation of the quarterly, semi-annual, or annual premium and applicable charges. Upon completion, the individual mails the form and initial premium payment to the LifeMap address that appears on the form. The completed form and premium payment are due within 31 days from the date the insured's coverage terminates under the Group Policy. The premium rates are included in the Portability form.

An insured may also contact LifeMap directly and request the **Request for Portability of Life Insurance** form. The insured will be responsible for having the Employer or Group Administrator complete the Employer section.

What benefit amount are insured individuals eligible to port?

All or a portion of the Life Insurance benefit amount in effect on the day coverage would otherwise end may be eligible to port. The ported amount cannot exceed the maximum coverage amount as defined in the portability section of the Group Policy for combined ported Basic and Voluntary Life Insurance.

How is Portability billed?

The Portability rates match the Group Life and/or Voluntary Life Insurance Policy premium rates and will change when the Group Policy rates change. Age-rated premiums will increase with the insured individual's age based on the policy's age/premium bracket during the period of coverage. Upon approval of Portability, LifeMap will bill the insured person directly based on the payment mode selected on their Portability application.

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Conversion

What is Conversion?

Conversion provides continued Life Insurance under an Individual Whole Life Insurance policy (that builds cash value) and is issued by Gerber Life Insurance Company, administered by Health Reinsurance Management Partnership (HRMP).

- It does not require approval of evidence of insurability

Who is eligible to apply for a Conversion policy?

Employees and dependents enrolled for Basic Life and/or Voluntary Life Insurance are eligible to convert their coverage, provided they submit their application and initial premium within 31 days from the date coverage ends under the group life policy(ies). All or part of the Life Insurance benefit may be converted due to:

- The employee's termination of employment
- Termination of membership in an eligible class
- Ceasing to be eligible according to the eligibility provisions of the Group Policy
- Retirement
- Termination or reduction of the benefit amount due to reaching a specified age as shown in the Group Policy

How does an insured individual request Conversion?

An insured individual who wants to apply for a conversion policy must complete a HRMP **Individual Life Conversion request for Information Form (RFI)** and submit it directly to HRMP. The form is available on our website at www.LifeMapCo.com/convert. Once HRMP receives the form, they will send the individual a Conversion Application with premium rates. The completed Conversion Application and initial premium payment must be received by HRMP within 31 days of the date the insured individual's coverage ends.

What are the Group Administrator's responsibilities for Conversion?

- Advise employee's that are losing coverage or have dependents that are losing coverage due to any reason, of the Conversion provision.
- Assist the insured individual with obtaining a HRMP **Individual Life Conversion Request for Information Form (RFI)** and fully completing the Employer section of the form.
- Inform employees who become **totally disabled** prior to age 60 that they should not request Conversion and keep all such employees insured under the Group Policy during the qualifying period for Extension of Life Insurance During Total Disability. Refer to the **Extension of Life Insurance During Total Disability** section for assisting the employee in filing for the extension benefit.

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What happens if an insured individual applies for both Conversion and Extension of Life Insurance During Total Disability?

If a request for Conversion is received by HRMP, they will send a request to LifeMap to confirm if the insured individual currently has a waiver of premium request under review or is already on waiver of premium.

- If the insured individual does not have a waiver of premium request under review or has been denied waiver of premium, the conversion request will be reviewed and/or accepted by HRMP.
- If the insured individual has a waiver of premium request under review, the conversion request will be reviewed and/or accepted by HRMP.
- If the conversion request is accepted by HRMP and the waiver of premium request is later approved, the insured individual must notify HRMP and surrender the conversion policy without a claim. Upon notification to HRMP by the insured individual, the conversion policy will be terminated, and all premiums will be refunded.
- If the insured individual is currently on waiver of premium, HRMP will deny the conversion request.

What benefit amount are insured individuals eligible to convert when the Group Policy is actively in force?

The insured individual can convert all or a portion of their Life Insurance benefit amount in effect under the group's policy prior to the date coverage ends. However, the face amount of the conversion policy must be at least $1,000.

What are the limitations and benefit amounts for insured individuals when the Group Policy terminates?

When the Group Policy is terminated, or amended to reduce or terminate coverage, the employee and dependents are limited to the following:

- The insured individual must be covered under the Group Policy for at least five years prior to the date of termination.
- The amount available to convert is limited to the lesser of: $10,000; or the amount which ended, less any other group Life Insurance through the same Employer for which the insured becomes eligible during the 31-day conversion period.

What happens if the insured individual dies during the 31-day conversion period?

A death benefit equal to the amount of Life Insurance which could have been converted is payable under the Group Policy, provided the insured:

- Was entitled to purchase a conversion policy, and
- Dies within the 31-day conversion period.

The death benefit will be paid even if the insured individual did not apply for the conversion policy. If the first premium was paid for the conversion policy, the premium will be refunded and the conversion policy will be void.

How is Conversion billed?

Conversion rates are age-rated. The initial rate is fixed at the age when the conversion policy is issued and will not change due to an increase in age. Upon approval of Conversion, Gerber Life, the whole Life Insurance carrier, will bill the insured individual directly based on the payment mode selected on the Conversion application.

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Repatriation Benefit

The Life Insurance Group Policy may also provide a Repatriation Benefit to assist a beneficiary with the expense incurred for preparation and transportation of an insured individual's body for burial or cremation. This benefit may be paid in addition to the insurance benefit, provided the insured individual's death meets the requirements outlined in the Repatriation Benefit section of the Group Policy.

Travel Assistance Program

LifeMap has partnered with AXA Assistance USA, Inc. to provide a no-cost Travel Assistance Program.

What is AXA Assistance USA, Inc. (AXA)?

If your group has purchased Life Insurance through LifeMap, AXA provides help with travel and medical services to employee and their immediate family members when traveling 100 or more miles away from their home or outside of the country.

How are employees enrolled?

Once an employee is enrolled in a LifeMap Life Insurance coverage, the employee and their immediate family members are automatically eligible to use the Travel Assistance Program.

What type of assistance is provided?

- Pre-trip help includes assistance with an embassy, passport, currency exchange or even weather
- Travel assistance includes accessing a translator or legal referral abroad
- Medical services include doctor referrals, replacement medication, medical record transfers or critical care monitoring
- Repatriation includes assisting with safe travel home for medical reasons

How can employees access the Travel Assistance Program?

Employees can contact AXA by phone at 1 (800) 230-5170 within the United States or 1 (63) 766-7772 outside the United States. Services must be authorized and arranged by AXA designated personnel to be eligible for this program.

Travel Assistance services are not insurance and are subject to specific terms, conditions and limitations. All additional costs or out-of-pocket expenses are the responsibility of the employee or immediate family member.

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Short Term Disability (STD) Insurance Administration Guidelines

Refer to the Group Policy(ies) to determine if this coverage is available to your group.

Enrollment and Eligibility

When are employees eligible?

Employees are eligible for coverage after completing the eligibility waiting period indicated in the policy.

Non-contributory (employer-paid) coverage
Eligible employees will be effective first of the month following completion of the new employee waiting period.

Contributory and/or Voluntary (employee-paid) coverage
Employees have up to 31 days from the end of their eligibility waiting period to enroll for coverage (this is the initial enrollment period).

- If coverage does not require approval of evidence of insurability, eligible employees will be effective first of the month following completion of the new employee waiting period.
- If evidence of insurability is required and coverage is approved by LifeMap, the employee will be effective the first of the month on the later of: completion of the new employee waiting period; or approval by LifeMap. There will be no mid-month effective dates.

Refer to the Enrollment sections within this guide for the enrollment requirements, and the Group Policy for specifics regarding the eligibility waiting period and effective date of coverage.

When do employees need to submit evidence of insurability?

Evidence of insurability will need to be provided for an employee as outlined in the Evidence of Insurability section of your group's policy and this guide. Some common reasons include, but are not limited to:

- The amount applied for is over any guarantee issue amount.
- The applicant is a late enrollee.
- Voluntary coverage is voluntarily cancelled then re-applied for at a later date.

Is there an annual enrollment period for Voluntary STD?

Annual enrollment is only available if provided specifically by your LifeMap policy. If provided by your policy, annual enrollment is a period of time as determined by the Employer and LifeMap, when employees may enroll for coverage if enrollment was not made when initially eligible. Evidence of Insurability is required when enrolling during the annual enrollment period.

Are employees on salary continuation eligible for STD benefits?

Yes. Employees receiving salary continuation may apply for STD benefits; however, the salary continuation may be considered a deductible source of income and the full STD benefit may not be payable. The employee may receive salary continuation during the elimination period.

What if an Employer changes disability carriers?

The LifeMap STD Group Policy includes continuity of coverage upon transfer of insurance carriers to ensure employees insured under a prior Group Policy will not lose insurance due to a change in carriers. See the Group Policy to review the continuity of coverage provision.

Continuity of Coverage applies to:

- Actively at Work Requirement
- Pre-existing Condition Exclusion

If your LifeMap STD policy terminates, any approved claim while insured under a LifeMap policy with a date of disability prior to the termination date of the Group Policy will remain LifeMap's liability.

Claim Submission

The Short Term Disability Claim Form can be found on LifeMapCo.com. For assistance in submitting Short Term Disability (STD) claims, you may contact a Claims Representative at 1(800) 286-1129.

How is the STD claim form completed and submitted?

