Administrative Guide

SafeGuard®

Self-Funding for the Small to Mid-Size Employer

ADMINISTRATIVE GUIDE
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To Our New SafeGuard Plan Sponsor:

Welcome to the SafeGuard family. We look forward to providing you and your employees with the exemplary service for which we have become known in the health benefits industry.

The attached Administrative Guide will assist you in easily and efficiently managing your Plan's health benefits. Within this guide, you will find advice and instructions for the maintenance of your group—policies and procedures for situations you will encounter.

Each enrollee in your Plan will receive a package at his or her home address containing member identification card(s). The member identification card contains all of the information necessary for providers and pharmacists to accurately submit claims. Every effort should be made by your members to have their providers update benefit information as soon as possible in order to avoid delays in claims processing.

To ensure the information security of your employees, member identification cards do not feature social security numbers, but rather a unique member identification number which is significant only within our system.

The SafeGuard website www.ushealthandlife.com will provide you and your members with valuable information and 24/7 assistance throughout your plan year. Links to a contact directory that you can keep on hand for quick access are included on page four.

If at any time you have questions or need assistance with a member or group issue, contact our dedicated SafeGuard sales support team toll-free at 844-828-5968.

Thank you for your business and we look forward to partnering with you in providing for your members' health in the year ahead.

Sincerely,

Michael McCollom
VP Sales & Underwriting
US Health and Life Insurance Company (USHL)

Dear Plan Member,

You will soon receive your member identification card(s) in the mail at your home address. Please note that your member identification card contains important information necessary for providers and pharmacies to accurately submit claims. *Make every effort to have your doctors and pharmacists update their records with your new card information at the time of your next visit.*

In the case that you or covered dependents require medical attention or a prescription drug prior to card receipt, please review the following information:

- Benefits can be verified by calling our toll free customer service line at 844-284-6750, available weekdays from 8:30 a.m. to 4:30 p.m. EST.

- Providers may also verify benefits 24/7 by calling our fax-recall system toll free at (888) 494-4600. The information required from providers when utilizing the fax recall system:

    - Provider's fax number
    - Employee's ID Number or Social Security Number
    - Dependent's date of birth (if requesting dependent information)
    - Provider's Tax Identification Number (TIN)

- Prescription drug questions will be addressed by USHL pharmacy benefits manager Magellan Rx Management at 800-424-5850.

Our SafeGuard website www.ushealthandlife.com also provides additional member resources, including:

- Contact information
- Schedules of Benefits
- Forms
- Member secure services

We welcome you to US Health and Life Insurance Company and look forward to providing you with exemplary service.

Sincerely,
Your Customer Service Team

Contact Directory for Employers

Client Services
clientservices@ushealthandlife.com

Enrollment
enrollment@ushealthandlife.com

CONTACT ENROLLMENT FOR ISSUES INCLUDING:

- Submitting paperwork for addition/termination of members to/from group coverage
- Member changes (such as addition/termination of dependent coverage, address changes and more)

Billing
ushlbilling@ushealthandlife.com

CONTACT BILLING FOR ISSUES INCLUDING:

- Status of invoices
- Late payments
- Reinstatement advice
- Invoice copies

Claims
- Due to laws governing disclosure of private health information (PHI), claims-related questions can only be addressed with the applicable member.
- Provide the following information to members seeking assistance or direct them to call the USHL claims number listed on their medical ID card.

Online Assistance

Summaries of Benefits and Coverage (SBCs) and Explanation of Benefits (EOBs) may be obtained online at www.ushealthandlife.com. Go to USHL Secure Online Services. Login and follow prompts

Rx Coverage Assistance

Magellan Rx
(800) 424-5850

Enrollment Guidelines

- New enrollees must be full-time, active employees at your establishment working a minimum of 30 hours per week.
- The employee will become eligible upon completion of your selected waiting period.
- An employee who is not “Actively at Work” on the day coverage will become effective on the date they return to work on a full-time basis.
- If an eligible employee’s employment is terminated and they are rehired within six (6) months (rehire limit may fluctuate depending on your company rules), they will not have to complete another employment waiting period unless required by your employment guidelines.
- If an eligible employee does not enroll within 31 days of the eligible effective date, the employee and dependents will not be eligible until the next open enrollment period for the group.
- If a dependent is disabled or hospital confined on the date they would otherwise become insured, they will become insured on the date the confinement ends. This does not apply to a newborn child.

Refer to your Master Plan Document / Summary Plan Description for a more detailed description of SafeGuard enrollment rules.

