Financial Protection

Product Administration Guide

UnitedHealthcare®

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Welcome

Thank you for selecting UnitedHealthcare for your insurance needs.

Contact and Mailing Information

The most frequently used contact numbers and addresses for UnitedHealthcare Specialty Benefits are listed below.

Topic	Contact	
Beneficiary Services	**Life Beneficiaries** Customer Service: (866) 302-4480	
Billing	**Inquiries/Questions** Customer Service: (866) 322-1210 Opt #1 Email: life_billing@uhc .com Fax: (612) 367-0986	
Claims	**Life Claims** Customer Service: (888) 299-2070 Fax: (800) 980-0298 Mailing Address: UnitedHealthcare P.O. Box 7149 Portland, ME 04112-7149 **Disability Claims (STD/LTD)** Customer Service: (888) 299-2070 Fax: (888) 505-8550 Mailing Address: UnitedHealthcare P.O. Box 7466 Portland, ME 04112-7466 **Critical Illness Claims** Customer Service: (888) 299-2070 Fax: (888) 505-8550 UnitedHealthcare P.O. Box 7466 Portland, ME 04112-7466	**Accident Protection Plan Claims** Customer Service: (800) 539-0038 Fax: (888) 505-8550 UnitedHealthcare P.O. Box 7466 Portland, ME 04112-7466 **FMLA & Leave Management Requests** Customer Service: (866) 556-8298 Fax: (888) 505-8550 UnitedHealthcare P.O. Box 7466 Portland, ME 04112-7466
Conversion	**Life Conversion** Conversion Customer Service: (888) 999-4767 Fax: (978) 762-4767	Mailing Address: HRMP Life Conversion Facility 300 Rosewood Drive, Suite 250 Danvers, MA 01923
Enrollment	**Life/ Disability/Critical Illness/Accident** Customer Service: (866) 322-1210 Opt #4 Email: life_eligibility@uhc .com Fax: (612) 367-0985	Mailing Address: UnitedHealthcare MN017-E800 9700 Healthcare Lane Minnetonka, MN 55343
Evidence of Insurability	**Inquiries/Questions** Customer Service: (866) 615-8727 Opt #3 - Opt #1 Email: eoi_underwriting@uhc .com Fax: (855) 290-5224	Mailing Address: Group Medical Underwriting Services P.O. Box 17829 Portland, ME 04112

List Billed Group Administration Guidelines

Enrollment Checklist

Please use this checklist to ensure that you meet the group enrollment administrative requirements.

☐ Review **Enrollment Form** for legible, complete and accurate information prior to forwarding to UnitedHealthcare.

☐ Be sure the employee has signed and dated the form.

☐ Complete the section marked "Completed by the Employer."

☐ Check that all necessary information has been provided, such as (but not limited to):

- ☐ Effective Date of Coverage
- ☐ Company Name and Division/Billing Location
- ☐ Social Security Number or Alternate ID
- ☐ Date of Full-Time Employment or Rehire Date
- ☐ Salary and Salary Mode
- ☐ Employee's Job Title
- ☐ Date of Birth
- ☐ Gender
- ☐ Employee's Full Home Address and Telephone Number

If applicable,

- ☐ Check that Beneficiary Information is completed.
- ☐ For contributory plans (Employee Paid), all desired insurance is checked.

Enrollment of New Hires

How do I enroll a new employee?

1 . Complete an **Enrollment Form** immediately after a new employee is eligible for insurance. This serves as the basic insurance record. Double check the form to be sure it is filled out completely. UnitedHealthcare may return incomplete forms.

2 . Keep a copy for your records.

3 . Fax or mail the form to UnitedHealthcare.

4 . All forms must be received within 60 days of the employee's effective date.

FAX completed forms to:		MAIL completed forms to:
(612) 367-0985	OR	UnitedHealthcare MN017-E800 9700 Healthcare Lane Minnetonka, MN 55343

☐ **Do not mail** enrollment forms with your premium payment.

☐ **Do not mail** the originals if you have faxed your enrollments.

What are the guidelines for Non-Contributory insurance?

If the **employer pays the full cost** of insurance, 100 percent of all eligible employees must be enrolled. Eligible employees cannot waive non-contributory insurances.

What are the guidelines for Contributory insurance?

☐ If the **employee pays any portion of the cost** of insurance, the employer should offer the employee the insurance.

☐ If insurance is elected, complete and submit an Enrollment Form.

☐ The employee's signature serves as the payroll deduction authorization.

Enrollment of Rehired Employees

Who is a rehired employee?

Any employee who returns to work after temporary termination may request insurance.

How do I enroll a rehired employee?

1. Complete a new **Enrollment Form** and include the rehire date* and current information. Double check the form to be sure it is filled out completely. UnitedHealthcare may return incomplete forms.
2. Keep a copy for your records.
3. Fax or mail the form to UnitedHealthcare.
4. All forms must be received within 60 days of the employee's effective date.
5. Begin payroll deductions after receiving the Notice of Approval.

FAX completed forms to:		MAIL completed forms to:
(612) 367-0985	OR	UnitedHealthcare MN017-E800 9700 Healthcare Lane Minnetonka, MN 55343

☐ **Do not mail** enrollment forms with your premium payment.

☐ **Do not mail** the originals if you have faxed your enrollments.

Why is the rehire date* important?

The rehire date will be used to determine eligibility, unless otherwise noted in the group insurance policy.

*The rehired employee may be considered a late applicant if applying for insurance more than 31 days after the date of eligibility. See Enrollment of Late Applicants Administration Guidelines.

Enrollment of Late Applicants

Who is a late applicant?

Any employee who applies for insurance more than 31 days after the date of eligibility is a late applicant.

Life & Disability

Non-Contributory Insurance (Employer Paid)

In the event an administrative error accidentally leaves an employee off the company's remittance to the insurer, insurance for the unintentionally omitted employee will be made effective on the employee's original effective date. Your company must pay all back premiums.

Contributory Insurance (Employee Paid)

The employee must submit the following completed forms:

- ☐ Enrollment Form.
- ☐ Evidence of Insurability Form, for any insurance issued over the guarantee issue amount.

The employee will be added after UnitedHealthcare sends a written Notice of Approval. If evidence of insurability was required, do not begin payroll deduction until you receive written Notice of Approval.

When is Evidence of Insurability required?

Evidence of insurability may also be required if an employee is applying for dependent coverage more than 31 days following the eligibility date.

- ☐ A completed **Evidence of Insurability Form** will be required for each dependent.
- ☐ The dependents may only be added to the plan after written approval is received.

How does Evidence of Insurability affect Guarantee Issue?

The amount not subject to evidence of insurability is the maximum benefit UnitedHealthcare will underwrite without requiring evidence of insurability. The amount not subject to evidence of insurability is only available during the first 31 days an employee is eligible for insurance. Any employee not applying within that time frame is not entitled to any Guarantee Issue insurance.

- ☐ Evidence of Insurability is required should the employee request a benefit amount or benefit increase, which exceeds the Guarantee Issue amount.
- ☐ An Evidence of Insurability Form must be submitted, and the excess benefit amount will be underwritten.

Note: Do not begin deducting any amounts/increases until you receive a written Notice of Approval.

Reporting Adjustments and Changes

How do I report changes and adjustments?

Use the **Enrollment Form** to report any of the following changes as they occur:

☐ Terminations of employee benefits.

☐ Occupational class changes.

☐ Salary changes (if benefit is salary-based, see below)

☐ Name change.

☐ Marital status change

☐ Dependent insurance change.

1. Complete an Enrollment Change Form immediately before the first of each month. 2.

Keep a copy for your records.

3 . Fax or mail the form to UnitedHealthcare.

4 . All forms must be received within 60 days of the change effective date.

5 . Enrollment forms must be received five business days prior to the 15th of the month to be included in the next month's invoice.

FAX completed forms to:
(612) 367-0985

OR

MAIL completed forms to:
UnitedHealthcare
MN017-E800
9700 Healthcare Lane
Minnetonka, MN 55343

☐ **Do not mail** enrollment forms with your premium payment.

☐ **Do not mail** the originals if you have faxed your enrollments.

How do salary changes affect premium?

Premium will be adjusted based on reported salary changes. Report salary changes as they occur on all employees whose insurance is determined according to their earnings.

How do additions and terminations affect premium?

☐ If an employee terminates after the premium due date, premiums are due for the entire month.

☐ If an employee is effective on or before the 15th of the month, premium will be charged for the entire month. If the employee is effective after the 15th of the month, premium will not be charged until the next premium due date. UnitedHealthcare does not prorate premium.

How do I add new employees resulting from merger or purchase of another company?

Notify your broker and your Regional UnitedHealthcare Sales Office. Provide the following information:

☐ Complete census or Enrollment Forms.

☐ Date of acquisition.

☐ Name of acquisition.

☐ Effective date of insurance.

Billing Statements and Premium Payment Procedure

When will I receive a Billing Statement?

You will receive a billing statement 10 days prior to the premium due date.

What does the Billing Statement include?

Clients who have selected list billing will receive statements that include:

☐ A list of each insured employee listed under the plan and premium date.

☐ A report of adjustments made from the previous month's statement, including a Summary page.

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

How do I mail premium payments?

It is very important to pay as billed. Your premium is due on or before the due date listed on your billing statement.

☐ To ensure proper credit on your account, you must use the Invoice Remittance page provided as the top of the cover sheet for the bill.

☐ If you have more than one bill coming to your address, send all Invoice Remittance pages with your payment.

☐ Document changes on the detailed invoice and submit along with your premium payment. (For new enrollment, refer to the Enrollment Administrative Guidelines.)

☐ Mail premium payments as indicated below.

MAIL payments to:

P. O. Address:
UnitedHealthcare
P. O. Box 860511
Minneapolis, MN 55486-0511

Overnight Address:
UnitedHealthcare
Lockbox 860511
1200 Energy Park Drive
St . Paul, MN 55108

OR

Overnight payments to:
UnitedHealthcare 2485
C/O Citibank Lockbox Operations
8430 W. Bryn Mawr Avenue, 3rd Floor
Chicago, IL 60631

To avoid delays in posting your payment to your account, do not mail your payment to our street address.

☐ Completing the Electronic Payment Authorization Form to utilize the online payment option using the e-Bill system.

☐ Submitting the Invoice Detail and payment, using the e-Bill system.

☐ Scheduled Direct Debit ACH to schedule monthly payments based upon "Payment Date" selection during the setup process, on either the 10th or the 25th calendar day of the month.

Forms for List Billed Groups

As the plan administrator, you should be familiar with several forms, including the following:

☐ Enrollment Form

☐ Evidence of Insurability

Life of a Claim

Financial Protection Products

Our Approach

Based in Maine, the claims unit for UnitedHealthcare's Financial Protection Products offer full lifecycle claim management and support out of a single office.

Intake, Indexing and Customer Service

Our customers can file a claim through several different channels — mail, email, fax or phone. Once materials make their way over to UnitedHealthcare's office, they are electronically scanned and indexed to the appropriate claim file. If no claim file currently exists, one is created.

Once all materials are received, the next step is to "post" the claim, meaning that it is assigned to a claim specialist. This process happens within 24 hours of the receipt of paperwork.

As an example — for any disability claim we would require:

1. Attending Physician Statement
2. Employee Statement
3. Employer Statement

Once these three documents are received, the claim can be posted for review.

Ongoing customer support is provided by the customer service team who work Monday to Friday 8 a.m. to 6 p.m. EST. Calls to our team range from claimants, brokers and employers and are recorded for quality assurance. UnitedHealthcare's Financial Protection customer service team receives over 30,000 calls per year and the goal is to answer these calls in less than 30 seconds. Those calls received after-hours will be returned the next business day.