The **Short Term Disability Claim Form** is downloadable for printing from the Forms tab on LifeMapCo.com. The form includes separate sections for the employee, attending physician and Employer. To avoid a delay in the processing of a claim, all sections should be completed in full and signed.

1. The employee must complete and sign the **Employee's Statement** and **Authorization to Obtain and Release Information** sections of the form.
2. The employee's attending physician must complete and sign the **Attending Physician's Statement** section of the form.
3. The Employer or Group Administrator is responsible for completing the **Employer's or Administrator's Statement** section of the form.
4. If the employee wishes to receive benefit payments through direct deposit, they must complete the **Claim Benefits – Direct Deposit Option** section of the form.

All pages of the claim form (original copy is not required) and any supporting documentation should be sent to LifeMap Claims. Refer to Claims and Appeals in the **Contact and Mailing Information** section at the beginning of this guide or the Claim Filing Instruction sheet for email, fax and mailing address.

Claim Determination

What is an STD benefit waiting period?

The benefit waiting period is the length of time the insured employee must be continuously disabled before a benefit is payable.

When will a decision be made regarding disability benefits?

The Claims Department strives to make an initial decision within 10 business days upon receipt of the completed claim form. This initial decision will either:

- Approve benefits and upon completion of the benefit waiting period, issue a payment to the claimant; or
- Pend the claim for additional information; or
- Deny the claim if the claim is not eligible for payment.

Additional information may be needed from the attending physician, Employer, or claimant and could impact the analysis necessary to make the initial decision. Upon receipt of the additional requirements, the Claims Department will review the new information within 7 business days.

Is there a pre-existing condition exclusion?

The STD plan may include a pre-existing condition exclusion. If the Group Policy includes a pre-existing condition exclusion, then disabilities due to pre-existing conditions are not covered under the Group Policy for a specified period of time. Refer to your group's policy to see if a pre-existing condition exclusion applies to your STD benefits.

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What is a pre-existing condition?

A pre-existing condition is a sickness or injury which causes a disability or contributes to a disability which is excluded from insurance, provided:

- The disability begins within a specific period of time (found in the Group Policy) following the employee's effective date of coverage; and
- The employee was diagnosed by or received treatment from a physician, had symptoms or had taken prescription medications within a specific period of time (found in the Group Policy) prior to the employee's effective date of coverage.

How are work-related disabilities handled?

The STD policy excludes work-related injuries and illness; therefore, a claim filed for any work-related condition will be denied, regardless of employer including self-employment. If LifeMap is asked to consider the claim, the employee will be asked to provide a copy of the Workers' Compensation denial.

Are maternity claims eligible for STD benefits?

The STD policy treats maternity the same as any other eligible sickness or disease. LifeMap considers the usual recovery from a vaginal delivery to be six weeks or a caesarian section to be eight weeks, but individual claim situations are taken into account. Refer to the Group Policy regarding any disability exclusions.

Must employees file a new claim for a recurrent disability?

- The claim of an employee who has attempted to return to full-time work for 14 consecutive days or less, and is unable to continue working, will be considered the same claim, provided it is for the same disabling condition as the first period of disability.
- An employee who has returned to work for more than 14 consecutive days must file a new claim.
- If the employee returns to work, even if for a period less than 14 days and becomes disabled with a new disabling condition, the employee must file a new claim.

Taxable Disability Income

If premiums are 100% employer paid, the benefit is taxable.

If premiums are 100% paid by the employee and premiums are paid with post-tax dollars the benefit is not taxable. (example: gross-up plan)

If premiums are 100% paid by the employee and premiums are paid with pre-tax dollars, the benefit is taxable.

If both the Employer and employee pay part of the premium, the benefit is partially taxable based on the percentage of premium paid by the Employer.

Benefit Determination

To whom are benefit checks paid?

Benefit checks are sent directly to the employee. There is also a direct deposit option which can be chosen by the employee when completing the STD Claim form.

How does a change in salary impact STD benefits?

- If the claim has a date of disability prior to the date of the increase in salary, the increase would not change the benefit.
- If the increase was effective prior to the date of disability and meets Group Policy requirements for reporting salary increase, the increase may be applied. The Group Administrator is responsible for submitting proof of the amount and date of the increase, and retroactive premiums based on the increased salary amount must be paid. Any retroactive benefits due would be paid to the employee.

Are partial disability benefits included?

The LifeMap STD Policy may or may not include a partial disability benefit. Refer to the Group Policy to see if it includes partial disability benefits. If the Group Policy includes partial disability benefits and the disabled employee is working a reduced schedule, then a partial disability benefit may be payable. The partial disability benefit is calculated as total disability minus a percentage of the employee's part-time earnings. The partial disability benefit percentage, maximum weekly benefit, and definition of basic weekly earnings which apply to STD coverage are outlined in the Group Policy.

How are state disability plans taken into account?

Most Employers in the states of California, Hawaii, New Jersey, New York, Puerto Rico, and Rhode Island are required to provide state-mandated disability income insurance for both full-time and part-time employees in those states. Employees who work in Washington are provided a state-mandated paid family and medical leave plan. The amount received through the state-mandated disability and medical leave plans are considered a deductible source of income and would be deducted from the claimant's benefit.

LifeMap is not an authorized insurance company to provide state mandated benefits.

Will LifeMap accept court orders for garnishment of disability benefits?

LifeMap will accept court orders for garnishments if a claimant is receiving a disability benefit. In order to do this, one of the following is required:

- A written request from the Employer with a copy of the court order for garnishment of disability benefits; or
- A copy of the court order if it is sent directly from the court or from any other entity.

The written request should be emailed to Claims@LifeMapCo.com.

What do I need to do if the employee returns to work early?

If the employee returns to work before the end of the approved benefit period, you will need to notify LifeMap, by sending an email to Claims@LifeMapCo.com. which includes the following information:

- Date the employee returned to work and whether it is full time, part time or with restrictions; and
- A doctor's release form, if available

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How can a denied claim be appealed?

The claimant has 180 days after receiving a claim denial to appeal. The appeal must be submitted in writing and must provide specific information outlining why the employee disagrees with LifeMap's decision, along with any additional documentation that was not previously submitted. Additional information to support the appeal may include medical records, test results, or payroll records.

If the denial was due to a waiting period or effective date issue, proof is required to support the employee's eligibility. Appropriate proof may include an enrollment form or copies of payroll deductions.

The written appeal and all supporting documentation should be sent to LifeMap Claims. Refer to Claims and Appeals in the **Contact and Mailing Information** section at the beginning of this guide.

LifeMap will provide a written response within 45 days from receipt of the appeal to advise the claimant if additional information is needed or if a decision has been reached. If additional review time is required, the employee will receive a letter outlining the reason for the delay. The appeal determination will not take longer than 90 days provided all documentation is received in a timely manner.

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Statutory Disability Administration Information

If an Employer has employees working in New York or New Jersey, LifeMap offers New York Disability Benefits Law (DBL), Paid Family Leave (PFL) plans, and New Jersey Temporary Disability Benefits (TDB) plans through Renaissance Life & Health Insurance Company.

These insurance plans provide a temporary weekly benefit to employees who are unable to perform the regular duties of their employment due to a sickness, pregnancy, mental disorder, or an off-the-job accidental injury. The plans meet the minimum requirements of the applicable statutory disability benefits law and offer competitive rates based on plan design and number of employees.

If your group has purchased services through Renaissance Life & Health Insurance Company, you can find the contact information in the **Contact and Mailing Information** section at the beginning of this guide.

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FMLA and Non-FMLA Leave Administration Guidelines

Some LifeMap group policies provide continued coverage **with** premium payment for employees during the following approved leaves. Refer to the Group Policy(ies) to determine what applies.

- **Family Medical and Leave Act (FMLA)**: Up to the greater leave period provided under FMLA or applicable state law.
- **Employee's Disability**; subject to the requirements in the Group Policy. If requirements are met coverage can be continued for up to 6 months (this does not apply to life coverage, if the employee is eligible under the Extension of Life Insurance During Total Disability provision).
- **Employer-approved Leave of Absence**; subject to written approval in advance by the Employer: coverage may be continued through the end of the month immediately following the month the leave of absence began.
- **Temporary Layoff or Labor Dispute**: Through the end of the month immediately following the month in which the temporary layoff or labor dispute began.
- **Military Service Leave of Absence** of 30 days or more: Up to the greater leave period provided under the leave of absence provision or FMLA.

Coverage ends as described above, once an employee reaches the end of their leave period and does not return to active employment.

What is FMLA?

FMLA is the Family and Medical Leave Act, which provides employees with an unpaid leave of absence of up to 12 weeks per year for the birth or adoption of a child, for an employee's own serious medical condition, or for the care of a family member with a serious medical condition. FMLA can provide up to 26 weeks of unpaid leave for the care of an injured service member.

How are FMLA and other leaves of absence administered?

The Group Administrator is responsible for correctly interpreting, fairly administering, and accurately documenting all FMLA matters. When an employee has reached the end of any approved leave period and does not return to work, the Group Administrator is responsible to notify LifeMap immediately. All coverage(s) will be terminated based on last day of the leave period(s).