Employee Enrollment Form
Instructions for Completion

Section A. Employer Information
This section is to be completed by an authorized representative of the employer or Plan Sponsor. Check the box that represents the reason for submission of this particular form:

- o **Initial Group Enrollment —** A group's first submission, just prior to the beginning of their coverage with USHL.
- o **New Hire —** An individual who was hired after an Initial Group Enrollment and is about to become eligible for benefits under the Plan.
- o **Re-Hire (within 6 months) —** An individual who has been eligible under the Plan within six months of the date on which they will again become eligible and become ineligible based on separation from the employer.
- o **Status Change —** An individual who is currently eligible for the Plan, but who has experienced a change that allows them to change their benefits in the middle of the plan year. (i.e. Married, Divorced, Birth of a Child)
- o **Re-Apply After Waiver —** May only apply for coverage during the open enrollment period for the group if there is not a life event.
- o **Open Enrollment —** Open enrollment period includes the month prior and the month of recontracting. Each full-time employee has the option to select benefits.

- **Effective Date —** The month, day and year on which the benefits being selected or changed by this form are to be effective. If a member begins or is terminated mid-month, payment must be made for the full month, as we do not pro-rate.
- **Group (Employer) Name —** The legal name of the employer or Plan Sponsor.
- **Division —** The group ID number.
- **Date of Hire —** The date on which this employee began working full time for the employer or Plan Sponsor.

Section B. Employee Information
This section, and all the subsequent sections on this form, are to be completed by the individual enrolling in benefits. Check the box that represents the reason for submission of this particular form.

- **Male or Female —** Place a mark in the box that corresponds with your gender.
- **Single**, **Married or Divorced —** Place a mark in the box that corresponds with your current legal status.
- **Name —** Print your legal first name, middle initial, and last name in the space provided.
- **Name Change —** Place a mark in the box if this name is different from the one you have most recently submitted. If you have never submitted a name, do not check this box.
- **Address —** Print your current street address and apartment number if applicable.
- **Address Change —** Place a mark in the box if this address is different from the one you have most recently submitted. If you have never submitted an address, do not check this box.
- **City —** Print the name of the city in which you currently reside.
- **State —** Print the name of the state in which you currently reside.
- **Zip —** Print the zip code assigned to your current home address.
- **Date of Birth —** Print the month/day/year on which you were born.
- **Social Security Number —** Print the nine-digit number that was assigned to you by the Social Security Administration.
- **Occupation —** Your title or job function with this employer.
- **Daytime Phone Number —** The best number at which to reach you during normal business hours.
- **Email Address —** Print your email address.
- **COBRA Eligibility —** Check yes or no if you are currently on COBRA coverage, along with the qualifying event date and start date of the COBRA coverage.
- **Life Insurance Beneficiary Name —** Print the name of the person who is your beneficiary.
- **Relationship —** The relationship you have with your beneficiary.

Section C. Dependent Information
This section must only be completed when enrolling dependents. *If dependents are being enrolled at a time other than the employee's initial enrollment, proof of relationship (copy of adoption form, birth certificate, tax return or marriage certificate) must be provided. If dependents with a different last name are being enrolled, proof of relationship (copy of adoption form, birth certificate, tax return or marriage license) must be provided.*

Are you

- **Enrolling —** Place a mark in this box if this is the first time you have purchased or been provided insurance through USHL, and you intend to provide coverage for a dependent(s).

- **Adding —** Place a mark in this box if you currently have USHL insurance and would like to extend that coverage to dependent(s) not covered by a SafeGuard plan.

- **Removing —** Place a mark in this box if you have dependent(s) currently enrolled in SafeGuard, and want to discontinue that coverage.

Definition of Eligible

- **Spouse —** The person to whom you are currently legally married.

- **Dependents —** Children of the employee and/or eligible spouse to the end of the month in which they attain the age of 26 or if there is a qualified medical child support order which states that the child must be covered**.**

- **First Name —** Print the legal first name of the spouse or dependent for which this action applies in the space provided.

- **Initial —** Print the legal middle initial of the spouse or dependent for which this action applies in the space provided.

- **Last Name —** Print the legal last name of the spouse or dependent for which this action applies in the space provided.

- **Relationship —** The nature of the relationship with the spouse or dependent for whom this action applies.

- **Date of Birth —** Print the month/day/year on which the spouse or dependent for whom this action applies was born.

- **Sex —** The gender of the spouse or dependent for whom this action applies.