Claim Review

The claim review process is a primary information gathering stage where documentation from the employer, employee and attending physician (if needed) are reviewed for accuracy and eligibility per the contract. Depending on the product, some claims can become actively managed for a longer period of time (up to and including permanent and total disability) . Once all of the information is gathered and assessed, a decision is made to pay, pend or close the claim.

Clinical and Vocational Resources

The clinical and vocational team have direct face-to-face interaction with our claim specialists (both teams are located in the same office). This provides easier communication internally which results in better coordination of efforts in the claim review process. This team also provides specialized training and support for the claim's organization.

The clinical team leads the review process for any vocational, disability or critical illness items that may arise, including Occupational Analysis, Transferrable Skill Analysis and Labor Market surveys. Our staff includes a full-time medical director, physician/vocational consultants and a team of full-time RNs.

Taxation Guide

Financial Protection Products

This guide should provide a high-level overview concerning the tax effects of UnitedHealthcare's Financial Protection Products: Group Life, Disability, Accident, Critical Illness and Hospital Indemnity.

Current Landscape

As healthcare costs increase throughout much of the country, employers are increasingly looking to broaden their offerings to protect their employees from financial hardship. Although percentages differ, medical expenses are a major cause of bankruptcy filing due to sickness or accident.

24 .5 Million:

Out of work or limited in work due to disability or health problem.

It is critical that employers understand various options when considering their plan design. In the example below, assume that a 25-year-old individual currently makes $50,000 with a 5 percent annual raise. We will see how taxation affects disability payments on the next page.

$6 Million:

Potential lost salary of a 25-year-old making $50K per year (to age 65).

Disability Taxation

The taxability of disability insurance is spelled out in the Internal Revenue Code (IRC) and additional detailed information can be found in IRS Publication 15-A. Disability insurance is categorized by the IRS as "sick pay" benefits and the taxation determination has to do with how the premiums for the insurance are paid.

Premium funding methods	Percentage taxable to employee
Employer Pays 100%	100%
ER Pays Portion / EE Pays w/AFTER-Tax Dollars	Only the % paid by ER
ER Pays Portion / EE Pays w/Pre-Tax Dollars	100%
EE Pays 100% w/AFTER-Tax Dollars	None
EE Pays 100% w/Pre-Tax Dollars	100%

Taxation and Monthly Benefit

The taxation of the monthly benefit greatly reduced the percentage of replacement income available to a claimant. In the example below, we have a claimant who is making $36,000 in pre-disability earnings with a 60 percent monthly benefit amount who is in a 25 percent tax bracket:

Funding Method	Monthly Covered Salary	Disability Benefit	Tax	Final Benefit Amount	Effective % of Pre-Disability Earnings
ER Pays 100%	$3,000	$1,800	25%	$1,350	45%
EE Pays 100% (Post Tax)	$3,000	$1,800	None	$1,800	60%

Disability "Gross Up"

If an employer is funding the group disability coverage, the concept of "gross up" can be used as a strategy for greater income replacement. "Gross up" means that the employer inflates the employee's salary in order to fund premiums which, in effect, provides a tax-free benefit while on claim.

The premiums for a "gross up" disability plan differ from a standard plan slightly due to the increased carrier risk (larger salary replacement paid out over time). Using the information above, we can illustrate two differing plan designs and how "gross up" could alter the effective benefits received by the claimant:

Benefit Amount	Monthly Covered Salary ($36K / 12)	Disability Benefit	Tax	Final Benefit Amount	Effective % of Pre-Disability Earnings
50% (with Gross Up)	$3,000	$1,500	None	$1,500	50%
60% (fully taxable)	$3,000	$1,800	25%	$1,350	45%

So even with the smaller salary replacement amount of 50 percent, the final replacement of earnings for the employee on claim is going to be higher than if he or she had a 60 percent benefit subject to tax.

Accident / Critical Illness / Hospital Indemnity Premium and Benefit Taxation

Accident, Critical Illness and Hospital Indemnity insurance are generally offered on a voluntary basis and the premiums are paid by the employee with post-tax dollars. As such, the benefit payout from these policies are received tax-free. Should the premiums be paid by the employee using pre-tax dollars, or if there are contributions from the employer, the benefit payout may be taxable.

The information below outlines the options for paying Supplemental Health premiums, but it should not be considered tax advice. Employers and employees should always consult their tax advisor for advice.

NOTE: For employers who offer Benefit Ally or the Supplemental Health Combo package to their employees, the Information below may be particularly relevant. These supplemental health products will likely have a portion of the premium contributed by the employer, so the issue of tax liability to the member is relevant.

Post-tax premiums: *Preferred method due to tax favored supplemental benefits*

In scenarios where the supplemental health premiums will be split between the employer and the employee (i.e. Benefit Ally and Supplemental Health Combo Plan), we recommend:

- **Employee** contributions to the supplemental health premium be paid using a post-tax payroll deduction.
- **Employer** contributions to the supplemental health premiums be included as part of the employee's wage Statement/W-2 (treated as imputed income). If premiums are not treated as imputed income, benefits paid Under the plan may be taxable.

The payment of supplemental health premiums as outlined above maximizes the benefits and tax advantages of the Supplemental health benefit

Pre-tax premiums:

Supplemental health premiums can be paid with pre-tax dollars, however, the benefits received by the employee may be taxable.

- **UHC** will issue a Form 1099 for supplemental health benefit payouts that are equal to or greater than $600 in a Calendar year.
- **The employee** should consult a tax advisor about how the supplemental health benefits/Form 1099 received may Impact their annual income tax filing

UHC Tax Services

We offer several services to employers to help them reduce the burden of time spent on disability tax-related issues. The value of these services is that they help reduce or minimize errors, avoid penalties paid to the IRS and prevent employees who are on claim from "falling through the cracks."

Standard Services

These are services that are offered across the board for our employer groups — there are no size limits, underwriting signoff or costs to the employer. They include:

- **Federal Income Tax (FIT)withholding**
- **Social Security and Medicare Taxwithholding (EEFICA)**

These deductions are remitted directly to the IRS and summary reporting is available to the employer. (See Employer Summary Report example below.)

Optional Services

These include our Standard Services plus one of the following (subject to Underwriting Approval):

- **W-2 Tax Reporting Services (2-99 Lives and Key Accounts)**
  - Includes Standard Services
  - Print/mail W-2 forms to Employee
  - Maintain copies of the W-2
  - Respond to inquiries
  - File forms with Federal/State Government
    - W-2
    - W-3 (summary of W-2s sent to Employees)
    - Form 941 (Employer's Quarterly Tax Return)

- **Employer FICA Match (only available to Key Account Groups 100+ Lives)**
  - Includes Standard Services + W-2 Services

  Can be one of two methods:

    - **With Reimbursement** – Calculate FICA amounts from benefit payments; obtain funds for payments from the employer; and deposit taxes under our Employer Identification Number.
    - **Without Reimbursement** – Calculate FICA amounts from benefit payments and deposit the employer-matching FICA contribution with no reimbursement from employer. This service must be elected at time of sale.

Employer Summary Report Example:

UnitedHealthcare Insurance Company
BENEFIT PAYMENT REPORT

01/01/2016 to 003/31/2016
SHORT TERM DISABILITY BENEFITS

0051 ABC Company, LLC
Attn: John Smith
111 Commercial St
Portland, ME 04101

Group Number: 333333	Sub-Group: 100

Payee TIN / Claim Number	Payee Name & Address	Insured Name	Insured State	Date of Dis.	Date of Death	W2's Y/N	Tax Year	Transaction Date	Interest	Net Before Taxes	Tax Withheld: FICA SS	FICA Med	Fed	State	Other	Post Tax Deduction	Check Amt	Taxable Wages: Income	SS	Med/FU	ER Contrib. %
Current Tax Year																					
012305678	Smith, John [illegible] Portland ME [illegible]	[illegible]	ME	11/22/15		Y		1/22/16	0.00	4,894.71	303.47	70.97	85.71	0.00	0.00	0.00	4,434.56	4,894.71	4,894.71	4,894.71	100
Payment period: 12/15/2015 - 1/15/2016																					
ID Totals:									0.00	4,894.71	303.47	70.97	85.71	0.00	0.00	0.00	4,434.56	4,894.71	4,894.71	4,894.71	
Current Tax Year																					
987456321	Mack, Mary [illegible] Wild Dunes Way, Old Orchard Beach, ME [illegible]	MARY MACK	ME	9/26/15		Y		1/4/16	0.00	841.73	52.18	12.21	20.00	0.00	0.00	0.00	757.33	841.73	841.73	841.73	100
Payment period: 12/28/2015 - 1/4/2016																					
987456321	Mack, Mary [illegible] Wild Dunes Way, Old Orchard Beach, ME [illegible]	MARY MACK	ME	9/26/15		Y		1/15/16	0.00	2,525.18	156.56	36.62	60.00	0.00	0.00	0.00	2,272.01	2,525.19	2,525.19	2,525.19	100
Payment period: 1/4/2016 - 1/25/2016																					
987456321	Mack, Mary [illegible] Wild Dunes Way, Old Orchard Beach, ME [illegible]	MARY MACK	ME	9/26/15		Y		3/21/16	0.00	8,056.56	499.51	116.82	191.43	0.00	0.00	0.00	7,248.80	8,056.56	8,056.56	8,056.56	100
Payment period: 1/25/2016 - 4/1/2016																					
ID Totals:									0.00	11,423.48	708.26	165.65	271.43	0.00	0.00	0.00	10,278.14	11,423.48	11,423.48	11,423.48	
Group Totals: *Includes refunds for prior year(s)*									0.00	16,318.19	1,011.73	236.62	357.14	0.00	0.00	0.00	[illegible]	16,318.19	16,318.19	16,318.19	

Timely tax reporting by employer is required on taxable disability payments. The employer is responsible for applicable Employer's matching portion of FICA and FUTA and SUTA.
Please see your tax advisor and IRS Publication 15A and Publication 525 for assistance.
If you have contracted with us to perform W2's or 1099's, please disregard the following notes.
Taxable sick pay benefits paid to a survivor or an estate after the claimant's death needs to be reported to the survivor or the estate on Form 1099-misc. Report the payments in Box 3 (Other Income).
If the recipient is an individual beneficiary, enter the name and social security number of the individual. If the recipient is the estate enter the name and identification number (EIN) of the estate.
Interest amounts paid $600 or greater on a yearly basis per payee, must be reported on a 1099 INT. Amounts under Interest is included in Net Before Taxes.

Please note our records indicate UnitedHealthcare Specialty Benefits will be providing W-2 service for the current tax year.

Corporation Structure and Disability Taxation

Corporations

Owners of C-Corporations are considered employees, so using the premium funding chart on page 2 we can determine the taxability of benefits received under a disability policy.

Partnerships / S-Corporations

Disability insurance premiums paid by an S-Corporation on behalf of its greater than 2 percent shareholders are treated as guaranteed payments and must be included in the owner's gross income while the business itself may treat the premiums as a tax-deductible expense. As such, disability benefits received by an owner are not taxable. As an employee, the taxable amount would depend on the premium funding method.

Group Term Life Taxation

Benefit

The life insurance benefit that is received by the beneficiary (generally speaking) is a tax-free benefit. This also includes amounts received due to an accelerated death benefit provision. Whether interest is payable on life insurance proceeds is determined by state law. Any interest received is taxable and should be reported.

Premium

Group term life insurance is mentioned specifically in IRC Section 61 and 79. The policy itself must meet certain conditions in order to receive favorable tax treatment:

- Provided to a group of employees in a manner that prevents individual selection.
  Factors include employee age, years of service, pay or position.
- Minimum of 10 employees (some exceptions could apply).

The premiums paid by the employer for $50,000 or less of group term life insurance may be excluded from taxable income to the employee. Any amount over the $50,000 will be treated as an economic benefit (imputed income) to the employee and a percentage of premiums must be included as taxable to the employee. IRS Publication 15-B has a table to calculate the taxable amount of premium which must be included.