- **List Billed Groups** - Upon notification from the Group Administrator, LifeMap will remove the employee from the next monthly billing statement and make any adjustments to reflect the employee's termination date of coverage.
- **Summary Billed Groups** - The Group Administrator will adjust the monthly premium details from the next summary bill including any overpayment of premium, to reflect the employee's termination date of coverage.
- If the employee returns to work at a later date, they will be enrolled per the rehire instructions in this guide.

If the Employer rules do not provide for continuation of coverage during FMLA, the employees coverage will be terminated on last day worked and reinstated when they return to active employment. The Group Administrator is responsible to provide this information when the employee is reinstated for coverage.

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FMLASource/ComPsych

FMLASource/ComPsych (FMLASource) is an available/optional LifeMap FMLA administrative partner. FMLA Source provides a convenient service staffed with HR specialists and attorneys to manage FMLA cases from start to finish, while reducing absences and costs.

If your group has purchased services through FMLASource, please follow the process below.

How is a leave request submitted?

1. The employee should notify their supervisor or manager of their absence from work.
2. Using the **Leave Request Checklist**, the employee should gather information about their absence and have this information ready when they call. If someone makes the call for them (e.g. a family member), they will need to provide this information on their behalf.
3. Employees can initiate a claim, check the status of their leaves, and report intermittent time at www.FMLASource.com. Additionally, email inquiries can be sent to FMLACenter@FMLASource.com
4. Call toll free at 1 (877) 462-3652. Hours of operation are Monday through Friday, 7:30 a.m. – 9:30 p.m. CT.
5. If the employee's absence from work is due to a health condition, they will sign and date an **Authorization Form**. This form is provided to the physician. The employee should also fax a copy of the signed and dated form to FMLASource at 1 (877) 309-0218.

What happens next?

Every absence is unique and next steps can differ depending upon the type of claim or leave requested. When the employee contacts FMLASource at 1 (877) 462-3652 and more is learned about their specific request, FMLASource will guide them through the process, answer any questions, and tell them what to expect next. FMLASource is committed to being responsive and supportive during an employee's time away from work.

What is the Leave Request Checklist?

The employee or their representative should have the following information ready when they call FMLASource:

- Employer's name and location
- Employee's full name and Social Security Number
- Employee's complete address and phone number
- Date of birth
- Marital status and number of dependents
- Occupation or job title
- Supervisor's name and phone number
- Last day worked and first day absent from work
- Date expected to return to work, if known, or the actual date if the employee has already returned to work at the time of the call
- If the absence or claim is due to their own health condition, have the following information available:
    - Description of medical condition, including any relevant dates of injury or if it is work-related
    - Physician's name, address, phone number, and fax number
    - Dates of the first visit, the most recent visit, and the next scheduled visit with their physician for this condition

To contact FMLASource, refer to the **Contact and Mailing Information** section at the beginning of this guide.

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Long Term Disability (LTD) Insurance Administration Guidelines

Refer to the Group Policy(ies) to determine if this coverage is available to your group.

Enrollment and Eligibility

When are employees eligible?

Employees are eligible for coverage after completing the eligibility waiting period indicated in the policy.

Non-contributory (employer-paid) coverage
Eligible employees will be effective first of the month following completion of the new employee waiting period.

Contributory and/or Voluntary (employee-paid) coverage
Employees have up to 31 days from the end of their eligibility waiting period to enroll for coverage (this is the initial enrollment period).

- If coverage does not require approval of evidence of insurability, eligible employees will be effective first of the month following completion of the new employee waiting period.
- If evidence of insurability is required and coverage is approved by LifeMap, the employee will be effective the first of the month on the later of: completion of the new employee waiting period; or approval by LifeMap. There will be no mid-month effective dates.

Refer to the Enrollment sections within this guide for the enrollment requirements, and the Group Policy for specifics regarding the eligibility waiting period and effective date of coverage.

When do employees need to submit evidence of insurability?

Evidence of insurability will need to be provided for an employee as outlined in the Evidence of Insurability section of your group's policy and this guide. Some common reasons include, but are not limited to:

- The amount applied for is over any guarantee issue amount.
- The applicant is a late enrollee.
- Voluntary coverage is voluntarily cancelled then re-applied for at a later date.

Is there an annual enrollment period for Voluntary LTD?

Annual enrollment is only available if provided specifically by your LifeMap policy. If provided by your policy, annual enrollment is a period of time as determined by the Employer and LifeMap, when employees may enroll for coverage if enrollment was not made when initially eligible. Evidence of Insurability is required when enrolling during the annual enrollment period.

What if an Employer changes carriers?

The LifeMap LTD Group Policy includes continuity of coverage upon transfer of insurance carriers to ensure employees insured under a prior Group Policy will not lose insurance due to a change in carriers. See the Group Policy to review the continuity of coverage provision.

Continuity of Coverage applies to:

- Actively at Work Requirement
- Pre-existing Condition Exclusion

In order to provide continuity of coverage, LifeMap must have a copy of the prior carrier's LTD policy. If continuity of coverage is a state mandated regulation, LifeMap must receive a copy of the prior policy before issuing our LTD Group Policy.

If your LifeMap LTD policy terminates, any approved claim while insured under a LifeMap policy with a date of disability prior to the termination date of the Group Policy will remain LifeMap's liability.

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Claim Submission

The **Long Term Disability Claim Form** can be found on LifeMapCo.com. For assistance in submitting Long Term Disability (LTD) claims, you may contact a Claims Representative at 1 (877) 254-0085.

How is the LTD claim form completed and submitted?

The **Long Term Disability Claim Form** is downloadable for printing from the Forms tab on LifeMapCo.com. The form includes separate sections for the employee, attending physician and Employer. To avoid a delay in processing of a claim, all sections should be completed in full and signed.

1. The claim should be submitted halfway through the elimination period to ensure a decision is made before the first payment is due (if the claim is payable).
2. The employee must complete and sign the **Employee's Statement** and **Authorization to Obtain and Release information** sections of the claim form.
3. The employee's attending physician must complete and sign the **Attending Physician's Statement** section of the form.
4. The Employer or Group Administrator is responsible for completing the **Employer's or Administrator's Statement** section of the form.

All pages of the claim form and any supporting documentation should be faxed or mailed to LifeMap Claims. Refer to Claims and Appeals in the **Contact and Mailing Information** section at the beginning of this guide or the Claim Filing Instruction sheet for fax # and mailing address.

Claim Determination

What is the elimination period?

The elimination period is the length of time the employee must be continuously disabled before a benefit is payable. It is comprised of calendar days and begins on the first day of disability. Benefits are not payable until the elimination period has been completed. The LTD Group Policy may also include an accumulation of elimination period. Refer to the Group Policy to see if it includes an accumulation of elimination period.

What is an accumulation of elimination period?

An accumulation of elimination period allows for the employee to return to work temporarily while satisfying the elimination period. It ensures:

- Disabled employees are not penalized for trying to work during the elimination period.
- The days the employee is not disabled will not count toward satisfying the elimination period.
- If the disabled employee is working, the days they are disabled will count towards the elimination period.
- The days an employee is not disabled may be consecutive or intermittent
- The employee must satisfy the elimination period within the accumulation period, or a new period of disability will begin.

The elimination period and accumulation period begin on the first day of the employee's disability.

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When will a decision be made regarding disability benefits?

The claim will be reviewed within 10 business days of receipt of the completed claim form and an initial decision will be made to either:

- Approve benefits and upon completion of the elimination period, issue a payment to the claimant; or
- Pend the claim for additional information; or
- Deny the claim if the claim is not eligible for payment.

An initial phone call to the Employee and Employer will be made during the 10-day period.

Is there a pre-existing condition exclusion?

LTD plans do include a pre-existing condition exclusion. Disabilities due to pre-existing conditions are not covered under the Group Policy for a specified period of time.

What is a pre-existing condition?

A pre-existing condition is a sickness or injury which causes a disability or contributes to a disability which is excluded from insurance, provided:

- The disability begins within a specific period of time (found in the Group Policy) following the employee's effective date of coverage; and
- The employee was diagnosed by or received treatment from a physician, had symptoms or was prescribed or taken prescription medications, within a specific period of time (found in the Group Policy) prior to the employee's effective date of coverage.

Are work-related disabilities covered?

Work related disabilities are covered; however, the Group Policy integrates with Workers' Compensation benefits. All benefits paid under the Workers' Compensation coverage are considered a deductible source of income from the total employee benefit under the LifeMap LTD policy.

Example

Employee benefit = $1,000 per month

Amount employee receives from Workers' Compensation = $300 per month

Net Disability Benefit from LTD = $700 per month

($1,000 - $300 = $700)

The Group Policy does not replace or affect the requirement for coverage by any Workers' Compensation or State Disability insurance.

Are employees required to file a new claim for a recurrent disability?

- The claim of an employee who has attempted to return to full-time work for six months or less, and is unable to continue working, will be considered the same claim, provided it is for the same disabling condition as the first period of disability
- An employee who has returned to work for more than six months must file a new claim
- If the employee returns to work, even if for a period less than six months and becomes disabled with a new disabling condition, the employee must file a new claim.

Taxable Disability Income

If premiums are 100% employer paid, the benefit is taxable.

If premiums are 100% paid by the employee and premiums are paid with post-tax dollars the benefit is not taxable. (example: gross-up plan)

If premiums are 100% paid by the employee and premiums are paid with pre-tax dollars, the benefit is taxable.