- **Social Security No. —** The nine-digit number assigned by the Social Security Administration for the spouse or dependent for whom this action applies.

- **Dependent Address —** If enrolled dependent(s) reside at an address other than that of the employee, provide the name of the dependent(s) and their residential address.

Section D. Other Health Coverage Information
If you have other medical, prescription drug or dental coverage, not including a plan currently provided to you by the employer or Plan Sponsor providing the coverage in which you are currently enrolling, please check all the boxes that apply to that coverage.

- **Source —** Through whom are you receiving other coverage?
- **Who is Covered? —** Which individuals receive insurance or benefits from this other plan?
- **Name of Covered? —** Print the names of those individuals who receive insurance or benefits from this other plan.
- **Effective Date —** The month/day/year on which this other coverage took effect.
- **Name of Carrier —** The insurance company from which this coverage is issued.
- **Type of Coverage —** What category of expense does this other coverage insure you against?
- **Reason for Medicare eligibility —** In order to receive benefits under Medicare you must meet at least some of the conditions as set forth by the Social Security Administration. Which conditions have you met that enable you to receive benefits under Medicare?
- **Date Eligible —** The date on which you became eligible for Medicare.

Section E. Employee Agreement/Authorization to Release HIPAA Medical Information
This section provides you with important information on your rights and responsibilities under this Plan, including:

- **Affirmations** of the truthfulness of your responses
- **Authorization** for USHL to obtain information pertaining to diagnosis, treatment and prognosis of any physical or mental condition; drug or alcohol abuse; HIV/AIDS test results, or diagnosis and/or treatment; and / or non-medical information for myself and any enrolling spouse / dependent(s).
- **Acknowledgement** that you have read and understand the entire form. In order for your application to be accepted and processed you must read and understand this section, and sign the bottom of the application.

Events Requiring Status Change Notification

Please use the Enrollment Adjustment Form to notify us of any changes. USHL must be notified in a timely manner if any of the following changes take place:

- **Newborn —** USHL must be notified within 31 days from date of the birth.
- **Legal Adoption —** USHL must be notified within 31 days of legal custody. Please provide a copy of the court order.
- **Marriage —** USHL must be notified within 31 days of the date of marriage. Please provide a copy of the marriage certificate.
- **Change in Job Status —** Please notify us immediately of a member's job classification change (i.e. part time to full time, reduction of hours, etc.).
- **Change of Address —** It is important to remember if you move or change residence to notify USHL as soon as possible.
- **Divorce —** USHL must be notified immediately. Please provide a copy of the divorce decree.
- **Removing Dependent —** When a dependent is no longer eligible for coverage, USHL must be notified within 31 days of the requested effective date and a waiver form must be completed.

Note: More detailed information regarding a change in status can be found in your Master Plan Document / Summary Plan Description (MPD/SPD)

Status Change Notification and Enrollment Procedures

The Enrollment Adjustment Form worksheet must be submitted to the Enrollment Department:

- Email: enrollment@ushealthandlife.com
- Telephone (844) 659-2517
- Fax (586) 693-4820 (send faxes to the attention of the Enrollment Department)

Please submit the following documents for either a status change or new enrollment:

- Employee Enrollment Form (both pages)
- Enrollment Adjustment Form

To assure timely processing of your request, please do not wait to notify us, submit the Enrollment Adjustment Form as events occur. Our policy allows a maximum of two months credit for terminations. Please see completion instructions below.

SafeGuard Billing Adjustment Worksheet completion instructions:

- **Group Name —** Fill in your company name.
- **Division Number —** Fill in your Group ID.
- **Employee SS# or Unique ID# —** List the employee's 9-digit social security number or unique ID#.
- **Employee Name —** Please list the employee's full name (last, first, middle initial).
- **Status Change Code —** Please enter the appropriate status change code. A SafeGuard Employee Enrollment Form must accompany certain codes.
- **Effective Date of Change —** Indicate the exact date of the change.
- **Remarks —** Indicate any additional remarks you feel may be necessary to process your request.

If we receive the completed Enrollment Adjustment Form by the fifth of the month, the change will appear on your next statement. If your change does not appear on the appropriate billing statement, please contact the Enrollment Department.

Group Plan Change Requests

If you need to make coverage change(s) to your plan, including changing the plan selection or prescription coverage (for both of these scenarios, benefit buy-downs are allowed mid plan year, but benefit buy-ups are not allowed until the time of re-contracting), changing the employee waiting period or network(s), or adding 24/7 work-related accident and illness coverage, you will need to submit the request on company letterhead. Please identify the change requested, effective date of requested change, group ID, and include the signature of an authorized group contact or owner. Submit the letter by email to SalesSupport@ushealthandlife.com.