Non-Discrimination Testing

As with most insurance programs, group term life insurance receives favorable tax treatment only if the plan is non-discriminatory, meaning that the plan does not favor highly compensated or key employees. For further definitions, see IRS Publication 15-B. If the plan is found to be discriminatory, the entire cost of the premiums must be included as a taxable benefit to the employees.

Partnerships / S-Corporations

As with disability insurance premiums, group term life premiums paid by an S-Corporation on behalf of its greater than 2 percent shareholders are treated as guaranteed payments and must be included in the owner's gross income.

Self-Billed Group Administration Guidelines

Enrollment Checklist

Please use this checklist below to ensure that you meet the group enrollment administrative requirements.

☐ Complete an Enrollment Form for each new employee hired.

- The Enrollment Form serves as the basic insurance record.
- Employee's signature serves as the payroll deduction authorization.

☐ Check that all necessary information has been provided, such as (but not limited to):

- Effective Date of Coverage
- Company Name and Division/Billing Location
- Social Security Number or Alternate ID
- Date of Full-Time Employment or Rehire Date Salary and Salary Mode
- Employee's Job Title
- Date of Birth
- Gender
- Employee's Full Home Address and Telephone Number

☐ File the completed Enrollment Form with your office records.

☐ Be sure to keep current beneficiary designation records.

☐ **Do not fax or mail** to UnitedHealthcare (except for late entrants).

☐ When a claim is filed, in order to ensure that UnitedHealthcare will consider paying full benefits, you are required to submit necessary records, including but not limited to:

- Payroll records Enrollment Forms
- Enrollment Forms indicating changes
- Current beneficiary designations at the time of a claim submission

The plan administrator will be responsible for maintaining all policy and enrollment records as well as calculating, reporting and submitting premiums to UnitedHealthcare.

Enrollment of Rehired Employees

Who is a rehired employee?

Any employee who returns to work after temporary termination may request insurance.

How do I enroll a rehired employee?

1.Complete a new **Enrollment Form** and include the rehire date and current information. 2.

Add the rehired employee to the Statement of Premium Due.

3. The rehire date will be used to determine eligibility unless otherwise noted in the group insurance policy.

Rehired employees may still be late applicants if they apply for insurance more than 31 days after the date of eligibility (see Enrollment of Late applicants' section).

Enrollment of Late Applicants

Who is a late applicant?

Any employee who applies for insurance more than 31 days after the date of eligibility is considered to be a late applicant.

Life & Disability

Non-Contributory Insurance (Employer Paid)	Contributory Insurance (Employee Paid)
☐ 100 percent of all eligible employees must be enrolled. ☐ In the event an administrative error occurs, and an employee is accidentally left off the company's remittance to the insurer, insurance for the late applicant unintentionally omitted employee will be made effective on the employee's original effective date. ☐ Your company must pay all back premiums. ☐ Eligible employees cannot waive non-contributory insurance.	The employee must submit the following completed forms: ☐ Enrollment Form ☐ Evidence of Insurability Form Do not begin payroll deduction until you receive written Notice of Approval.

When is Evidence of Insurability required?

Evidence of Insurability may also be required if an employee is applying for dependent coverage more than 31 days following the eligibility date.

A completed Evidence of Insurability Form will be required for each dependent. The dependents may only be added to the plan after written approval is received.

How does Evidence of Insurability affect Guarantee Issue?

The Guarantee Issue limit is the maximum benefit UnitedHealthcare will underwrite without requiring evidence of insurability. The amount not subject to evidence of insurability is only available during the first 31 days an employee is eligible for insurance. Any employee not applying within that time frame is not entitled to any Guarantee Issue insurance.

☐ Evidence of Insurability is required should the employee request a benefit amount or benefit increase, which exceeds the Guarantee Issue amount.

☐ An Evidence of Insurability Form must be submitted, and the excess benefit amount will be underwritten.

Do not report the amount requested over the Guarantee Issue amount on the Statement of Premium Due until you receive a written Notice of Approval.

Billing Statements and Premium Payment Procedure

What are my responsibilities as Group Administrator?

☐ Monthly updating of information on the e-Bill system for each line of insurance at the subgroup level, including:

- Number of lives
- Volume
- Premium
- Age-branded products: counts, volumes and premium, if applicable

☐ Keeping all necessary paperwork in your office. Do not fax or mail forms to UnitedHealthcare. This includes, but is not limitedto:

- Enrollment Forms
- Enrollment Forms indicating thechange
- Beneficiary Designation Forms

☐ Completing the Electronic Payment Authorization Form to utilize the online payment option using the e-Bill system.

☐ Submitting the Invoice Detail and payment, using the e-Bill system.

☐ Scheduled Direct Debit ACH to schedule monthly payments based upon "Payment Date" selection during the setup process, on either the 10th or the 25th calendar day of the month.

How do I complete the Statement of Premium Due?

The samples provided on the following page may not list the same products that are available as part of your group plan. These procedures are applicable for all lines of insurance that are self-billed.

Premium Calculation Examples

Rates and benefits shown on the next few pages are illustrative only. Please see your contract for actual benefit amounts.

Calculating Premium

Please follow the formulas included in the examples on the next few pages to calculate the premium due for a particular product. Refer to your schedule of benefits to determine the benefit amounts for your employees.

Example: Life/AD&D Insurance (Basic and Supplemental)

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, considering age reductions where appropriate. Use this formula to calculate the cost:

Benefit Amount/1,000 x Rate = Premium

Example #1

Life Insurance for John Smith

25,000 Benefit/1,000 = 25

25 x $0.30 = $7.50

Example #2

Life Insurance for all employees of ABC, Inc.

610,000 Benefit/1,000 = 610

610 x $0.30 = $183.00

Example #3

AD&D Insurance for John Smith

25,000 Benefit/1,000 = 25

25 x $0.05 = $1.25

Example #4

AD&D Insurance for all employees of ABC, Inc.

610,000 Benefit/1,000 = 610

610 x $0.05 = $30.50

Example: Dependent Life Insurance

Dependent Life Insurance rates are either per family unit or per $1,000. In cases where the rate is per family unit, charge the same rate per family regardless of the actual number of dependents insured. Use this formula to calculate the cost of dependent life insurance when the rate is per family unit:

Family Unit x Rate = Premium

Example #1

Dependent Life Insurance for John and Sara Smith and children

1 family unit x $1.20 = $1.20

Example #2

Dependent Life Insurance for all families of ABC, Inc .

20 family units x $1.20 = $24.00

Example: Long-Term Disability Insurance

Long-Term Disability (LTD) Insurance monthly rates are per $100 of insured Monthly Covered Payroll (MCP). Base the premium calculations on MCP. Use this formula to calculate the cost of LTD Insurance.

Monthly Earnings/100 x Rate = Premium

Example #1

LTD Insurance for Julie Johnson

According to the group policy, this plan will cover 60 percent of the MCP up to a maximum monthly benefit of $5,000 at a rate of $0.38 per $100 of MCP.

Julie's monthly earnings: $3,012

MCP insured by plan: $8,333 (maximum monthly benefit divided by 60 percent of benefit) .

Cost of Julie's insurance:
$3,012 monthly earnings/100 = $30.12
$30.12 x $0.38 = $11.44

Example #2

LTD Insurance for all employees of ABC, Inc.

According to the group policy, this plan will cover 60 percent of the Monthly Covered Payroll (MCP) up to a maximum monthly benefit of $5,000 at a rate of $0.66 per $100 of MCP.

Step 1: Determine the MCP based on the plan design
Take the Maximum Monthly Benefit and divide by the Benefit Percentage:
$5,000/60% = $8,333 MCP Maximum

Step 2: Determine the MCP for each person. Anyone who exceeds the Monthly Covered Payroll Maximum calculated in Step 1 must be capped at that amount.

Census File	Annual Salary	Monthly Salary	Maximum MCP	Actual MCP
CEO	$500,000	$41,667	$8,333	$8,333
CFO	$280,000	$23,333	$8,333	$8,333
Managing Director	$50,123	$4,177	$8,333	$4,177
Clerk	$25,000	$2,083	$8,333	$2,083
Sales & Marketing	$65,000	$5,417	$8,333	$5,417
			Total MCP	$28,343
			Total MCP divided by 100	$283.43
			Times rate per $100 of MCP	$0.66
			Monthly Premium	$187.06
			Annual Premium	$2,244.77

Example: Short-Term Disability Insurance

Short-Term Disability (STD) Insurance monthly rates are per $10 of insured Weekly Covered Benefits (WCB). Base the premium calculations on WCB. Use this formula to calculate the cost of STD insurance:

Benefit Amount/10 x Rate = Premium

Example #1

STD Insurance for John Smith

According to the group policy, this plan will cover 60 percent of weekly earnings (this percentage of earnings is also known as WCB . Assume in this example the maximum WCB is $1,500 and the rate is $0 .44 per $10 of WCB .

John's weekly earnings: $750.00 John's WCB: $450 (60% of $750 Maximum weekly benefit: $1,500. Cost

of John's insurance:
$450.00 weekly earnings / 10 = $45.00
$45.00 x $0.44 = $19.80

Example #2

STD Insurance for all employees of ABC, Inc.

According to the group policy, this plan will cover 60 percent of weekly earnings (this percentage of earnings is also known as WCB up to a maximum WCB of $1,500 at a rate of $0.50 per $10 of WCB.

Step 1: The WCB maximum weekly benefit is $1,500.

Step 2: Determine the WCB for each person. Anyone who exceeds the maximum weekly benefit must be capped at that amount.

Census File	Annual Salary	Weekly Salary	WCB	Maximum WCB	Actual WCB
CEO	$500,000	$9,615	$5,769	$1,500	$1,500
CFO	$280,000	$5,385	$3,231	$1,500	$1,500
Managing Director	$50,123	$964	$578	$1,500	$578
Clerk	$25,000	$481	$288	$1,500	$288
Sales & Marketing	$65,000	$1,250	$750	$1,500	$750

Total MCP	$4,616
TotalMCPdividedby10	$461.60
Times rate	$0.50
Monthly Premium	$230.80
Annual Premium	$2,769.60

Example #3

STD Insurance for all employees of ABC, Inc. based on the MCP method

Before using this example: Please validate if your STD rate is based on the MCP method. If you are not sure or have questions, contact the billing department or your Strategic Account Executive/Account Manager.

Occasionally, STD premiums may be calculated using the method defined in the LTD Monthly Covered Payroll MCP example.

For example:
According to the group policy, this plan will cover 60 percent of the MCP up to a maximum weekly benefit of $1,500 at a rate of $0.66 per $100 of MCP.

Step 1: Convert Maximum Weekly Benefit to Maximum Monthly Benefit:
Based on plan design, take Maximum Weekly Monthly Benefit, then multiply by 52, then divide by 12 to get the Maximum Monthly Benefit:
$1,500 x 52 weeks ÷ 12 months = $6,500 Maximum Monthly Benefit

Step 2: Convert Maximum Monthly Benefit to Maximum Monthly Covered Payroll:
Based on plan design, take Maximum Monthly Benefit from Step 1 and divide by benefit percentage:
$6,500 ÷ 60% = $10,833 Maximum Monthly Covered Payroll

Step 3: Determine the MCP for each person. Anyone who exceeds the Maximum Monthly Covered Payroll calculated in Step 2 must be capped at that amount.

Census File	Annual Salary	Monthly Salary	Maximum MCP	Actual MCP
CEO	$500,000	$41,667	$10,833	$10,833
CFO	$280,000	$23,333	$10,833	$10,833
Managing Director	$50,123	$4,177	$10,833	$4,177
Clerk	$25,000	$2,083	$10,833	$2,083
Sales & Marketing	$65,000	$5,417	$10,833	$5,417
			Total MCP	$33,343
			Total MCP divided by 100	$333.43
			Times rate per $100 of MCP	$0.66
			Monthly Premium	$220.06
			Annual Premium	$2,640.72

Example: FMLA & Leave Management

FMLA & Leave Management rates are calculated on a PEPM basis (Per Member Per Month). Base your calculations on the PEPM rates as noted on your invoice.