If both the Employer and employee pay part of the premium, the benefit is partially taxable based on the percentage of premium paid by the Employer.

Benefit Determination

To whom are benefit checks paid?

At the time of claim approval, the employee will be offered the following options:

- Benefit checks sent directly to the employee; or
- Direct deposit of benefit payment.

How does a change in salary impact LTD benefits?

- If the claim has a date of disability prior to the date of the increase in salary, the increase would not change the benefit.
- If the increase was effective prior to the date of disability and meets Group Policy requirements for reporting salary increase, the increase may be applied. The Group Administrator is responsible for submitting proof of the amount and date of the increase, and retroactive premiums based on the increased amount must be paid. Any retroactive benefits due would be paid to the employee.

Are partial disability benefits included?

The LifeMap LTD Policy may or may not include a partial disability benefit. Refer to the Group Policy to see if it includes partial disability benefits. If the Group Policy includes partial disability benefits and the disabled employee is working a reduced schedule, then a partial disability benefit may be payable.

Will LifeMap accept court orders for garnishment of disability benefits?

LifeMap will accept court orders for garnishments if a claimant is receiving a disability benefit. In order to do this, one of the following is required:

- A written request from the Employer with a copy of the court order for garnishment of disability benefits; or
- A copy of the court order if it is sent directly from the court or from any other entity.

The written request should be submitted to the LifeMap LTD Claims team. Refer to Claims and Appeals in the **Contact and Mailing Information** section at the beginning of this guide.

What do I need to do if the employee returns to work early?

If the employee returns to work before the end of the approved benefit period, you will need to notify LifeMap, by faxing of mailing to LifeMap LTD Claims, the following information:

- Date the employee returned to work and whether it is full time or part time.
- If the employee did not return to their prior occupation or has restrictions, provide a job description with physical demands for the new position.
- A doctor's release form.

Refer to Claims and Appeals in the **Contact and Mailing Information** section at the beginning of this guide for fax # and mailing address.

How can a denied claim be appealed?

The claimant has 180 days after receiving a claim denial to appeal. The appeal must be submitted in writing and must provide specific information outlining why the employee disagrees with LifeMap's decision, along with any additional documentation that was not previously submitted. Additional information to support the appeal may include medical records, test results, or payroll records.

If the denial was due to a waiting period or effective date issue, proof is required to support the employee's eligibility. Appropriate proof may include an enrollment form or copies of payroll deductions.

The written appeal and all supporting documentation should be sent to LifeMap Claims. Refer to Claims and Appeals in the **Contact and Mailing Information** section at the beginning of this guide.

LifeMap will provide a written response within 45 days from receipt of the appeal to advise the claimant if additional information is needed or if a decision has been reached. If additional time is required the employee will receive a letter outlining the reason for the delay. The appeal determination will not take longer than 90 days provided all documentation is received in a timely manner.

Waiver of Premium

LifeMap Long Term Disability (LTD) Insurance policies include waiver of premium. This is an automatic benefit once the claim is approved, and the employee is receiving LTD benefit payments. The employee and Employer will receive notification from LifeMap Claims indicating approval of Waiver of Premium. Premiums will be adjusted as follows:

- **List Billed Groups** - The LifeMap Enrollment Department will be notified of the approval of LTD benefits and will adjust the group's monthly billing statement accordingly.

- **Summary Billed Groups** - The Group Administrator must make the adjustment to the monthly Summary Bill upon receiving a copy of the approval letter. Do not make adjustments to waive the premium until you have been notified of the date that benefits will begin. Premium cannot be waived until the date benefits are payable.

Vocational Rehabilitation Services Administration Guidelines

The LifeMap Long Term Disability Group Policy may or may not include vocational rehabilitation services to assist claimants in returning to work to the extent of their ability. Refer to the Group Policy to see if it includes vocational rehabilitation services.

How do vocational rehabilitation services work?

Each disability claim is reviewed by a vocational rehabilitation professional designated by LifeMap to determine if rehabilitation services might help the claimant return to gainful employment. If the claimant is eligible for these services and medically able to participate, the vocational rehabilitation professional will create a Vocational Rehabilitation Plan in accordance with the provisions of the Group Policy. LifeMap will make the final determination of the claimant's eligibility for these services.

What is a vocational rehabilitation plan?

The vocational rehabilitation plan is a written plan developed specifically for the claimant and agreed upon by the claimant's doctor. It may include, but is not limited to, the following services to assist the claimant in returning to work:

- Coordination with the Employer
- Evaluation of adaptive equipment or job accommodations
- Evaluation of possible workplace modifications which might allow the claimant to return to their occupation or another job or occupation
- Vocational evaluation to determine how the claimant's disability may impact employment options
- Job placement services, including resume preparation services and training in job-seeking skills
- Alternative treatment plans such as recommendations for support groups, physical therapy, occupational therapy, or other treatment designed to enhance the claimant's ability to work
- Family care expense assistance

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Social Security and Medicare Tax (FICA)

The following applies to Short Term Disability and/or Long Term Disability only

Unless specific arrangements for the Policyholder have been otherwise agreed to, LifeMap will pay the Employer's share of Social Security and Medicare Tax on Short Term Disability (STD) and Long Term Disability (LTD) benefit payments made by LifeMap. LifeMap also assumes the responsibility of preparing all STD and LTD W-2 Tax Statements. These services will be provided without additional cost to the Policyholder.

Following is a summary of LifeMap's W-2 and tax reporting procedures:

STD Claims: The only tax standardly withheld on STD claims is the employee's portion of FICA. Upon request, federal and state taxes can be withheld. LifeMap pays the Employer's portion of FICA. The W-2 is prepared by LifeMap, reported under our tax ID number, and sent directly to the employee. LifeMap prepares the Form 941, reports the employee and Employer portions of FICA, and any federal taxes withheld directly to the IRS under our tax ID.

LTD Claims: The employee's portion of FICA is automatically withheld on LTD claims. LifeMap pays the Employer's portion of FICA. The LTD claim form allows the option of federal taxes to be withheld. The W-2 is prepared by LifeMap, reported under our tax ID number, and sent directly to the employee. LifeMap prepares the Form 941, reports the employee and Employer portions of FICA, and any federal taxes withheld directly to the IRS under our tax ID.

LifeMap does not assume responsibility for paying or reporting any Federal Unemployment Tax (FUTA), State Unemployment Tax (SUTA), or any other payroll taxes associated with STD and LTD benefit payments LifeMap makes to claimants.

The Policyholder/Employer remains responsible for reviewing and immediately notifying LifeMap of any errors on the reports provided to them (claimant name, Social Security number, employer contribution percentage, etc.), to ensure correct government reporting and tax statement information.

Employee Assistance Program (EAP) Administration Guidelines

LifeMap has partnered with Reliant Behavioral Health (RBH) to provide EAP services.

What is EAP?

If your group has purchased services with RBH through LifeMap, RBH provides private, expert support during difficult times, with issues such as an aging parent's health crisis or an employee's adolescent daughter experiencing depression.

How are employees enrolled?

If EAP is provided through the LTD plan: once an employee is enrolled in LTD, the employee and household members are eligible to use the EAP benefit.

If EAP is provided as a stand-alone benefit: once an employee is enrolled in EAP coverage and premium has been paid, employees and household members are eligible to use the EAP benefit.

How can employees access the EAP resources?

Employees can access the EAP by contacting RBH by phone at 1 (866) 750-1327, or by visiting www.ibhsolutions.com.

Employees who are covered under COBRA can access the EAP by contacting RBH at the number above, or by visiting www.ibhsolutions.com and providing their Employer's group number.

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Dental Insurance Administration Guidelines

Refer to the Group Policy(ies) to determine if this coverage is available to your group.

All eligible employees and dependents are covered for the same dental benefits, with the exception of some provisions based on age of member. If Orthodontic coverage is included, refer to the orthodontic benefits provision to determine if children only, or all family members are covered.

Enrollment and Eligibility

When are employees and dependents eligible?

Employees are eligible for coverage after completing the eligibility waiting period indicated in the policy.

Non-contributory (100% employer-paid) coverage
Eligible employees will be effective first of the month following completion of the new employee waiting period. Eligible dependents will be effective on the same day as the employee.

Contributory (1% to 70% employee-paid) and/or Voluntary (71% to 100% employee-paid) coverage
Employees have up to 31 days from the end of their eligibility waiting period to enroll themselves and any eligible dependents for coverage (this is the initial enrollment period).

If enrollment for coverage is made during the initial enrollment period, the employee and all eligible dependents will be effective the first of the month following completion of the new employee waiting period. If enrollment for coverage is made after the initial enrollment period or during the annual enrollment period, the employee and all eligible dependents will be effective on the earlier of: first of the month based on election date; or first of the month following the receipt of the application for coverage. There will be no mid-month effective dates.

Refer to the Enrollment sections within this guide for the enrollment requirements, and the Group Policy for specifics regarding the eligibility waiting period and effective date of coverage.

Once employees and/or dependents are enrolled, LifeMap will send member ID cards to the address provided in the employee's record.

Can employees waive coverage?

Non-contributory coverage
Employees can only waive coverage if currently covered under another carrier.

Contributory and/or Voluntary coverage
Employees can waive coverage.