Monthly Invoice Statement

DESCRIPTION OF SERVICES	INVOICE AMOUNT	CREDIT AMOUNT	TOTAL DUE
PREVIOUS BALANCE			$0.00
ADMINISTRATION FEES	$768.30	$0.00	$768.30
MEDICAL PREMIUM	$1,097.60	$0.00	$1,097.60
EXCESS LOSS PREMIUM	$1,792.73	$0.00	$1,792.73
PHARMACY PREMIUM	$0.00	$0.00	$0.00
PLEASE PAY AS INVOICED			$3,658.63

Detailed Listing

Detailed Adjustment Listing

The first segment of your statement represents a detailed adjustment listing of any debits and credits. IT IS VERY IMPORTANT THAT ALL CHANGES IN EMPLOYEE STATUS ARE REPORTED BY THE FIFTH OF THE MONTH. Any delay in submitting the Enrollment Adjustment Form could result in rejected claims or payment of claims for an ineligible employee/dependent. Also, any delay in submitting status changes may create inaccuracy for your next statement.

- The month you are being credited or charged
- Employee's Name
- Employee's Unique Identifier Number
- Employee's date of birth
- Employee's benefit effective date/age
- The individual amounts (credits/charges) for that month
- The total credits/charges per employee*

*You must pay as billed. All changes will be reflected on the next invoice/bill.

Detailed Employee Listing and Benefit

The second segment of your invoice is a breakdown of each enrolled employee in alphabetical order and the total charges due for them.

- **Billing —** The current statement month
- **Employee's Name** (last, first)
- Employee's **Unique Identification Number**
- Employee's **Date of Birth**
- The employee's **coverage effective date**/employee's age
- Employee's **life volume and premium** amount (if any)
- Employee's **AD&D volume and premium** amount (if any)
- **Administrative fee**
- **Excess loss premium**
- **Pre-funded claims account** contribution
- **PPACA taxes**
- **Dental premium** (if any)
- **Total** indicates the combined total monthly charges due for each individual employee

Monthly Statement Detail

EMPLOYEE CLASS: C001 ACTIVE

09/2020 Billing

Employee Name / Subscriber ID	Date of Birth	Gender / Age	Med Family Indicator Medical/ RX Claim Fund	Excess Loss Premium	Den Family Indicator Dental Premium	Life Volume Premium	AD&D Volume Premium	Admin Fee	Total
EMPLOYEE NAME		M	Subscriber Only			0	0		
ID NUMBER	02/09/66	55	$161.64	$264.01	$0.00	$0.00	$0.00	$113.14	$538.79
EMPLOYEE NAME		M	Subscriber Only			0	0		
ID NUMBER	02/28/60	60	$161.64	$264.01	$0.00	$0.00	$0.00	$113.14	$538.79
EMPLOYEE NAME		M	Subscriber & Spouse			0	0		
ID NUMBER	01/28/62	59	$331.71	$541.79	$0.00	$0.00	$0.00	$232.20	$1,105.70
EMPLOYEE NAME		M	Subscriber Only			0	0		
ID NUMBER	12/01/69	51	$161.64	$264.01	$0.00	$0.00	$0.00	$113.14	$538.79
EMPLOYEE NAME		M	Subscriber & Dependents			0	0		
ID NUMBER	04/23/60	60	$280.97	$458.91	$0.00	$0.00	$0.00	$196.68	$936.56

09/2020 Billing

Employee Class Month Totals

	Total Count Medical/RX Claim Fund	Total Count Excess Loss Premium	Total Count Dental Premium	Total Count Life Volume Premium	Total Count AD&D Volume Premium	Total Count Admin Fee	Total
SUMMARY	5	5		0	0	5	
	$1,097.60	$1,792.73	$0.00	$0.00	$0.00	$768.30	$3,658.63
Subscriber Only	3	3		0	0	3	
	$484.92	$792.03	$0.00	$0.00	$0.00	$339.42	$1,616.37
Subscriber & Spouse	1	1		0	0	1	
	$331.71	$541.79	$0.00	$0.00	$0.00	$232.20	$1,105.70
Subscriber & Dependents	1	1		0	0	1	
	$280.97	$458.91	$0.00	$0.00	$0.00	$196.68	$936.56

Premium Payment Procedure

Monthly ACH Withdrawal Procedure

SafeGuard invoices will be mailed monthly and indicate the amount to be withdrawn via ACH on the first business day of that billing cycle.