Use this formula to calculate the cost:

- PEPM rate x number of total covered employees

Forms for Self-Billed Groups

As the plan administrator, you should be familiar with several forms, including the following:

- ☐ Enrollment Form
- ☐ Evidence of Insurability
- ☐ Statement of Premium Due
- ☐ Beneficiary Designation
- ☐ Electronic Payment Authorization Form
- ☐ Claim Form

Voluntary Life Insurance Administration Guidelines

Eligibility

To whom is voluntary life insurance offered?

☐ Employee Only
☐ Employee and Child
☐ Employee and Spouse
☐ Spouse Only
☐ Spouse and Child
☐ Employee, Spouse and Child

When are employees eligible?

Employees are eligible for insurance after completing the waiting period, if applicable. All new employees will be added to the bill effective the first of the month following completion of the waiting period or upon signing the Enrollment Form, whichever is later. There will be no mid-month premium calculation.

Note: Employees contractually have 31 days from the effective date to enroll. Please refer to your plan for specifics regarding effective date of coverage.

When do employees or dependents need to complete the medical questions?

Employees or dependents need to complete medical questions (Statement of Insurability) if:

☐ They apply for an amount over the amount not subject to evidence of insurability.

☐ They did not enroll initially and are now requesting insurance. Applicants will be responsible for any medical fees incurred as late enrollees.

☐ Dependent insurance is over Guarantee Issue limit.

☐ Dependent applies for insurance after initially declining coverage.

☐ An employee wants to increase insurance for self or dependents.

☐ For employees within 31 days from a qualifying life status change due to a change in marital status (marriage, divorce, legal separation, annulment) or a change in the number of dependents for tax purposes (birth, legal adoption of a child, placement of a child with the employee for adoption or death of a dependent), elections:

- Greater than one increment;or
- One multiple of earningsor
- $50,000;
- Or exceeding the Guarantee Issue limit.

Premium

How do I calculate an employee's age for premium purposes?

Calculate the premium based on the employee's age on the eligibility date. If a person's age changes from one age band to another, premium will not increase until the employer's next policy anniversary date or the month following the date of change, depending on the method in place for your plan. Please refer to your policy for specifics.

What is the deduction amount?

Deduct premiums to cover the amount not subject to evidence of insurability. Upon approval, begin deductions to the full amount of premium.

Life Policies Administration Guidelines

Claim Submission

For assistance regarding life claims, please contact a Claims Representative at 1-888-299-2070 or fax (888) 980-0298.

The AD&D benefit does not apply to all life insurance. Please see your policy to determine whether this feature applies to you.

How do I submit a death claim?

1. The claimant is responsible for completing the Claimant portion (Section 1) of the **Proof of Death Form.** 2

. Complete the Employer or Plan Administrator portion (Section 2) of the **Proof of Death Form.**

3. Include a certified death certificate with the death claim. Typically, a photocopy of the certified death certificate is acceptable; however, an original copy may be needed in some instances. Mail the completed Proof of Death Form and the certified death certificate to the address on the Claim Form.

4. If the death was not a result of natural causes (i.e., accident, homicide) a copy of the official report (i.e., police, accident, coroners, toxicology, fire, FAA, OSHA) must be provided in order to consider payment of the AD&D benefit.

   ☐ AD&D benefits cannot be paid on any claim without an investigative report regarding the insured person's/dependent's death.

   ☐ If your AD&D policy contains alcohol or drug exclusions, a toxicology report will be required.

5. Claims submissions must also include:

   ☐ Enrollment Form

   ☐ Copies of any beneficiary changes

   ☐ Absolute Assignments* (if applicable)

   ☐ Funeral Assignments (if applicable)

MAIL completed forms to:
UnitedHealthcare
P. O. Box 7149
Portland, ME 04112-7149

How do I submit a dismemberment claim?

1. . Complete the Employer portion of the Statement of Claim for Accidental Dismemberment Benefits

Form. 2. Ask the insured person to:

   ☐ Complete the employee portion of the Claim Form.

   ☐ Have the insured's physician complete the attending physician statement on the Claim Form.

   ☐ Provide a copy of the accident report.

   ☐ Provide a copy of the toxicology report (if one is performed).

MAIL completed forms to:
UnitedHealthcare
P. O. Box 7149
Portland, ME 04112-7149

* An Absolute Assignment is used to change certain ownership rights of a policy and must be signed by the current owner of the policy. The new owner will have the right to change the beneficiary designation. Ownership is usually transferred for tax purposes.

Beneficiary Information

How do I complete a funeral home assignment?

A funeral home assignment means the beneficiary (or beneficiaries) has assigned all or a portion of the policy benefits to a funeral home in order to cover funeral expenses. As the administrator, you must request the necessary form(s) from the funeral home. Be sure that the form(s):

☐ Indicate the amount of the benefit assigned and the funeral home's tax ID number.

☐ Accompanies the funeral home bill and is submitted through the group with the Proof of Death Form.

☐ Is/are signed by all named beneficiaries. If only one beneficiary signs the form, proceeds will be deducted from the portion allotted for that beneficiary only.

Note: To assign benefits, the beneficiary must be of legal age; therefore, a minor cannot sign a funeral home assignment. UnitedHealthcare does not accept collateral assignments (use of life insurance as collateral).

What is Form 712?

Form 712 is a government form required from some beneficiaries for income tax returns. The form includes the amount of money paid on a life claim without interest. This form can be sent upon request.

What if the primary beneficiary is deceased?

If the primary beneficiary is no longer living, a certified death certificate (for the primary beneficiary) must accompany the claim before payment can be made to the contingent (secondary) beneficiary. If the contingent (secondary) beneficiary is also deceased, a certified death certificate will also be required.

What if there is no beneficiary?

Payment may be made to certain relatives or the insured person's estate, as provided in the policy.

Payment to the estate can be made only after court documents of appointment are forwarded to UnitedHealthcare. The documents of appointment must name the personal representative of the estate (also called the executor, executrix, administrator or similar title) to whom the benefits can be paid and the estate tax ID number.

Payment to a trust can be made when a copy of the trust document is provided with the claim. Such documents must designate a trustee to whom proceeds will be paid and the associated tax ID number.

What if the beneficiary is a minor child?

According to state law, a minor lacks capacity to sign a binding release of an insurance policy. Only the lawfully court-appointed representative of a minor may give release for the payment to a minor. Life insurance benefits, therefore, cannot be paid to anyone who has not reached the age of majority. If court-appointed financial guardianship documents are not secured, the proceeds will be held in an interest-bearing account until the beneficiary reaches the age of majority.

Beneficiary Services

This service does not apply to all life insurance. Please check with your Account Executive to determine if it applies to your plan.

What are Beneficiary Services?

UnitedHealthcare's Beneficiary Services give the insured peace of mind that the surviving family will be taken care of. The survivors may call our toll-free Beneficiary Services Line to reach out following the insured's death and talk with a caring, supportive Specialist about grief and loss, legal issues, financial issues or issues surrounding the loss. The Master's-Level Specialist focuses on the caller's strengths, coping skills and goals to help the survivor identify next steps for him or her and other surviving family members. The Specialist will provide referrals to local community resources including grief support groups for children and, if the survivor needs or requests face-to-face counseling, the Specialist will refer the caller to local clinicians with grief counseling expertise for up to two sessions.

Beneficiary Services packets are mailed to each claimant upon receipt of claim at UnitedHealthcare. This packet advises claimant of the toll-free Beneficiary Services Line and other services that he or she can access.

Disbursement of Proceeds

What is an Optum HealthBank Wealth Management Account?

A Wealth Management Account is a personal, FDIC insured, interest-bearing account through OptumHealth Bank into which UnitedHealthcare will place the proceeds from a life insurance policy in the name of the beneficiary. Once the claim is approved, the beneficiary's account will be set up and will receive a debit card and convenience checks. A Wealth Management Account provides safety and security of funds, as well as immediate access to the funds. Interest on the account balance is compounded daily and credited to the account monthly.

Placing the funds into a Wealth Management Account provides additional time to make important financial decisions during what can be a particularly difficult and stressful period. Determining what to do with insurance proceeds is an important decision that should not be rushed. The beneficiary's funds will earn interest while beneficiaries evaluate their options.

What claims do not qualify for a Wealth Management Account?

Not all claims qualify for automatic deposit into a Wealth Management Account. Some claims will be settled with a lump sum payment via check. This includes:

☐ Claims below $5,000.

☐ Claims for non - U.S. citizens.

☐ Claims assigned to a company.

In addition, beneficiaries who reside in Arkansas (AR), Colorado (CO), Kansas (KS), Maryland (MD), North Carolina (NC), North Dakota (ND), New York (NY) and Nevada (NV) are not eligible for automatic deposit of claim proceeds into a Wealth Management Account. They will be provided an opportunity to elect establishment of a Wealth Management Account via completion of an OptumHealth Bank Signature Card that is included in the beneficiary packet.

How do beneficiaries access money in a Wealth Management Account?

The money is readily accessible by using the Wealth Management Debit MasterCard or writing a check in any amount up to the account balance.

☐ The funds are FDIC insured through OptumHealth Bank so the beneficiary can be assured that the account balance is safe.

☐ Free, monthly statements will be mailed which will reflect the account balance, interest earned and the transactions for the month.

☐ Interest earned on the account is taxable as ordinary income. Our financial institution will report the interest earned to the Internal Revenue Service and send the beneficiary a 1099-INT form to claim the interest on the annual tax return.

☐ There are no monthly fees for this account, however, charges do apply for special services such as checks returned unpaid, stop payments, etc.

☐ The beneficiary receives a checkbook that contains deposit slips, so that funds can be added to the account.

Notes:

☐ It is important that the beneficiary inform OptumHealth Bank of address changes as they occur.

How do beneficiaries close Wealth Management Account?

The Wealth Management Account is closed for either of the following circumstances:

☐ The beneficiary closes the account by withdrawing the entire account balance. A separate check for interest earned for that month will be issued on the 20th of the month.

☐ When the balance of the account is less than $500, the account will automatically be closed on the 20th of the month. The beneficiary will receive a check for the balance of the account plus interest.

Accelerated Benefit

The accelerated benefit does not apply to all life insurance. Please see your policy to determine whether this feature applies to you.

Who qualifies to receive an Accelerated Benefit?

This benefit allows advance payment of part (based on policy language) of the insured person's life insurance. It may be paid to a person in a lump sum once during his or her lifetime.

To qualify, the insured person must:

☐ Have at least the dollar amount of the life insurance stated in the policy on the date the accelerated benefit is paid. (Check the specific policy for the amount.)

☐ Be insured under the policy on the date the accelerated death benefit is to be paid.

How does an insured apply to receive an Accelerated Benefit?

The insured person (or his or her legal representative) must apply for the benefit. To do so, the insured must:

☐ Complete a **Notice of Claim – Accelerated Benefit Form.**

☐ Provide satisfactory proof that the insured person is terminally ill*. Include a physician's written statement indicating the approximate life expectancy.

* Terminally ill is defined as the insured person has a medical condition which is expected to result in death within 12 months, despite appropriate medical treatment. Definitions vary by state laws; please check with your client services administrator.

How much can be withdrawn?

The amount of benefit may be withdrawn in $1,000 increments subject to minimums and maximums defined in the policy (i.e., a minimum of $10,000 or 10 percent, whichever is greater).

Note: The Accelerated Benefit payment may be taxable to the insured person. This individual should seek assistance from a personal tax advisor regarding taxes that may be levied as a result of claiming Accelerated Benefits.

Life Insurance Waiver of Premium

The Life Insurance Waiver of Premium does not apply to all life insurance. Please see your policy to determine whether this feature applies to you.