If an employee elects to waive coverage, regardless if coverage is employer-paid, contributory, or voluntary, they must complete the **Dental Waiver Form** and send to Billing@LifeMapCo.com. Dependents cannot be enrolled if an employee elects to waive coverage for themselves.

Are there penalties for late enrollees or re-enrollment?

All enrollments after the initial enrollment period may be subject to a Late Enrollment Penalty.

- An employee and/or dependent enrolling late due to a qualifying life event will not be subject to the late enrollment penalty described in the policy.
- If your group operates under the IRS Section 125 rules, the late enrollment penalties will not apply to the following:
    - An employee and/or dependent enrolling late but during an annual enrollment
    - An employee and/or dependent re-enrolling during an annual enrollment, after initially terminating coverage at an annual enrollment or due to a qualifying event

Refer to the Group Policy for more information.

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Is there an annual enrollment period?

Annual enrollment is only available if provided specifically by your LifeMap policy. If provided by your policy, annual enrollment is a period of time as determined by the Employer and LifeMap, when employees and/or dependents may enroll for coverage if enrollment did not occur during the initial enrollment period. If you did not enroll during your initial enrollment period, you and your dependents may be subject to the Late Enrollment Penalty.

Claim Submission

Enrolled employees are provided with identification cards for themselves and enrolled dependents to present to the dentist prior to receiving care.

How is a dental claim submitted?

A claim must be submitted to LifeMap, as indicated on the dental id card, in order for us to pay for covered services. The ADA Dental Claim Form – LifeMap is downloadable for printing from the Forms tab on LifeMapCo.com.

- Providers who participate in a LifeMap dental network are referred to as a Participating Dentist or In Network Provider. Participating Dentists have agreed to supply us with the forms and information necessary to process a claim.
- Providers that do not participate in a LifeMap dental network are referred to as Nonparticipating Dentists or Out-of-Network Provider. The Nonparticipating Dentist may supply us the forms and information or may require that the member submit the claim.

If the member is required to submit the claim, they will submit the ADA Dental Claim Form - LifeMap completed by their Dentist or a Dental statement, which includes the following:

- The treating Provider's name, address, and phone
- Patient Information (full name, address, date of birth, ID number and group number)
- An itemized list of services rendered including date of service, procedure codes, description of service, and paid amounts
- Proof of payment in the form of a receipt, check copy, or a ledger statement from the Provider showing a positive payment against the services rendered

Dental claims can be mailed to the address provided under Claims and Appeals in the **Contact and Mailing Information** section at the beginning of this guide.

How can a denied claim be appealed?

The claimant has 180 days after receiving a claim denial to appeal. The appeal must be submitted in writing and must provide specific information outlining why the employee disagrees with LifeMap's decision, along with any additional documentation that was not previously submitted. Additional information to support the appeal may include dental records, test results, or payroll records.

If the denial was due to a waiting period or effective date issue, proof is required to support the employee's eligibility. Appropriate proof may include an enrollment form or copies of payroll deductions.

The written appeal and all supporting documentation should be sent to LifeMap Claims. Refer to Claims and Appeals in the **Contact and Mailing Information** section at the beginning of this guide.

LifeMap will provide a written response within 30 days from receipt of the appeal to advise the claimant if additional information is needed or if a decision has been reached. If additional review time is required, the employee will receive a letter outlining the reason for the delay. The appeal determination will not take longer than 120 days provided all documentation is received in a timely manner.

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COBRA Continuation of Coverage

The Dental Group Policy provides COBRA Continuation of Coverage (COBRA) to insured employees and dependents if certain events cause a loss of eligibility. COBRA only extends coverage for a limited time and does not apply to all Employers.

1. The qualifying events for employees are:
   - Voluntary or involuntary termination of employment for reasons other than gross misconduct
   - Reduction in the number of hours of employment
2. The qualifying events for spouses are:
   - Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct
   - Reduction in the hours worked by the covered employee
   - Covered employee's becoming entitled to Medicare
   - Divorce or legal separation of the covered employee
   - Death of the covered employee
3. The qualifying events for dependent children are the same as for the spouse with one addition:
   - Loss of dependent child status under the plan rules

See the Group Policy for more information regarding COBRA Continuation of Coverage.

Coordination of Benefits

The Dental Group Policy standardly includes Coordination of Benefits (COB). Under the COB provision; if an insured individual is covered under one or more plans, the benefits of the Group Policy will be coordinated with the benefits of the other dental plan(s). Refer to the Group Policy for more information.

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Vision Insurance Administration Guidelines

Refer to the Group Policy(ies) to determine if this coverage is available to your group.

All eligible employees and dependents are covered for the same vision services and hardware.

Enrollment and Eligibility

When are employees and dependents eligible?

Employees are eligible for coverage after completing the eligibility waiting period indicated in the policy.

Non-contributory (100% employer-paid) coverage
Eligible employees will be effective first of the month following completion of the new employee waiting period. Eligible dependents will be effective on the same day as the employee.

Contributory (1% to 70% employee-paid) and/or Voluntary (71% to 100% employee-paid) coverage
Employees have up to 31 days from the end of their eligibility waiting period to enroll themselves and any eligible dependents for coverage (this is the initial enrollment period).

If enrollment for coverage is made during the initial enrollment period, the employee and all eligible dependents will be effective the first of the month following completion of the new employee waiting period. If enrollment for coverage is made after the initial enrollment period or during the annual enrollment period, the employee and all eligible dependents will be effective on the earlier of: first of the month based on election date; or first of the month following the receipt of the application for coverage. There will be no mid-month effective dates.

Refer to the Group Policy for specifics regarding eligibility waiting periods and the effective dates of coverage.

Can employees waive coverage?

Non-contributory coverage
Employees can only waive coverage if currently covered under another carrier.

Contributory and/or Voluntary coverage
Employees can waive coverage.

If an employee elects to waive coverage, regardless if coverage is employer-paid, contributory, or voluntary, they must complete the **Vision Waiver Form** and send to Billing@LifeMapCo.com. Dependents cannot be enrolled if an employee elects to waive coverage for themselves.

Are there penalties for late enrollees?

There are no penalties for late enrollment for Vision coverage. Enrollment for coverage can be made during the initial enrollment period, after the initial enrollment period, or during an annual enrollment period. However, the coverage effective date may be delayed if application is made at any time other than, the initial enrollment period or during an annual enrollment period.

Are there penalties for re-enrollment?

All re-enrollments after an employee has terminated vision coverage for themselves and/or their dependents may have a re-enrollment penalty.

- An employee and/or dependent re-enrolling due to a qualifying life event will not be subject to the re-enrollment penalty described in the policy.
- If your group operates under the IRS Section 125 rules, the re-enrollment penalty will not apply to an employee and/or dependent re-enrolling during an annual enrollment, after initially terminating coverage at an annual enrollment or due to a qualifying event

Refer to the Group Policy for more information.

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Is there an annual enrollment period?

Annual enrollment is only available if provided specifically by your LifeMap policy. If provided by your policy, annual enrollment is a period of time as determined by the Employer and LifeMap when employees and/or dependents may enroll for coverage if enrollment did not occur during the initial enrollment period.

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Claim Submission

LifeMap's provider for vision services is Vision Service Plan (VSP).

How is a vision claim submitted?

1. When treatment is received from a Participating Provider who has contracted with LifeMap's provider, Vision Service Plan (VSP), and benefit authorization is obtained prior to treatment, the provider will furnish VSP with the forms and information needed to process the claim.
2. If benefit authorization is not obtained by a Participating Provider prior to treatment, or if treatment is provided by a provider who has not contracted with VSP; a claim must be submitted to VSP within 180 days of the date of service or as soon as reasonably possible. The claim form or written notice of claim must include the following information:
   - An itemized description of the services given and the charges for them;
   - The date treatment was given;
   - The patient's name, date of birth;
   - The group name or ID, with LifeMap Assurance Company noted as the carrier;
   - The treating Provider's name, address, Tax Identification Number (TIN), and license number; and
   - Itemized receipts of the expenses to be reimbursed.

   Additional information may be requested by VSP to process the claim.

All vision claims should be mailed to Vision Service Plan. Refer to Claims and Appeals in the **Contact and Mailing Information** section at the beginning of this guide.

How can a grievance or appeal be addressed or submitted?

Grievances

- If a member has a grievance in regard to access to care, quality of care, treatment or service they should first call VSP Customer Service at (800) 877-7195 to discuss the matter. VSP Customer Service will make every effort to resolve the matter informally.
- If the matter is not initially resolved to the satisfaction of the member, a grievance should be communicated to VSP in writing by using the complaint form that can be obtained from the VSP Customer Service department. A written reply will be sent within 30 days of receipt of the grievance, or within 120 days if an extension of time is required.
  - The member will be notified in writing of the final resolution. If the grievance is denied, a second level of appeal may be requested within 60 calendar days from the date of the determination.

Appeals

- If a member has a concern or complaint regarding billing or eligibility, a written appeal or request for review can be submitted along with any supporting documentation to LifeMap for consideration. LifeMap will send a written reply within 30 days of receipt of the appeal. If additional time is needed for review, written notification will be sent providing reason for delay.

If the denial was due to a waiting period or effective date issue, proof is required to support the employee's eligibility. Appropriate proof may include an enrollment form or copies of payroll deductions.

Refer to Claims and Appeals in the **Contact and Mailing Information** section at the beginning of this guide. Refer to the Group Policy for full details regarding the Grievance and Appeal provisions.