If any changes to group billing are necessary, notification must be made by submitting an Enrollment Adjustment Form.

ACH withdrawals for monthly billing payments occur on the first business day of each month.

If there is a change to the account from which USHL is authorized to make monthly ACH withdrawals, you must notify USHL.

For billing questions please contact:

Email: ushlbilling@ushealthandlife.com
Telephone: (844) 659-2517
Fax: (586) 693-4820

Monthly Payment by Check Procedure

After you have reviewed your invoice and advised USHL of any changes necessary via the Enrollment Adjustment Form, please submit the premium payment which is due on the first of each month. **You must pay as invoiced.**

Please make your check payable to US Health and Life Insurance Company and mail to the address on your invoice.

Important: Please remit your payment on time. Untimely premium remittance may result in delayed claim payments. All changes will be reflected on the next invoice.

Death Claim Instructions

If your group has elected life insurance coverage through USHL and you need to file a death claim for a deceased member, follow the instructions below.

- Complete the USHL Death Claim Form
- When completed, submit the death claim form along with the following information:
    - **Death Certificate —** A certified copy of the death certificate bearing a raised seal must be furnished. An uncertified photocopy is not acceptable.
    - **Enrollment Card —** The original enrollment card or a photocopy must be submitted with this form. Any changes in coverage and/or beneficiary information must also be attached.
    - **Check Recipient —** Provide the name and address to which the claim check should be sent. If not provided, a claim check will be sent directly to the beneficiary(ies).
    - **Accidental Death and Dismemberment —** If loss was the result of an accident, send all available documents pertaining to the accident such as: policy reports, newspaper article giving details of the accident and medical examiner's report. In addition, if the accident was work related, provide an employer accident report.
    - **Benefits Payable to the Estate —** If insurance proceeds are payable to an individual's estate, or to a minor or mentally incompetent person, a certified copy of the certificate showing the appointment of such Executor, Administrator, Guardian or Conservator for that individual's property must be submitted.

Note: The above information is generally needed to process the claim. However, we may find it necessary to request additional information when needed.

Submit completed death claim information to:

Email: SalesSupport@ushealthandlife.com
Telephone (844) 828-5968
Fax (248) 593-5803 *(send faxes to the attention of Sales Support)*

Medical Claim Submission Instructions

When using an in-network or out-of-network physician or facility, you are not required to complete any paperwork. Your healthcare facility where your services are rendered will process any necessary paperwork and submit your claim for processing and payment directly.

Magellan Rx Management:
The SafeGuard Prescription Benefit Manager (PBM)

Magellan Rx Management is a nationwide PBM with over 67,000+ participating retail pharmacies including, but not limited to, Costco, CVS, Rite Aid, Target, Sav-More, Kroger, Walgreens and Walmart. Magellan Rx Management is dedicated to giving members the best service and resources to help them and their families make better healthcare decisions.

Key points in working with Magellan Rx Management:

- **Using Member Identification Card(s) at Retail Pharmacies**
  SafeGuard member identification cards include prescription benefit information. Members present their identification card along with their prescription to any of Magellan's 67,000+ retail pharmacies; a participating pharmacy list is available at www.MagellanRx.com.
- **Online Tools - www.MagellanRx.com**
  Secure online connection, protecting member confidentiality and providing:
  - Easy-to-use tools that allow members to view, refill, renew and transfer prescriptions
  - Drug formulary & lookup tools
  - Trusted drug and health condition information & education
  - Real-time benefit information
  - Medical supply ordering capabilities
  - Text message medication reminders
  - Caregiver access to manage prescriptions
- **Prior Authorization**
  Your prescription benefit program may have a prior authorization process for certain medications. Prior authorization is a requirement that a member's physician obtain approval from the health plan to prescribe a specific medication. Please visit www.MagellanRx.com or call Customer Service at 1-800-711-4550 to determine if any medications require prior authorization or are subject to step therapy requirements. Support is available 24 hours a day, 7 days a week.
- **Mail Service Benefit**
  Mail service prescription benefits are provided by Magellan. Members can save money by ordering their maintenance medication(s) by mail order. To retrieve a mail order form please submit a request to Sales Support at SalesSupport@ushealthandlife.com.

Questions regarding SafeGuard prescription benefits should be directed to customer service at 844-828-6750.