What is a Waiver of Premium?

The Waiver of Premium benefit allows the employee/employer to forego premium payment on life insurance for a totally disabled* employee. The employee is required to provide proof of continued total disability as required by UnitedHealthcare. After the employee has been totally disabled for two years, proof will be required once a year. Please refer to your policy for the specific reason Waiver of Premium would terminate.

How does an employee apply for a Waiver of Premium?

Complete the **Statement of Continuance of Life Insurance** to make application for these benefits. The employee must be totally disabled as defined by the policy.(See the specific policy for plan details, as age and waiting period may vary.) The employer should continue to pay the employee's premium during the waiting period.The covered person must supply proof of claim no later than 12 months after the date he or she becomes "Totally Disabled" in accordance with the policy definition*.

If the employee is covered under Long-Term Disability Insurance with UnitedHealthcare, and has filed a claim for Long-Term Disability benefits, it is not necessary to complete the Statement of Continuance of Life Insurance in order to apply for the Life Waiver of Premium benefit. The Life Waiver of Premium benefit will be processed in conjunction with the Long-Term Disability claim.

Note*: The definition of Total Disability on the Continuance of Life Insurance requires that the employee be unable to perform the duties of his or her own or any occupation for which he or she may be suited by training, education or experience. Long-Term Disability (LTD) language generally requires the employee to be totally disabled from his or her own occupation initially for a period of time and then from any occupation at the change in definition.

Premium Adjustment

The standard policy provides Waiver of Premium for Life and Voluntary Life. The Accidental Death and Dismemberment (AD&D) policy premium cannot be waived and will terminate upon approval of waiver on the life coverage. Please refer to your specific policy for verification.

List-Billed Groups

UnitedHealthcare Administration area will adjust the billing.

Self-Billed Groups

The employer should continue to pay the premium for the employee during the waiting period. The Plan Administrator should adjust upon receipt of the Approval for Waiver of Premium, using the effective date indicated.

* Footnotes for above * go here.

Portability and Conversion

What are Portability and Employee Conversion?

Portability does not apply to all life insurance. Please see your Group policy to determine whether this feature applies to you .

Portability	Conversion
☐ Term life insurance (no cash value). ☐ Age-banded rates increase with current age. ☐ Must be insured for three months. ☐ Guaranteed full amount when employment terminates for reasons other than disability.	☐ Individual Whole life insurance (builds a cash value). ☐ Age-banded rates are fixed at the age when conversion insurance is issued. ☐ Employee changed insurance to a different policy with much higher premiums. ☐ Guaranteed full amount when eligibility ends for reasons other than non-payment of premium . Spouse and child insurance may also be converted when employee terminates for reasons other than disability. **See certificate plan details.

Portability

Which employees are eligible to port their coverage?

Employees who have purchased basic life, supplemental life may be eligible (refer to the Group policy) to port their coverage upon termination of employment provided that they submit their request for portability within 31 days of their termination date.

How do employees request to port their coverage?

The employer and employee must complete the Request for Portability of Supplemental Group Life Insurance Form.

Employer	Employee
The employer initiates the process by completing the Employer Information sections.	The employee completes all remaining sections of the form, including the calculation of the quarterly or annual premium and applicable charges. Upon completion, the employee forwards the form and initial premium payment to the UnitedHealthcare address that appears on the form.

What benefit amount are the employees eligible to port?

The employee can port all or a portion of his or her amount of Life Insurance, however, the ported amount cannot exceed what the insured has at the time he or she elects to port. (Refer to the Group Policy.)

How are employees billed for their coverage?

Upon approval, UnitedHealthcare will bill the employee directly, based on the payment mode selected.

Note: Refer to your Portability Form for the rates.

Life Conversion Privileges

Which employees are eligible to receive conversion privileges?

Be sure to check specific policy to ensure conversion privilege is available.

Employees may convert their coverage if:

☐ All or part of their Life Insurance to an individual policy of life insurance, other than term insurance, if their insurance terminated because they cease to be a member of a class eligible for insurance, and

☐ The amount of insurance to an individual policy of life insurance, other than term insurance, that is lost due to a reduction of insurance because of age.

Employees may convert a limited amount of insurance to an individual life policy, other than term if:

☐ All or part of their insurance terminates due to amendment or termination of the policy, and

☐ The employee has been insured continuously under the policy for at least five years.

Any conversion policy issued due to a policy termination or amendment will be subject to the same conditions as a policy issued under the General Conversion Benefit except the amount may not exceed the lesser of:

☐ $10,000 (see the specific policy), or

☐ The amount of life insurance that terminates is less than the amount of any group life insurance for which the insured person becomes eligible within 31 days after the termination.

Note: If an employee is disabled prior to age 60, he or she should not request conversion, but should be kept on the existing policy until he or she qualifies for Waiver of Premium.

What is a conversion policy?

Employees may purchase an individual life policy, known as a conversion policy, without evidence of insurability. Any policy issued under the General Conversion Benefit will be issued:

☐ For an amount not to exceed the amount of the life insurance that was terminated.

☐ At the insured person's age at nearest birthday.

☐ Without disability.

How can an insured apply for a conversion policy?

1 . The insured person can obtain a quote for insurance by completing the **Individual Life Conversion Request for Information Form** available through Customer Service at **(888) 999-4767.** The Plan Administrator will be required to provide the following information:

   ☐ Policy number

   ☐ Age

   ☐ Sex

   ☐ Amount requested

   ☐ Last day worked and/or termination date

2 . Once the insured person completes his or her information, he or she can fax the information to **978-762-4767**

3 . If the insured decides to apply for a conversion policy, the Plan Administrator should send the insured the Application for Conversion.

4 . The employee should complete the form and mail it to:

> HRMP
> Life Conversion Facility
> 300 Rosewood Drive, Suite 250
> Danvers, MA 01923

5 . Information regarding the conversion will be sent to the applicant so premium can be determined and premium submitted. The insurance provided by a conversion policy will be effective the later of:

- ☐ Date of issue, or
- ☐ 31 days after the date on which the insured person's life insurance terminated.

Is an insured entitled to death benefits during the conversion period?

UnitedHealthcare will pay a death benefit under the policy equal to the amount of the life insurance which could have been converted, provided the person:

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

The death benefit will be paid even if no one applied 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.

Minnesota Life Continuation

If an employer is in another state but has Minnesota employees, the residents of Minnesota must be offered the opportunity to continue their insurance. The only exceptions are if **all** the following are true:

- ☐ The policyholder or certificate holder exists primarily for purposes other than to obtain insurance.
- ☐ The policyholder or certificate holder is not a Minnesota corporation and does not have its principal office in Minnesota.
- ☐ The policyholder or certificate covers fewer than 25 persons who are residents of Minnesota and the Minnesota residents represent less than 25 percent of all insured persons.
- ☐ Upon the request of the commissioner, the issuer files with the commissioner a copy of the policy and a copy of each form of certificate.

Forms for Life Policies

As the plan administrator, you should be familiar with several forms, including the following:

- ☐ Proof of Death for Group Insurance.
- ☐ Statement of Claim for Accidental Dismemberment Benefits.
- ☐ Form 712.
- ☐ Notice of Claim – Accelerated Benefits.
- ☐ Statement of Continuance of Life Insurance.
- ☐ Approval for Waiver of Premium Letter.
- ☐ Request for Portability of Supplemental Group Life Insurance.
- ☐ Individual Life Conversion Request for Information.

Short-Term Disability Administration Guidelines

Enrollment

When are employees eligible for Short-Term Disability (STD) Insurance?

Employees are eligible for insurance after completing the waiting period. Add all new employees to the bill effective the first of the month following completion of the waiting period or upon signing the Enrollment Form, whichever is later . There will be no mid-month premium calculation.

Employees contractually have 31 days from the effective date to enroll. If employees enroll during this 31-day eligibility period, the effective date will be the first of the month following the date of signature. We strongly suggest that employees complete and submit applications during the waiting period.

Which employees must complete and sign the Statement of Insurability?

☐ Employer paid (non-contributory) coverage: no Statement of Insurability required.

☐ **Voluntary (contributory) coverage:** Statement of Insurability required if applicant is applying for an amount over the guaranteed issue amount.

☐ **Late entrants:** Statement of Insurability is required.

Is there an open enrollment period for voluntary STD?

Yes. There is open enrollment for voluntary plans only. Open enrollment is defined as the time when the plan is initially offered.

☐ The only time Guarantee Issue (GI) amounts are available to current employees is during the open enrollment period.

☐ When a new employee is hired, he or she may apply for insurance. GI is available for new employees during the initial eligibility period.

☐ Employees may enroll after the initial open enrollment by completing the Statement of Insurability Form.

Premium

What age should I use to calculate premium?

The employee's age on the eligibility date is used to calculate premium. If a person's age changes from one age band to another, the premium will not increase until the employer's next policy anniversary date or the month following the date of change, depending on the method chosen by the employer group. Please refer to your policy for specifics of your plan.

Taxable Income

If the deductions are made on a post-tax basis, then the benefit is non-taxable to your employees. As such, there will be no matching FICA payments either.

Claim Submission

For assistance regarding Short Term Disability (STD) claims, please call **(866) 615-8727.**

How do I submit an STD claim?

Complete the STD Claim Form, which includes separate portions for the employer, employee and the physician. To avoid delay in the processing of a claim, be sure to completely answer all questions on the Claim Form and include a signed authorization.

1. Complete the Employer's portion of the Claim Form.
2. Ask the employee to complete the Employee portion of the Claim Form, including having the physician's portion of the form completed. Advise the employee to submit as much information as possible.
3. Submit all pages of the claim form (original copy is not required):

FAX completed forms to:		MAIL completed forms to:
(888) 505-8550	OR	UnitedHealthcare Disability P.O. Box 7466 Portland, ME 04112-7466

When will a decision be made regarding disability benefits?

The Claims department will make an initial decision within five working days upon receipt of the completed Claim Form. This initial decision will either:

☐ Approve benefits and issue a check to the claimant

☐ Pend the claim for additional information

☐ 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 five working days.

To be eligible for benefits, a person must be found to be totally disabled according to our policy. Total disability means the employee is unable to perform all of the material and substantial duties of his or her regular occupation due to sickness or injury and has a 20 percent or more loss in his or her indexed pre-disability weekly earnings. Each claim must be reviewed. Benefits are not guaranteed even if the doctor indicates total disability on the Claim Form. Benefits are paid based upon evidence submitted that supports a total disability status and not solely based upon a physician's opinion.

The supporting medical documentation, such as office and treatment records (i.e., test results, X-rays), must support the policy definition of totally disabled. Office and treatment records created by a physician following each visit are considered to be objective documentation.

What guidelines are used to help determine the duration of a disability?

The Medical Disability Advisor is a set of guidelines developed by a respected independent physician, Dr. Presley Reed, working with a team of accredited experts. These guidelines are utilized by the disability staff to outline expectations for the length of disability for a specific diagnosis or procedure. Several factors are considered when applying the guidelines such as occupation, age and variability with a diagnosis.

How are state disability plans considered?

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 (the state TDI plan) for both full-time and part-time employees. The amount received through the state TDI plan would be deducted from the claimant's benefit.

How are work-related disabilities handled?

The standard policy excludes any work-related conditions. A claim filed for any work-related condition would be denied. If UnitedHealthcare is asked to reconsider the claim, the employee will be asked to provide a copy of the Worker's Compensation denial.

Are maternity claims eligible for STD benefits?

Our standard policy treats maternity the same as any other illness. We consider the usual recovery from either a vaginal delivery or a Caesarean section to be six weeks, but individual claim situations are taken into account.

Benefit Payment

To whom are checks paid?

Employers who self-fund claims can have checks sent to them for distribution to their employees. Fully insured clients' checks are sent directly to the employee.

Are employees on Salary Continuance eligible for STD benefits?