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COBRA Continuation of Coverage

The Vision Group Policy provides COBRA Continuation of Coverage (COBRA) to insured employees and dependents if certain events cause a loss of eligibility. COBRA only extends coverage for a limited time and does not apply to all Employers.

1. The qualifying events for employees are:
   - Voluntary or involuntary termination of employment for reasons other than gross misconduct
   - Reduction in the number of hours of employment
2. The qualifying events for spouses are:
   - Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct
   - Reduction in the hours worked by the covered employee
   - Covered employee's becoming entitled to Medicare
   - Divorce or legal separation of the covered employee
   - Death of the covered employee
3. The qualifying events for dependent children are the same as for the spouse with one addition:
   - Loss of dependent child status under the plan rules

See the Group Policy for more information regarding COBRA Continuation of Coverage.

Coordination of Benefits

The Vision Group Policy includes Coordination of Benefits; therefore, if an insured individual is covered under one or more vision plans, the benefits of the Group Policy will be coordinated with the benefits of the other plan(s). Refer to the Group Policy for more information.

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Certificates of Credible Coverage

What are certificates of credible coverage?

Certificates of credible coverage were designed by the Federal Health Insurance Portability and Accountability Act (HIPAA) to provide proof of coverage under a prior plan when an insured individual changes carrier.

These certificates confirm the dates an insured individual had group dental and/or vision coverage in effect and may include the following information:

- Date issued
- Name of group plan
- Type of coverage
- Name of employee
- Group Policy number
- Coverage effective date
- Waiting period, if any
- Date coverage terminated
- Covered dependents

How does the Employee or Group Administrator request a certificate of credible coverage from LifeMap?

A certificate of credible coverage is available by contacting the LifeMap Enrollment Department at Billing@LifeMapCo.com.

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Critical Illness Insurance Administration Guidelines

Refer to the Group Policy(ies) to determine if this coverage is available to your group.

Critical Illness provides a lump-sum benefit to an insured individual upon a confirming diagnosis of a covered critical illness or covered surgical procedure. The Employer has the option of providing dependent coverage along with employee coverage. If dependent coverage is available, all eligible employees and dependents are covered for the same conditions.

Enrollment and Eligibility

When are employees and dependents eligible?

Employees are eligible for coverage after completing the eligibility waiting period indicated in the policy.

Non-contributory (employer-paid) coverage
Eligible employees will be effective first of the month following completion of the new employee waiting period. Eligible dependents will be effective on the same day as the employee.

Contributory and/or Voluntary (employee-paid) coverage
Employees have up to 31 days from the end of their eligibility waiting period to enroll themselves and any eligible dependents for coverage (this is the initial enrollment period).

- If coverage does not require approval of evidence of insurability, the employee and/or dependents will be effective the first of the month following completion of the new employee waiting period.
- If evidence of insurability is required and coverage is approved by LifeMap, the employee and/or dependents will be effective the first of the month on the later of: completion of the new employee waiting period; or approval by LifeMap. There are no mid-month effective dates.

Refer to the Enrollment sections within this guide for the enrollment requirements, and the Group Policy for specifics regarding eligibility waiting periods, coverage waiting periods, and effective dates of coverage.

When do employees or dependents need to submit evidence of insurability?

Evidence of insurability will need to be provided for an employee or dependent as outlined in the Evidence of Insurability section of your group's policy and this guide. Some common reasons include, but are not limited to:

- The amount applied for is over any guarantee issue amount.
- An employee wants to increase coverage for self or dependents.
- Application for coverage is made after the initial enrollment period (late enrollee).

Is there an annual enrollment period?

Annual enrollment is only available if provided specifically by your LifeMap policy. If provided by your policy, annual enrollment is a period of time as determined by the Employer and LifeMap when employees and/or dependents may enroll for coverage if enrollment did not occur during the initial enrollment period.

When can a change in coverage be requested?

If additional coverage options are available, an employee may request to increase or decrease the amount of coverage for themselves or an eligible dependent during the annual enrollment period. Increases in coverage are subject to evidence of insurability. If coverage is approved by LifeMap, the employee and/or dependent will be effective on the later of: the requested effective date; or date assigned by LifeMap upon approval. The pre-existing conditions limitation will apply to any increase from the date the increase becomes effective. An increase in coverage will only be effective if the insured/employee is actively at work, or for dependents, the dependent is not totally disabled. There will be no mid-month effective dates.

Claim Submission

The Critical Illness Cancer Care Claim Form can be found on LifeMapCo.com. For assistance in submitting Critical Illness claims or to request a claim form, you may contact a Claims Representative at 1(800) 286-1129.

How is the Critical Illness claim form completed and submitted?

The **Critical Illness Cancer Care Claim Form** is downloadable for printing from the Forms tab on LifeMapCo.com. The form includes separate sections for the insured and the physician. To avoid a delay in the processing of a claim, all sections should be completed in full and signed.

1. The insured (or their legal representative) must complete and sign the **Insured's Statement** and the **Authorization to Obtain and Release Information** sections of the form.
2. The insured's attending physician must complete and sign the **Attending Physician's Statement** section of the form.

All pages of the claim form and any supporting documentation should be sent to LifeMap Claims. Refer to Claims and Appeals in the **Contact and Mailing Information** section at the beginning of this guide or the claim form for the mailing address.

Claim Determination

Is there a pre-existing condition exclusion?

The Critical Illness plan may include a pre-existing condition exclusion. If the Group Policy includes a pre-existing condition exclusion, then any loss for an illness or procedure that is caused by a pre-existing condition are not covered under the Group Policy for a specified period of time. Refer to your group's policy to see if a pre-existing condition exclusion applies to your Critical Illness benefits.

Benefit Determination

To whom are benefit checks paid?

All benefits are payable to the employee. Any benefit paid upon the death of an employee will be paid to the Employee's Estate.

How can a denied claim be appealed?

The insured (or legal representative) has 180 days after receiving a claim denial to appeal. The appeal must be submitted in writing and must provide specific information outlining why the employee disagrees with LifeMap's decision, along with any additional documentation that was not previously submitted. Additional information to support the appeal may include medical records, test results, or payroll records.

If the denial was due to a waiting period or effective date issue, proof is required to support the employee's eligibility. Appropriate proof may include an enrollment form or copies of payroll deductions.

The written appeal and all supporting documentation should be sent to LifeMap Claims. Refer to Claims and Appeals in the **Contact and Mailing Information** section at the beginning of this guide.

LifeMap will provide a written response within 45 days from receipt of the appeal to advise the claimant if additional information is needed or if a decision has been reached. If additional review time is required, the employee will receive a letter outlining the reason for the delay. The appeal determination will not take longer than 90 days provided all documentation is received in a timely manner.

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Accident Only Insurance Administration Guidelines

Refer to the Group Policy(ies) to determine if this coverage is available to your group.

Accident Only coverage provides a specific benefit amount for a specific injury, treatment, or expense due to covered accident. The Employer has the option of providing dependent coverage along with the employee coverage. If dependent coverage is available, all eligible employees and dependents are covered for the same accidents and conditions.

Enrollment and Eligibility

When are employees and dependents eligible?

Employees are eligible for coverage after completing the eligibility waiting period indicated in the policy.

Non-contributory (employer-paid) coverage
Eligible employees will be effective first of the month following completion of the new employee waiting period. Eligible dependents will be effective on the same day as the employee.

Contributory and/or Voluntary (employee-paid) coverage
Employees have up to 31 days from the end of their eligibility waiting period to enroll themselves and any eligible dependents for coverage (this is the initial enrollment period).

If enrollment for coverage is made during the initial enrollment period, the employee and all eligible dependents will be effective the first of the month following completion of the new employee waiting period. If enrollment for coverage is made after the initial enrollment period or during the annual enrollment period, the employee and all eligible dependents will be effective on the earlier of: first of the month based on election date; or first of the month following the receipt of the application for coverage. There will be no mid-month effective dates.

Refer to the Group Policy for specifics regarding eligibility waiting periods and the effective dates of coverage.

Is there an annual enrollment period?

Annual enrollment is only available if provided specifically by your LifeMap policy. If provided by your policy, annual enrollment is a period of time as determined by the Employer and LifeMap when employees and/or dependents may enroll for coverage if enrollment did not occur during the initial enrollment period.

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Claim Submission

The Accident Claim Form can be found on LifeMapCo.com. For assistance in submitting Accident claims or to request a claim form, you may contact a Claims Representative at 1(800) 286-1129.

How is the Accident Only claim form completed and submitted?

The **Accident Claim Form** is downloadable for printing from the Forms tab on LifeMapCo.com**.** The form includes separate sections for the insured, attending physician and Employer. To avoid a delay in the processing of a claim, all sections should be completed in full and signed.

1. The insured (or legal representative) must complete and sign the **Insured's Statement** and the **Authorization to Obtain and Release Information** sections of the form.
2. The insured's attending physician must complete and sign the **Attending Physician's Statement** section of the form.
3. The Employer or Group Administrator is responsible for completing the **Employer's or Administrator's Statement** section of the form.

All pages of the claim form and any supporting documentation, such as; copies of all itemized bills (not EOBs), any motor vehicle/incident/accident reports, and/or police reports related to the accident, should be sent to LifeMap Claims. Refer to Claims and Appeals in the **Contact and Mailing Information** section at the beginning of this guide or the Claim Filing Instruction sheet for email, fax and mailing address.

Benefit Determination

To whom are benefit checks paid?

Benefits for accidental death of employee will be paid to the Beneficiary(ies). Benefits for ambulance transportation will be paid directly to the provider of the ambulance transportation. All other benefits are payable to the employee. Refer to the Group Policy for additional payment details.

How can a denied claim be appealed?

The insured (or legal representative) has 180 days after receiving a claim denial to appeal. The appeal must be submitted in writing and must provide specific information outlining why the employee disagrees with LifeMap's decision, along with any additional documentation that was not previously submitted. Additional information to support the appeal may include medical records, test results, or payroll records.

If the denial was due to a waiting period or effective date issue, proof is required to support the employee's eligibility. Appropriate proof may include an enrollment form or copies of payroll deductions.

The written appeal and all supporting documentation should be sent to LifeMap Claims. Refer to Claims and Appeals in the **Contact and Mailing Information** section at the beginning of this guide.

LifeMap will provide a written response within 45 days from receipt of the appeal to advise the claimant if additional information is needed or if a decision has been reached. If additional review time is required, the employee will receive a letter outlining the reason for the delay. The appeal determination will not take longer than 90 days provided all documentation is received in a timely manner.

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LifeMap Member Advantages

LifeMap Member Advantages is a program available to all LifeMap members who have an in-force insurance policy that is issued by, administered by, or serviced by LifeMap. Member Advantages provides access to certain value-added services and products that are not insurance and are offered in addition to your plan(s) to help members stay healthy and live better.

Advantages programs available may include:

- Allergy Relief
- Alternative Medicine
- Dental supplies
- Fertility Services
- Funeral Planning
- Healthy Lifestyle options
- Hearing Services
- Pet Care
- Senior Solutions
- Vision Services

Visit LifeMapCo.com/member-advantages for details and the latest programs available.

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Premium Calculation Examples

The following premium calculation examples are applicable for all lines of insurance and may or may not be part of the Employer's current insurance offerings.

Rates and benefits shown on the next few pages are for illustrative purposes only. See the Group Policy for actual benefit amounts.

Age-Rated and Contributory/Voluntary Premium

What age should be used to calculate premium?

If coverage is age-rated, when an employee or applicant is first enrolled and effective the premium will be determined based on the employee's or applicant's age, as of the last anniversary date for your group. If an insured's age changes from one age band to another while covered, the premium will increase or decrease, whichever is applicable, on the group's next policy anniversary date. If a claim should occur between anniversary dates, we will pay claims based on the actual age of the insured at time of claim.

How much should be deducted from the employee's paycheck and when?

If applicable, deduct premiums from the employee's paycheck to cover the amount not subject to evidence of insurability (up to the guarantee issue amount). If amount requested requires evidence of insurability, you will begin deductions for the full amount of premium based on the effective date provided by LifeMap's written approval.

Calculating Premium

Follow the formulas included in the examples on the next few pages to calculate the premium due for a particular product. Refer to the benefit schedule in the Group Policy to determine the benefit amounts available to employees.

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Employee Basic Life and AD&D Insurance Volume

Per Employee Calculation of Volume: Multiple of Salary Benefit (Benefit Schedule)

1. Annual Salary x Multiple of Salary = Benefit
2. Round the result from #1. The rounding rule is to round up to the next higher $1,000.
3. Compare the benefit determined in #2 to the plan maximum; cap the employee's benefit at the plan maximum if necessary.
4. The benefit amount must be reduced if an employee's age falls into the age reduction schedule. Reduction is based on the percentages listed in the benefit schedule provided in the Group Policy.
5. The final benefit amount, including any reductions for an employee's age, is the employee's volume.

Per Employee Calculation of Volume: Flat Benefit (Benefit Schedule)

1. The flat benefit amount is the employee's volume.
2. The benefit amount must be reduced if an employee's age falls into the age reduction schedule. Reduction is based on the percentages listed in the benefit schedule provided in the Group Policy.
3. The final benefit amount, including any reductions for an employee's age, is the employee's volume.

Example: Basic Life and AD&D Insurance Premium

Basic Life and AD&D monthly rates are usually per $1,000 of insurance. Base the premium calculations on the actual benefit amounts provided to each employee in thousands, taking into account age reductions where appropriate.

Use this formula to calculate the cost:

1. Total the volume of coverage for all insured employees.
2. Divide total volume by 1,000.
3. Life premium calculation: multiply the result from #2 by the monthly Life premium rate to determine total monthly Life premium due.

Volume / 1,000 x Monthly Premium Rate = Premium

Example
Life Insurance for all covered employees
610,000 Volume/1,000 = 610
610 x $0.30 rate = $183.00
AD&D Insurance for all covered employees
610,000 Volume/1,000 = 610
610 x $0.05 rate = $30.50
Total Combined Monthly Premium = $213.50
($183.00 + $30.50 = $213.50)

4. AD&D premium calculation: multiply the result from #2 by the monthly AD&D premium rate to determine total monthly AD&D premium due.

NOTE: Life and AD&D premium and volume must be reported separately on your summary bill template.

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Dependent Basic Life Insurance Volume

To determine the dependent life volume, use the higher volume between spouse and child. (i.e. Spouse $10,000; Child $5,000) and multiply by the total number of benefit eligible employees.

Example: 100 employees that are benefit eligible and all are charged for dependent life with or without dependents a rate of .65 PEPM

Cost calculation 100 x .65 = $65.00

Volume calculation 100 x 10,000 = $1,000,000.

Examples: Dependent Life Premium

Dependent Life is billed in one of three ways:

1. 100% employer paid for employees with or without dependents, 100% participation required
   - 50 employees x .50 PEPM = $25.00 per month
2. 100% employer paid for employees ONLY with dependents, 100% participation of employees with dependents required
   - 50 employees, 30 have dependents: 30 x .60 Per Family Unit = $18.00 per month
3. 50%-99% employer paid with a minimum of 75% participation of employees with dependents enrolling required
   - 50 employees, 30 have dependents, a minimum of 23 must be enrolled for coverage to be put in place: 23 x .67 Per Family Unit = $15.41 per month

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Voluntary Life and Voluntary AD&D Insurance Premium

Use this formula to calculate the cost for employees and spouses:

1. Total the volume of coverage for the insured individual.
2. Divide total volume by 1,000.
3. Multiply the result from #2 by the monthly premium rate to determine total monthly premium due.

Volume / 1,000 x Monthly Premium Rate = Premium

Example

Voluntary Life Insurance for an insured employee
300,000 Volume/1,000 = 300
300 x $0.07 (rate for Employee's age) = $21.00

Voluntary AD&D Insurance for an insured employee
300,000 Volume/1,000 = 300
300 x $0.03 (rate for Employee Voluntary AD&D) = $9.00

Total Monthly Premium for Voluntary Life Only = $21.00
Total Monthly Premium for Voluntary AD&D Only = $9.00
Total Monthly Premium for Combined Voluntary Life and Voluntary AD&D = $30.00 ($21.00 + $9.00)

Voluntary Life Insurance for dependent child(ren)
10,000 Volume/2,000 = 5
5 x $0.02 (rate) = $0.10

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Long Term Disability (LTD) Insurance Volume (Covered Payroll)

Per Employee Calculation of Volume (Covered Payroll): Benefit Percentage: 60%

1. Divide the LTD plan's maximum monthly benefit by the plan's benefit percentage to determine the LTD plan's maximum covered payroll (maximum covered salary).

   Example:

Maximum Monthly Benefit		Benefit Percentage		Maximum Covered Payroll (maximum covered salary)
$6,000	/	60% (0.60)	=	$10,000

2. Calculate the monthly salary for each insured employee.

Example:	Annual Salary		Number of Months		Monthly Salary
	$50,000	/	12	=	$4,166.6666 ($4,167)

3. Round the result from #2 up to the next higher $1.
4. If the employee's monthly salary exceeds the plan's maximum covered payroll, the employee's salary must be capped at the maximum covered payroll.
5. The final monthly salary or capped monthly salary for the insured employee is the employee's volume (Monthly Covered Payroll).

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Long Term Disability (LTD) Premium

LTD monthly rates are per $100 of insured Monthly Covered Payroll (MCP). Premium calculations are therefore based on MCP.

Use this formula to calculate the total monthly premium:

1. Divide the monthly covered payroll for each insured employee by 100.
2. Multiply the result from #1 by the LTD monthly premium rate. The result is the monthly premium.
3. Add together each insured employee's result from #2 for the total monthly premium due.