Salary continuance is considered to be any money paid by the employer to the employee excluding vacation time or any money earned by the employee. Since salary continuance is an exclusion under the standard Short-Term Disability policy, any monies deemed as salary continuance provided to an employee may make him or her ineligible for benefits or reduce his or her benefit. The employee may receive salary continuance during the elimination period.

Note: Elimination period is the length of time the insured person must be continuously disabled before a benefit is payable.

What are Partial Disability benefits?

Partial Disability provides benefits to an employee who returns to work on a part-time basis. Partial Disability Benefit equals the lesser of one of the following:

☐ The insured person's basic weekly earnings multiplied by the benefit percentage (limited to the maximum weekly benefit).

☐ The insured person's basic weekly earnings minus earnings received from any form of employment for that period of disability.

The benefit percentage, maximum weekly benefit and definition of basic weekly earnings are shown in the Schedule of Benefits.

Example #1

Pre-Disability Earnings $300.00
Benefit Percentage 60%
Maximum $150.00

Part-Time Earnings $220.00
1. $300.00 x .60 = $180.00
2. $300.00 - $220.00 = $80.00

The lesser is #2, $80.00. This is the amount the claimant would receive.

Example #2

Pre-Disability Earnings $200.00
Benefit Percentage 66 2/3%
Maximum $90.00

Part-Time Earnings $150.00
1. $200.00 x .6667 = 133.34
2. $200 - 150.00 = $50.00

The lesser is #2, $50.00. This is the amount the claimant would receive.

How can denial of claims be appealed?

The claimant has 180 days to appeal a denial. The appeal must be in writing and must provide specific information outlining why the employee disagreed with our original decision. Please attach supporting documentation.

Send a written appeal to: UnitedHealthcare Disability
P.O. Box 7466
Portland, ME 04112-7466

The company has 45 days to respond to the appeal; however, STD appeals are generally resolved in a much shorter time frame.

Forms for STD Policies

☐ Statement of Insurability.

☐ STD Claim Form.

Long-Term Disability Administration Guidelines

Enrollment

When are employees eligible for Long-Term Disability (LTD) Insurance?

Employees are eligible for insurance after completing the waiting period. Add all new employees to the bill effective the first of the month following completion of the waiting period or upon signing the Enrollment Form, whichever is later. There will be no mid-month premium calculation.

Employees contractually have 31 days from the effective date to enroll. If employees enroll during this 31-day eligibility period, the effective date will be the first of the month following the date of signature. We strongly suggest that employees complete and submit applications during the waiting period.

Which employees must complete and sign the Statement of Insurability?

☐ **Employer-paid (non-contributory) coverage:** No Statement of Insurability required.

☐ **Voluntary (contributory) coverage:** Statement of Insurability required if applicant is applying for an amount over the guarantee issue (GI) amount.

☐ **Late entrants:** Statement of Insurability is required. If a Statement of Insurability is required, the insurance becomes effective the later of the date he or she just became eligible or on the date the Statement of Insurability is approved by UnitedHealthcare.

What are pre-existing conditions?

Any disability which occurs during the first year of insurance for which the employee has received medical treatment in the three months prior to becoming insured is considered pre-existing. **Pre-existing condition(s) will not be a payable benefit.**

Is there an open enrollment period for LTD?

There is open enrollment for voluntary plans only. Open enrollment is defined as the time when the plan is initially offered.

☐ The only time GI amounts are available to current employees is during the open enrollment period.

☐ The new employee may apply for insurance at time of hire. GI is available for new employees during the initial eligibility period.

☐ Employees may enroll after the initial open enrollment by completing the Statement of Insurability Form.

Premium

What age should I use to calculate premium?

The employee's age on the eligibility date is used to calculate premium. If a person's age changes from one age band to another, the premium will not increase until the employer's next policy anniversary date or the month following the date of change, depending on the method chosen by the employer group. Please refer to your policy for specifics of your plan.

Taxable Income

If the deductions are made on a post-tax basis, then the benefit is non-taxable to your employees. As such, there will be no matching FICA payments either.

Claim-Submission

For assistance regarding Long Term Disability (LTD) claims, please call **(866) 615-8727.**

How do I submit an LTD claim?

The claim should be submitted half way through the elimination period to ensure a decision is made before the first payment is due (if the claim is payable).

Before the claim can be processed, all portions of the LTD Claim Form must be completed, including:

☐ Physical Requirements. ☐ Physician's Portion.

☐ Employee's Portion. ☐ The Employee's Job Description.

Send the completed Claim Form to UnitedHealthcare Disability for processing:

FAX completed forms to:		MAIL completed forms to:
(888) 505-8550	OR	UnitedHealthcare Disability P.O. Box 7466 Portland, ME 04112-7466

Note: Claims should be submitted as soon as the employee believes that the disability will last as long as the elimination period. For disability tracking purposes, it is preferable to receive a claim during the elimination period rather than have to obtain medical information retroactively after the elimination period has been satisfied. Advise the employee to submit as much medical information as possible.

Waiver of Premium

How do I apply for waiver of premium?

Long-Term Disability Insurance includes waiver of premium. This is an automatic benefit once the claim is approved, provided the disability extends beyond the period required to qualify. The employee and employer will receive a notification from the claims area indicating, "Your waiver of premium is effective _ (date)."

The premiums will be adjusted:

For List-Billed Groups	For Self-Billed Groups
UnitedHealthcare Administration area will be notified of the waiver and will adjust the bill.	The plan administrator must make the adjustment upon receipt of the copy of the approval letter and use the effective date indicated on the correspondence. The employer should not make the adjustment until notified that the claim has been approved for waiver of premium.

Approval of Benefits

When will a decision be made regarding disability benefits?

The claim will be reviewed within 10 working days of receipt and an initial decision will be made to either:

☐ Approve benefits and issue a check to the claimant.

☐ Pend the claim for additional information.

☐ 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.

What is the elimination period?

The elimination period is the length of time the employee must be continuously disabled before a benefit is payable. No benefits are payable for that period.

What is accumulation of elimination period?

Accumulation of the elimination period wording allows for the temporary recovery during the elimination period and is designed to reward a covered employee's attempt to return to work. It ensures that:

☐ Disabled employees are not penalized for trying to go back to work during the elimination period.

☐ The days the employee is not disabled will not count toward satisfying the elimination period.

☐ The days an employee is not disabled may be consecutive or intermittent.

☐ All or part of the elimination period can be completed while working if the covered employee is considered disabled under the terms of our policy during the period of work activity.

How are pre-existing conditions excluded?

Disabilities caused by, or contributed to by, a pre-existing condition are excluded from insurance under the policy unless certain conditions have been met. A pre-existing condition applies to a sickness or injury including mental illness, substance abuse or subjective symptoms for which the insured person, within a specified time prior to the Effective Date of insurance, was diagnosed by or received treatment from a legally qualified physician; or had symptoms for which an ordinarily prudent person would have sought treatment.

What if the employees change carriers?

LTD insurance has a Continuity of Insurance upon transfer of insurance carrier's provision to ensure that employees insured under a policy will not lose insurance due to a change in carriers. Continuity of Insurance applies to the traditional policy provisions such as the:

☐ Active at Work Requirement, and

☐ Pre-existing Condition Exclusion.

In order to provide Continuity of Insurance, UnitedHealthcare must have a copy of the prior carrier's policy, certificate of insurance or plan booklet. If Continuity of Insurance is a state-mandated regulation, UnitedHealthcare must receive a copy of the prior policy, etc. before issuing the policy.

Benefit Payment

How is the benefit payment calculated?

The policy dictates the percent of benefit (some policies provide for a flat benefit amount) that the employee is entitled to receive. The Schedule of Benefits page in the policy specifies:

☐ The benefit amount or percentage of benefit.

☐ The percentage is multiplied by the pre-disability income of the employee.

☐ The policy also contains a minimum and maximum benefit amount available under the policy.

Some common reasons for differences in the amount paid versus amount expected on disability claims are:

☐ Unreported salary increase.

☐ Length of the payment period.

☐ Taxes.

☐ Integration of other income.

When is the benefit paid?

The initial payment, when appropriate, is made when a decision is rendered on a claim. If the period for payment has passed, payment is released to a current date. If the employee has a 30-day elimination period, payment will not usually be released until the period for which payment is to be made has passed.

Example:

If the elimination period is from 09/01 to 11/01, payment is made for the period from 10/01 to 11/01. This payment will usually be sent approximately seven days prior to November 1. Payment is not released until the period for which payment is being made has passed.

Payment will not be made beyond the date the physician has released the employee without supporting documentation. If a claim is submitted indicating a release date prior to the current date, payment will not be made beyond that date. Checks are sent directly to the employee.

How does a change in salary impact LTD benefit check amounts?

If the claim was incurred prior to the date of increase, the increase would not be reflected in the benefit. If the increase was effective prior to the date of disability or death and meets policy requirements for reporting salary increase, you must provide the amount and date of the increase and pay back premium on the increased amount. After receipt of the premium for the increased amount, the adjustment to the benefit will be made and any retroactive benefits due would be paid to the employee.

How do I submit information for a part-time employee receiving disability?

Provide the number of hours the employee works each day and the rate of pay. Provide this information on either a weekly or monthly basis by submitting an Earnings Statement.

Are work-related disabilities covered?

Work-related disabilities are insured; however, our standard policy integrates with Workers' Compensation benefits. We deduct the Workers' Compensation benefit from the total employee benefit.

Example:

Employee's benefit	$1,000 per month
Employee received from Workers' Comp	- 300 permonth
Net Disability Benefit from LTD	$700 per month

Maximum Benefit Period

Please see your policy for your plan's specific provisions regarding LTD Maximum Benefit Periods.

Reducing Benefit Duration (RBD).

This approach provides a graded benefit period for disabilities commencing on or after age 60. Also referred to as "To Age 65 Reducing Benefit Duration," it is one of the most common maximum benefit periods. Please see your policy for the specific benefit duration for your plan.

Social Security Normal Retirement Age (SSNRA).

The SSNRA benefit period schedule adapts the RBD schedule by including a simple statement incorporating the Social Security Normal Retirement Age. The Insured Person's normal retirement age under the Social Security Act depends on the year of birth. Please see your policy for the specific benefit period for your plan.

Will UnitedHealthcare honor court orders for garnishment of disability benefits?

Yes, UnitedHealthcare will honor court orders for garnishments if a claimant is receiving a disability benefit from our Company. In order to do this, we will accept one of the following:

☐ 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 request must be made in writing and submitted to the claim's specialist handling the claim.

Must employees file a new claim for a recurrent disability?

The employee who has attempted to return to full-time work for six months or less 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, it will be handled as a new claim.

How can denial of claims be appealed?

In order to appeal a denied claim, the employee must submit a written appeal indicating the reason the claim should be reconsidered, which must be received within 180 days from the date of the denial.

If the denial was due to a waiting period or effective date issue, proof will be required to support the employee's position. Appropriate proof would be an Enrollment Form or copies of payroll deductions. The employee should also provide additional information to support the appeal such as medical records, test results or payroll records.

A written response will be completed within 45 days advising the claimant if additional information is needed or if a decision has been reached. If additional time is needed, the employee will receive a letter outlining the reason for the delay. The appeal determination will not take longer than 90 days.

Send a written appeal to: UnitedHealthcare Disability
P.O. Box 7466
Portland, ME 04112-7466

What is needed to notify UnitedHealthcare that the employee has returned to work?

The following information is required and may be provided via telephone call:

☐ Date the employee returned to work.

☐ If the employee did not return to the prior occupation, provide a job description with physical demands for the new position.

A doctor's release form must be faxed or mailed to UnitedHealthcare.

FAX completed forms to:
(888) 505-8550

OR

MAIL completed forms to:
UnitedHealthcare Disability
P.O. Box 7466
Portland, ME 04112-7466

LTD Portability Provision

This is an optional benefit. Please check your contract to determine if your coverage includes Portability.

Which employees are eligible to port their coverage?

Employees are eligible to port their coverage upon termination of employment if they submit their Request for Portability within 31 days of their termination date.

How do employees request to port their coverage?

The employer and employee must complete the Request for Portability Long-Term Disability Form.

Employer	Employee
The employer initiates the process by completing the Employer Information sections (A and B) .	The employee completes all remaining sections of the form (C, D and E), including the calculation of the quarterly or annual premium and applicable charges. Upon completion, the employee forwards the form and initial premium payment to the UnitedHealthcare address that appears on the form.

How are employees billed for their coverage?

Upon approval, UnitedHealthcare will bill the employee directly, based on the payment mode selected.

Forms for LTD Policies

As the plan administrator, you should be familiar with several forms, including the following:

☐ Enrollment Form.

☐ Statement of Insurability.

☐ LTD Claim Forms and Instructions for Group Long-Term Disability.

☐ Earnings Statement.

Rehabilitation Services Administration Guidelines

What are Rehabilitation Services?

We partner with local independent agencies to provide rehabilitation benefits to assist the claimant in returning to the previous work site or to seek alternative work sites. We provide, free of charge, professional case managers (Vocational Counselors and Registered Nurse Case Managers) to assist claimants. These professionals are certified and experienced in the management of long-term and short-term disability cases.

Our Company provides this service at our cost and we are billed directly by the rehabilitation service. Vendors are selected by contacting national companies experienced in this business and local contacts that have performed excellent services in the past.

Who uses Rehabilitation Services?

Rehabilitation candidates are selected using criterion that indicates the person will benefit from Rehabilitation Services. These criteria include the following:

- ☐ Age (usually below 55).
- ☐ Motivated and interested in rehabilitation services.
- ☐ In need of retraining or "hands-on" assistance.
- ☐ Stable physical condition that would not prevent work in other occupations.
- ☐ Liability over the life of the claim outweighs cost of services (if person is at a minimum monthly benefit, it would be too costly to provide rehabilitation services).

Example of a Rehabilitation Case:

A teacher had a psychological problem and was unable to return to work as a teacher. He received benefits for a few years and after this amount of time, his psychological condition stabilized. His physician released him to return to employment as long as it was not in his previous occupation. We initiated rehabilitation services and a vocational counselor met with him over the course of a few months. The counselor spoke with the physician and claimant, tested the claimant, explored community resources, assisted the claimant in writing his resume, practiced a job interview and facilitated the job search. As a result, the claimant now has a new full-time job where he is very satisfied.

Early Return to Work

Our Company can provide excellent partial benefits plans to help facilitate an employee returning to work. Accommodation funds are also available if the claimant should need special equipment or accommodation.

Contact is made with the employer to communicate a release to return to work and the restrictions that have been assigned by the physician. Our Company is staffed with Registered Nurse Case Managers and Vocational Coordinators who coordinate "Return to Work" efforts between the claimant, employer and the physician.

How are rehabilitation benefits coordinated with LTD claims?

Managing LTD claims with rehabilitation benefits is coordinated with each state's vocational rehabilitation offices, such as Job Service, Employment Office and local therapy.

UnitedHealthcare uses the Medical Disability Advisor by Dr. Presley Reed, M.D., and refers to governmental guidelines through the Agency for Health Care Policy and Research (AHCPR). We also use the AMA Guide to the Evaluation of Permanent Impairment and various other guides and expert research.

All physicians performing Independent Medical Evaluations (IME) and filing reviews are board certified in their specialty areas. We often use an IME appointment service that has put all their associated physicians through a credentialing test and has all applications and background information regarding these physicians in their files. Other physicians are well known to us as well-respected board-certified experts in their fields. We also utilize the ABMS Director of Board-Certified Medical Specialists to help research local expert physicians.

All LTD claims, and many new claims, are reviewed by a registered nurse and case direction is recommended. When necessary, cases are referred for physician review. This provides for:

- ☐ Immediate assessment for rehabilitation.
- ☐ Social Security assistance.
- ☐ Early back to work efforts.
- ☐ Identification of questionable claims that are inconsistent with policy provisions and national guideline standards.

UnitedHealth Allies® Administration Guidelines

Enrollment

Ongoing Enrollment

How do I submit ongoing enrollments?

Your company can use one of two methods to submit ongoing enrollment data to UnitedHealth Allies:

☐ Continuing with the **electronic enrollment process** – This process simply continues the enrollment process utilized in the initial enrollment. Your company will establish a scheduled time frame with UnitedHealth Allies to send updated employee information for new hires, termination and updated employee information (such as name or address changes). This process is detailed in the Customer Update Process document.

☐ Moving to a **manual enrollment process** – This process may be more suitable if your company cannot maintain a process for sending electronic census to UnitedHealth Allies beyond the initial enrollment.

This process is determined in the Group Application/Agreement.

How do I add employees?

The manual process requires your company's Benefit Administrator to manually add each new employee through the UnitedHealth Allies website using the following steps:

1. Log onto **www.HealthAllies.com** and select "Create Account."

2. Select "No, I have not received my membership card," then select "But I have a Group ID

number." 3. Enter your company's Group ID to begin the online enrollment process.

4. Enter all the employee information.

5. Assign each enrolled employee a username and password. The suggested username is "firstname.lastname" or a similar simple format (e.g. "john.smith" or "jsmith") and password "password1."

6. Inform each employee of the username and password you assigned. The employee can change the password using the "My Account" tool.

Your Group ID will be provided by UnitedHealth Allies if the Manual Enrollment process is selected in the Group Application/Agreement.

How do I update employee information?

If your organization follows the manual enrollment process, employees can log on to the website (**www.HealthAllies.com**) and update their own information (name, address, spouse, dependents, etc.) in the "My Account" section of the website. Or, they can speak with a Customer Service Representative at **(800) 377-0263** to change the information.

How do I remove an employee who has been terminated?

If your organization follows the manual enrollment process, notify UnitedHealth Allies of termination by sending an email to **Client-Support@HealthAllies.com.** Be sure to include your company's name and the complete name of the employee who is to be terminated. The benefit for the employee will terminate at midnight of the last day of the month in which UnitedHealth Allies is notified of the termination. (UnitedHealth Allies does not do retroactive termination.)

How do I enroll late applicants?

Because UnitedHealth Allies program is not an insurance program, members can be enrolled at any time. Membership becomes effective immediately either when the data is loaded (electronic enrollment process) or when the Benefits Administrator adds the employee (manual enrollment process).

Who is considered to be a rehired employee?

Any employee who returns to work after temporary termination may re-enroll in the UnitedHealth Allies program.

How do I enroll a rehired employee?

☐ Complete a new Enrollment Form and include the rehire date and current information.

☐ Rehires are treated as "ADDS" on the next month's eligibility file.

☐ Re-enrollees will receive new membership cards and member numbers unless the same employee/customer ID is submitted to UnitedHealth Allies in the eligibility file (electronic enrollment process only).

Membership Kits

Am I responsible for distributing and maintaining membership cards?

No. UnitedHealth Allies sends Membership kits, which include the membership card(s) and Welcome Brochure to employees' homes.

Can members order replacement cards?

Yes. Members can order replacements for lost/stolen cards or additional cards for dependents that are away at school in either of the following ways:

☐ Call the UnitedHealth Allies Customer Service Center at **(800) 377-0263.**

☐ Log onto **www.HealthAllies.com** and order cards using the "My Account" tool.

Enrollment Checklist

You are required to obtain a completed Enrollment Form for each employee or group member enrolled in the program, whether offered on a contributory or non-contributory basis. These forms are for the Employer's records and are a substitution for the file required by UnitedHealth Allies to update eligibility. File the completed Enrollment Form with your office records.

Do not fax or mail the enrollment forms to UnitedHealthcare or to HealthAllies .

Please use this checklist as a guide when collecting enrollment information.

☐ Review Enrollment Form for legible, complete and accurate information.

☐ Be sure the employee or group member has signed and dated the form.

☐ Be sure required spouse and dependent information has been provided (UnitedHealthcare Health Value Program offers family membership).

☐ Be sure the employee or group member has provided a daytime phone number(s) so that UnitedHealth Allies can confirm provider selections.

☐ If the Health Value Program is offered on a contributory basis, be sure the employee or group member has signed the payroll deduction authorization.

Forms for Health Value Program

These forms/documents are pertinent for administering the UnitedHealthcare Specialty Benefits Health Value Program.

☐ UnitedHealth Allies Group Agreement and Application Client Agreement and Group Application.

☐ Enrollment Form.

☐ Customer Update Process Document.

Critical Illness Protection Plan Product Administration Guidelines

What is the Critical Illness Protection Plan Product?

The Critical Illness Protection Plan can help employees financially by paying a lump-sum benefit upon diagnosis of one of the covered critical illnesses.

What conditions are covered under this product?

Covered critical illnesses include: Cancer-invasive, cancer-non-invasive, heart attack, coma, stoke, ALS, Alzheimer's, child-only covered conditions.

For a full list of covered conditions, please refer to your Certificate of Coverage.

Is there an individual underwriting requirement for this product?

Critical Illness is sold as guarantee issue only. There are no medical questions required to be answered to obtain coverage.

What are the requirements for late entrants?

Late enrollees are not allowed. An employee can elect coverage during his or her initial open enrollment period or during a subsequent annual/re-enrollment period.

Is the Critical Illness Protection Plan Product List-Billed or Self-Billed?

The Critical Illness Protection Plan Product can be either List-Billed or Self-Billed. Refer to the appropriate section of this manual for specific procedures for each billing type.

Eligibility

Employees are required to be actively at work for minimum number of hours (see your Certificate of Coverage) per week. Dependent coverage is only available if employee elects coverage.

Claims Submission

How do I submit a claim?

1 . Be sure employee has completed the Claim Form and Instructions for Critical Illness Protection Plan in full.

2 . Employee should attach copies of any supporting medical records he or she has to validate the claim. Direct employees to refer to Certificate of Coverage for the definition that applies to each critical illness and ask their physicians to provide information in support of thatdefinition.

3 . Employee should complete the Employee's Authorization for Release of Information to allow UnitedHealthcare to secure additional information if necessary, to decide on the claim for benefits. Instruct employees to also provide a copy of the form to their physician(s).

4 . Claims submissions must include:

- ☐ Employer's Statement.
- ☐ Employee's Critical Illness Statement.
- ☐ Supporting Documentation.
- ☐ Employee's Authorization for Release of Information.

FAX completed forms to:		MAIL completed forms to:
(888) 505-8550		UnitedHealthcare Disability
Phone: (888) 299-2070	OR	P.O. Box 7466
		Portland, ME 04112-7466

Note: Instruct physicians to respond to any requests for information by sending requested records to address above.

Optional Benefits

(Check your policy for the specifics on your plan)

Are employees eligible to port their coverage?

If portability is included on the policy, employees who have purchased coverage are eligible to port their coverage upon termination of employment.

- The Covered Person must be insured under the Policy for at least six months prior to the date employment ends.
- Covered Person must apply for Portability within 31 days of the date his or her insurance ends.

To apply for Portability, the Covered Person must complete and submit the **Request for Portability Form** to the address listed on the form.

Is a Wellness Benefit available?

Yes. If the Wellness Benefit is included on the policy, the insured will be paid the amount per the policy for specified health screening tests. Insured must provide proof of having a contract specified health screening test performed.

Employees must complete and submit the **Group Critical Insurance Wellness Benefit Claim Form** to the address listed on the form with a copy of the invoice for the screening test they are requesting reimbursement for.

Is an Occupational HIV Benefit available?

Yes . If the Occupational HIV Benefit is included on the policy.