Example: Monthly Covered Payroll (MCP) / 100 x Rate = Premium

LTD for one insured employee

$4,177 (MCP) / 100 = 41.77

41.77 x $0.66 (rate) = $27.57

LTD for all insured employees

$28,343 (MCP) / 100 = 283.43

283.43 x $0.66 (rate) = $187.06

Total Group Monthly Premium = $187.06

Example: Volume/Premium using a 60% to $5,000 Maximum Monthly Benefit using a rate of $0.66 per $100 of Covered Payroll

$5,000 / 0.60 (60%) = $8,333 Maximum Covered Payroll

Job Title	Annual Salary	Monthly Salary	Maximum MCP	MCP to be used for premium calculation
CEO	$500,000	$41,667	$8,333	$8,333
CFO	$280,000	$23,333	$8,333	$8,333
Manager	$50,123	$4,177	$8,333	$4,177
Clerk	$25,000	$2,083	$8,333	$2,083
Sales	$65,000	$5,417	$8,333	$5,417

Total MCP	$28,343.00
Total MCP divided by 100	$283.43
Times rate per $100 of MCP	$0.66
Monthly Premium	$187.06

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Short Term Disability (STD) Insurance Volume

Per Employee Calculation of Volume: Benefit is Salary Based (Benefit Schedule)

1. Determine each insured employee's weekly salary

   Example:

Annual Salary		Number of Weeks		Weekly Salary
$65,000	/	52	=	$1,250.00

2. Round the result up to the nearest $1.00, if necessary
3. The employee's weekly salary times the benefit percentage equals the employee's weekly benefit.

   Example:

Weekly Salary		Benefit Percentage		Weekly Benefit
$1,250.00	x	60%	=	$750

4. If the employee's calculated weekly benefit exceeds the plan's weekly benefit maximum, the employee's benefit must be capped at the weekly benefit maximum.

   Example: Benefit plan of 60% to $1,500 Employee's Annual Earnings $280,000

Annual Salary		Number of Weeks		Weekly Salary
$280,000	/	52	=	$5,385.00

Weekly Salary		Benefit Percentage		Weekly Benefit	Capped Amount
$5,385.00	x	60%	=	$3,231.00	$1,500.00

5. The final weekly benefit amount (capped if necessary) for each insured employee is each employee's volume.

Per Employee Calculation of Volume: Weekly Flat Benefit (Benefit Schedule):

The weekly flat benefit amount elected for each insured employee is the employee's volume.

1. Flat benefit for all employees $200 per week
2. Divide the flat benefit ($200) by $10 (rates is based on $10 increments) to get $20.00
3. Multiply increments by rate to get per employee per monthly premium

   $20. X rate .225 = $4.50 PEPM

4. Multiply $4.50 PEPM x # of employees to get group monthly premium.

   $4.50 x 2,560 = $11,520

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Short Term Disability (STD) Premium

STD monthly rates are either per $10 of each insured employee's covered weekly benefit or per insured employee per month.

Use this formula to calculate the total monthly premium when premium is per $10 of weekly benefit:

1. Total the volume of coverage for all insured employees.
2. Divide total volume by 10.
3. Multiply the result from #2 by the STD monthly premium rate to determine total monthly premium due.

Example: Volume / 10 x per $10 Rate = Monthly Premium

10,937 Volume/10 = 1,093.70 x $0.225 (rate) = $246.08 monthly premium

Use this formula to calculate the total monthly premium when rates are per employee per month:

1. Total the number of insured employees.
2. Multiply the result from #1 by the STD monthly premium rate to determine total monthly premium due.

Example: No. of Employees x Per Employee Per Month Rate = Monthly Premium

17 x $5.00 (rate) = $85.00 monthly premium

Example: Volume/Premium using a 60% to $1,500 maximum weekly benefit, using a rate of $0.50/$10 of Covered Benefit

Job Title	Annual Salary	Weekly Earnings	Weekly Benefit	Maximum Weekly Covered Benefit	Weekly Covered Benefit to be used for premium calculation
CEO	$500,000	$9,615	$5,769	$1,500	$1,500
CFO	$280,000	$5,385	$3,231	$1,500	$1,500
Manager	$50,123	$964	$578	$1,500	$578
Clerk	$25,000	$481	$288	$1,500	$288
Sales	$65,000	$1,250	$750	$1,500	$750

Total Weekly Covered Benefit	$4,616.00
Total Weekly Covered Benefit divided by 10	$461.60
Times rate per $10 of Weekly Covered Benefit	$0.225
Monthly Premium	$103.86

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Dental Insurance Premium

Dental premium is based on who the insured employee is covering. Is it the Employee Only (EE), the Employee and Spouse (ES), the Employee and Child(ren) (EC) or the Employee, Spouse, Child(ren) (EF).

There are various tier structures, with 4-tier being the most common.

Example: Dental 4-Tier Premium

Tier Rates	# of Employees Enrolled	Rate	Premium	
EE Only	6	23.00	(23.00 x 6)	$138.00
ES	4	46.20	(46.20 x 4)	$184.80
EC	5	45.80	(45.80 x 5)	$229.00
EF	3	99.00	(99.00 x 3)	$297.00
		Total Monthly Premium		$848.80

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Vision Insurance Premium

Vision premium is based on who the insured employee is covering. Is it the Employee Only (EE), the Employee and Spouse (ES), the Employee and Child(ren) (EC) or the Employee, Spouse, Child(ren) (EF).

The tier structure LifeMap administers is a 4-tier.

Example: Vision 4-Tier Premium

Tier Rates	# of Employees Enrolled	Rate	Premium	
EE Only	6	4.99	(4.99 x 6)	$29.94
ES	4	9.96	(9.96 x 4)	$39.84
EC	5	10.66	(10.66 x 5)	$53.30
EF	3	17.05	(17.05 x 3)	$51.15
		Total Monthly Premium		$174.23

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Critical Illness Insurance Volume

The critical illness benefit amount elected by each employee, spouse, or dependent child(ren) is the insured's volume. If applicable, the volume may be reduced due to age.

Examples: Critical Illness Per Insured Premium

Critical illness monthly rates are usually based on per $5,000 of insurance (volume). Base the premium calculations on the actual benefit amount elected by each employee, spouse, or dependent child(ren) in increments of one thousand (1,000), taking into account age-banded rates and age reductions where appropriate. One rate covers all eligible dependent children in the family regardless of number.

Use this formula to calculate the total monthly premium for an employee and/or spouse using age-banded rates:

1. Determine the per $5,000 rate for each insured employee and spouse based on the insured employee's or spouse's age.

   Example: Employee age 43 Rate: $5.334/$5,000 Amount of coverage $20,000

   Spouse age 39 Rate: $3.449 Amount of coverage $10,000

2. Divide the insured's elected amount by 5,000.

   Example: Employee $20,000 / $5,000 = 4

   Spouse $10,000/ $5,000 = 2

3. Multiply the insured's employee or spouse rate as determined in #1 by the result from #2 to determine the total monthly premium due for each insured employee and spouse.

   Example: Employee 4 x$5.334 = $21.336 – round to nearest cent $21.34

   Spouse 2 x $3.449 = $6.898 – round to nearest cent $6.90

4. Employee and spouse premium must be reported separately.

Use this formula to calculate the total monthly premium for dependent child(ren):

1. The rate and benefit amounts are only calculated once, regardless of number of children covered.
2. Divide the child(ren) elected amount by 1,000.

   Example for one employee's child(ren):

   Child Rate .12/$1,000 Amount of Coverage $5,000 $5,000/$1,000 = 5

3. Multiply the result from #2 by the child $1,000 monthly rate to determine the total premium due per employee electing dependent child(ren) coverage.

   Example: Child 5 x .12 = .60

4. Add together each result from #3 for the total dependent child(ren) monthly premium due.

Use this formula to calculate the total monthly premium for an employee when coverage is 100% employer-paid:

1. Divide the insured employee's benefit amount by 5,000.
2. Multiply the result from #1 by the employee per $5,000 monthly premium rate to determine the total premium due for each employee.
3. Add together each insured employee's result from #2 for the total monthly premium due.

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Accident Only Insurance Premium

Accident insurance is Tier billed, similar to Dental and Vision, and based on who the insured employee is covering. The tiers are: Individual, Employee and Spouse, One parent + Child(ren) or Family. Accident can also be sold with a Wellness Rider and/or a Sickness Hospital Confinement Rider of which both have the same tiering structure.

If coverage includes the Wellness Rider, then all insureds covered under the Accident Only plan, will also be automatically covered under the Wellness Rider.

If coverage elected by the Employer includes the Sickness Hospital Confinement Rider, then an insured must elect the Rider in order to have it included with the Accident Only plan.

Cost Summary	Accident Rate	Wellness Rider Rate	Sickness Hospital Confinement Rider Rate
Individual	$14.84	$2.44	$8.97
Employee and Spouse	$28.69	$4.88	$17.94
One Parent + Child(ren)	$26.66	$3.42	$12.49
Family	$41.88	$5.86	$21.46

Example: Accident with both Wellness and Sickness Hospital Confinement Riders

Tier Rates	# of Employees Enrolled	Rates	Premium	
Individual	6	14.84 + 2.44 + 8.97	(26.25 x 6)	$157.50
Employee and Spouse	4	28.69 + 4.88 + 17.94	(51.51 x 4)	$206.04
One Parent + Child(ren)	5	26.66 + 3.42 + 12.49	(42.57 x 5)	$212.85
Family	3	41.88 + 5.86 + 21.46	(69.20 x 3)	$207.60
		Total Monthly Premium		$783.99

FMLA and Leave Management

FMLA and Leave Management rates are calculated on a per employee per month (PEPM) basis. Base the calculations on the PEPM rates as noted on the summary bill template.

Example: FMLA and Leave Management Premium

Use this formula to calculate the cost:

PEPM rate x total number of covered employees = FMLA and Leave monthly premium

($1.25 (rate) x 312 (total number of covered employees) = $390.00 (monthly rate)

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