We will pay the Occupational HIV Benefit shown on the Schedule of Benefits in a lump sum for exposure to the Human Immunodeficiency Virus (HIV) if:

1 . A Covered Person, who elected coverage under the benefit is included within the Eligible SIC Codes shown below, sustains an Injury in the performance of his or her occupational duties;

and

2. As a result of such Injury, the Covered Person acquires and tests positive for HIV.

Eligible SIC Codes:

1. 801x-804x Physicians and Dentists
2. 805x-906x Hospitals, Nursing Facilities
3. 807x-809x Medical/Dental Labs, Clinics, Home Health Care, Other Health Services
4. 922x Police/Fire/Corrections

Forms for the Critical Illness Protection Plan Product

As the plan administrator, you should be familiar with the following documents/forms.

At the bottom of the list, add an additional bullet and say Certificate of Coverage.

☐ Statement of Insurability – Group Critical Illness Insurance.

☐ Authorization for the Release of Information (HIPAA).

☐ Request for Portability of Critical Illness.

☐ Group Critical Illness Insurance Health Screening Benefit Claim Form.

☐ Critical Illness Enrollment Form.

☐ Critical Illness Claim Form.

Accident Protection Plan Product Administration Guidelines

What is Accident Protection?

Accident Protection Plan is an indemnity product providing financial protection for expenses related to injuries due to a covered accident. Payments are based off of amount per the insured's plan/schedule of benefit. Benefit payments are paid directly to the insured to use at his or her discretion.

What conditions are covered under this product?

The Accident Protection Plan offers coverage for accidental death and dismemberment, initial care, hospital care, follow-up care and covered injuries and services. The Plan covers things like emergency room visits, fractures, dislocations, X-rays and rehabilitation. Refer to your Certificate of Coverage for coverage details and benefits schedule.

Is there an individual underwriting requirement for this product?

There is no underwriting required for this product.

What are the requirements for late entrants?

Late enrollees are not allowed. An employee can elect coverage during his or her initial open enrollment period or during a subsequent annual/re-enrollment period.

Is the Accident Protection Plan Product List-Billed or Self-Billed?

The Accident Protection Plan Product can be List-Billed or Self-Billed. Refer to the appropriate section of this manual for specific procedures for each billing type.

Eligibility

Employees' are required to be actively at work for minimum number of hours (see your Certificate of Coverage) per week. Dependent coverage is only available if employee elects coverage.

Claims Submission

How do I submit a claim?

1. Be sure employee has completed the Accident Protection Plan Claim Form. The Claim Form is available on eAdministration/eBill.
2. Employee should attach copies of any supporting medical records he or she has to validate the claim. Direct employees to refer to Certificate of Coverage and the schedule of benefits for the covered conditions. Ask their physicians to provide information in support of that condition.
3. Employee should complete the Employee's Authorization for Release of Information to allow UnitedHealthcare to secure additional information if necessary, to make a decision on the claim for benefits. Instruct employees to also provide a copy of the form to their physician(s).
4. Claims submissions must include:

   ☐ Employer's Statement.
   ☐ Supporting Documentation.
   ☐ Completed Claim Form.
   ☐ Employee's Authorization for Release of Information.

FAX completed forms to:		MAIL completed forms to:
(888) 505-8550	OR	UnitedHealthcare Disability
Phone: (888) 299-2070		P.O. Box 7466
		Portland, ME 04112-7466

Note: Instruct physicians to respond to any requests for information by sending requested records to the same address as printed above.

Optional Benefits

(Check your policy for the specifics on your plan)

Are employees eligible to port their coverage?

Portability is included in the Accident Protect Plan Protection. Employees who have purchased Accident Protection Plan Coverage are eligible to extend their coverage for 12 months upon termination of employment provided that they submit their Request for Portability and pay first month's premium within 31 days of their termination date.

Is a Wellness Benefit available?

Yes. If the Wellness Benefit is included on the policy, the insured will be paid the amount per the policy for specified health screening tests. Insured must provide proof of having a contract specified health screening test performed.

Employees must complete and submit the Wellness Benefit Claim Form to the address listed on the form with a copy of the invoice for the screening test they are requesting reimbursement for.

Is an Occupational HIV Benefit available?

Yes. If you have purchased this benefit, insured will be paid according to their selected plan level/schedule of benefits. A Covered Person who elected coverage under the benefit is included within the Eligible SIC Codes shown below, sustains an Injury in the performance of his occupational duties. Refer to your Certificate of Coverage for additional conditions/exclusions.

Eligible SIC Codes:

5. 801x-804x Physicians and Dentists
6. 805x-906x Hospitals, Nursing Facilities
7. 807x-809x Medical/Dental Labs, Clinics, Home Health Care, Other Health Services
8. 922x Police/Fire/Corrections

Forms for the Accident Protection Plan Product

As the plan administrator, you should be familiar with several forms, including the following:

☐ Statement of Insurability – Group Accident Protection Plan Insurance.

☐ Authorization for the Release of Information (HIPAA).

☐ Request for Portability.

☐ Wellness Benefit Claim Form.

☐ Accident Protection Plan Enrollment Form.

☐ Accident Protection Plan Claim Form.

☐ Your Company's Certificate of Coverage.

Hospital Indemnity Plan Product Administration Guidelines

What is Hospital Indemnity Protection Plan?

Hospital Indemnity Protection Plan is an indemnity product that pays cash directly to you. The money can be used anyway you choose it can be saved, used for hospital expenses, related treatments, health plan deductibles or other out-of-pocket expenses.

What are the benefits under this product?

Base Plan benefits include:

- Hospital admission
- Hospital confinement
- Intensive Care Unit (ICU)confinement

Base + Enhanced Plan benefits include:

- Hospital admission
- Hospital confinement
- Intensive Care Unit (ICU)confinement
- ICU admission
- Emergency Room
- Lodging
- Transportation

Covered conditions may vary by state; please see your Certificate of Coverage.

Is there a medical underwriting requirement for this product?

No medical underwriting is required for Hospital Indemnity.

What are the requirements for late entrants?

Late entrants are not allowed. A late entrant is a term used on plans where the employees enroll for coverage and contribute to the premium. An employee has 31 days from his or her initial eligibility date to sign up for coverage. If he or she does not sign up during this initial 30-day period, and later requests to sign up for benefits, he or she is considered to be a late enrollee.

Is the Hospital Indemnity Plan Product list-billed or self-billed?

The Hospital Indemnity Protection Plan Product can be either list-billed or self-billed. Refer to the appropriate section of this manual for specific procedures for each billing type.

Eligibility

All full, time active employees working the required minimum hours per week (see your Certificate of Coverage for required hours). Employees are eligible for coverage; dependent coverage is optional at the policyholder level. Dependent coverage cannot exceed that of the employee's.

Claims Submission

How do I submit a claim?

1 . Be sure employee has completed the Claim Form and Instructions for Hospital Indemnity Protection Plan in full.

2 . Employee should attach copies of any supporting medical records he or she has to validate the claim. Direct employees to refer to Certificate of Coverage for the definition that applies to each benefit and ask their physicians to provide information in support of that definition.

3 . Employee should complete the Employee's Authorization for Release of Information to allow UnitedHealthcare to secure additional information if necessary, to decide on the claim for benefits.

4 . Instruct employees to also provide a copy of the form to their physicians

5 Claims submissions must include:

- Employer's Statement.
- Employee's Statement Supporting Documentation.
- Employee's Authorization for Release of Information.

FAX completed forms to:		MAIL completed forms to:
(888) 505-8550 Phone: (888) 299-2070	OR	UnitedHealthcare Disability P.O. Box 7466 Portland, ME 04112-7466

Note: Instruct physicians to respond to any requests for information by sending requested records to address above.

Optional Benefits

(Check your policy for the specifics on your plan)

Are employees eligible to port their coverage?

If you have purchased portability, employees who have purchased Hospital Indemnity Protection Plan Coverage are eligible to extend their coverage for 12 months upon termination of employment provided that they submit their **Request for Portability** within 31 days of their termination date.

Is a Wellness Benefit available?

Yes, if this benefit is included on your plan. Insureds will be paid the designated benefit amount (see your Certificate of Coverage for amount) per calendar year for specified health screening tests. Insured must provide adequate proof of having had a contract-specified health screening test performed.

Employees must complete and submit the **Group Hospital Indemnity Wellness Benefit Claim Form** to the address listed on the form with a copy of the invoice for the screening test they are requesting reimbursement for.

Forms for the Hospital Indemnity Plan Product

As the plan administrator, you should be familiar with several forms, including the following:

- Certificate of Coverage.
- Authorization for the Release of Information (HIPAA) Request for Portability of Hospital Indemnity.
- Hospital Indemnity Enrollment Form.
- Hospital Indemnity Claim Form.
- Hospital Indemnity Wellness Claim Form.

FMLA & Leave Administration Guidelines

Submitting a Leave Request

UnitedHealthcare is committed to supporting your employees during their absence and helping them achieve a timely and healthy return to work. We have prepared a guide titled “Requesting a Family Medical Leave or Short-Term Disability Claim” for employees and this is available by calling UnitedHealthcare or by downloading the form from the eAdministration site. This guide will assist an employee in submitting a request for scheduled or unscheduled absences. This process applies to short-term disability (STD), the Family Medical Leave Act, and related state or company specific leave policies.

Follow These Simple Steps

1. Employees should notify their supervisor or manager of their absence from work.
2. Using the Information Checklist, employee should gather information about their absence and have this information ready when they call us. If someone makes the call for them (e.g., a family member), he or she will need to provide this information on their behalf.
3. Call us toll free at **(866) 556-8298.** Hours of operation are Monday through Friday, 8 a.m. – 6 p.m. ET.
4. If the employee’s absence from work is due to his or her health condition, his or her will sign and date an Authorization Form. This Form is provided to the physician. The employee should also fax a copy of the signed, dated form to us
at **(866) 334-0985.**

What Happens Next

Every absence is unique and next steps can differ depending upon the type of claim or leave request. When employees contact us at **(866) 556-8298** and we learn more about their specific request, we will guide them through the process, answer any questions and tell them what to expect next. They have our commitment to be responsive and supportive during their time away from work.

Information Checklist

Employees should have the following information ready when they call:

- 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 they were absent from work.
- Date they expect to return to work (if they know), or the actual date (if they have already returned to work at the time of call).
- If the absence or claim is due to their own health condition, please 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 and phone number.
  - Dates of their first visit, their most recent visit, and their next scheduled visit with their physician for this condition.

EAP Program Administration Guidelines

Contact and Mailing Information

EAP

Basic Plan Phone	**(866) 302-4481**
Enhanced Plan Phone	**(866) 302-4482**

What is EAP?

Whether the issue is an aging parent's health crisis, an employee's adolescent daughter experiencing depression, an employee on disability experiencing difficulty returning to work, or confusion about college costs and financial aid options — help is available with a single phone call to the UnitedHealthcare EAP toll-free line. The UnitedHealthcare EAP approach is founded upon meeting the needs of the whole person, recognizing the interplay between the various components of our clients' lives and the impact that a problem in any one area can have on others.

How do I enroll employees?

The EAP is available to all of your employees and their immediate family members. Once you have completed the necessary forms, your employees or their family members can call into the toll-free number to receive services. This includes the original enrollment, rehires and new employees.

How will I receive communication materials?

Your SAE will provide you with the enrollment packets (enhanced), electronic materials (basic) and schedule web-based training (enhanced).

How do I access the EAP website?

By visiting www.liveandworkwell.com, access code: UHC. The website features a comprehensive menu of online participant resources that is unmatched in the industry. It includes thousands of articles on a wide range of topics related to well-being, as well as interactive learning tools and helpful resources.

How do I access Educational Seminars?

Simply call **(866) 876-2785** and speak to a Training Consultant.

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In the event of conflicting information in this administration guide, refer to the group policy and individual certificate for resolution.

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For costs and complete details of the coverage, call or write your insurance agent or the company. Some products are not available in all states. UnitedHealthcare Insurance Company is located in Hartford, CT and Unimerica Life Insurance Company is located in Milwaukee, WI.

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