Employer Group Administrative Guide

Associated Industries Management Services | HEALTH BENEFITS ADMINISTRATION

PROVIDED FOR:

Associated Employers Health & Welfare Trust Commercial Construction
Columbia Retail Benefits Trust
Greater Columbia Manufacturing Benefits Trust
Greater Northwest Health Benefits Trust
Pacific Business Resource Benefits Trust

The most current version of this document can be found on the web at: the www.aimstpa.com. The contents of this guide are for informational purposes only and in no way supersedes any insurance contract. In cases of conflicting information, the insurance contract and Trust provisions prevail.

Index

Associated Industries Management Services

From Your Associated Industries Management Services Staff

Hello,

Our Associated Industries Management Services (AIMS) team is pleased to welcome you. We look forward to working with you as you take advantage of everything our member-driven organization can offer your company and employees.

Our staff is ready to support your healthcare plan administrative needs – from enrollment and COBRA to billing. Our experienced staff are here to assist participating members and their employees with their benefit management needs.

If there is anything we can do to help you realize the full value of your benefits experience, please let us know.

We look forward to working with you.

Sincerely,

Your AIMS Team

Participating Benefit Partners

WELCOME TO THE ASSOCIATED INDUSTRIES MANAGEMENT SERVICES (AIMS) GUIDE

YOUR HEALTHCARE BENEFITS GUIDE

Thank you for choosing the Benefit Trust for your employee benefits which are administered by AIMS. We have designed this Guide as a useful tool in making administration elections and changes easily and efficiently. The Guide is a summary of terms and conditions set forth for participation in all AIMS-supported benefit programs, including brief descriptions of plan administration.

It is intended to direct member companies' administrative representatives through the day-to-day management of their benefits program. While all attempts have been made to provide accurate information, this guide is not a contract, booklet of insurance or a certificate of coverage. In all cases, the information provided by the insurers or program manager in your benefit booklets, contracts and certificates of insurance govern the conditions and limitations of coverage.

Customer Service Contact Information

For administrative services contact: Associated Industries		
1206 N Lincoln, Suite 200 Spokane, WA 99201-2559	**TP>** 800.274.5309 **P>** 509.326.6892 **F>** 509.777.2690	**Email >** AIMS@aiin.com **Web >**www.aimstpa.com

For quoting and sales services contact: Advanced Professionals	
To submit RFPs, visit: www.APConnect.ADVProfessionals.com	**New and Renewing Groups Processing and Broker Accreditation** Paul.Baker@advprofessionals.com

Our partners in serving you:

ASURIS NORTHWEST HEALTH

Magellan HEALTHCARE SM

Regence

Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

vsp Vision care for life

DELTA DENTAL®

Delta Dental of Washington

TheStandard®

Eligibility and Enrollment Guidelines

WEB TOOLS

Forms, documents and other resources. Save time and be confident you are using the most up-to-date forms, documents and resources. Visit www.aimstpa.com to access up-to-date forms, summaries, booklets and comparisons on benefits including medical, dental, life and disability and EAP coverage.

EMPLOYER ELIGIBILITY GUIDELINES

To be eligible for coverage through the Benefit Program an employer must meet the following requirements:

- All companies must be an active, dues-paying member of an endorsing sponsor to obtain or renew coverage. Proposals issued to qualified prospective groups are released on the condition that membership will be secured by the prospective group prior to the insurance placement. Proof of membership is required.
- The employer must be headquartered in Washington State. At least 51% of the enrolled employees must reside in the service areas of Washington, Oregon and Idaho.
- The employer must be a corporation, partnership, proprietorship, or other organization unit or entity that is engaged in business and that employs at least two (2) regular full-time employees who work a minimum of 20 hours per week and are paid on a regular basis through a payroll system. “Employees” do not include seasonal, temporary, or independent contractors.
- The employer must sponsor the plan. This means the employer must contribute no less than 50% of the employee cost of coverage and 75% of the eligible employees must participate in the plan. Note: employees enrolled on a spouse’s group plan or federal employee plan are not considered eligible for the participation percentage. The employer is not required to contribute toward the dependent cost.
- Groups of 10 or fewer subscribers must have “common eligibility” for all lines of coverage. Groups of 11 or more subscribers, with less than 100% employer/dependent contribution, may have “uncommon eligibility” between Medical, Vision and Dental.
- “Common Eligibility” is defined as follows: Enrollment is consistent across all lines of coverage for employees and their benefit eligible dependents.
- Employer participation in the Vision and Dental plans is optional. Only one Vision and one Dental plan may be offered.

EMPLOYEE ELIGIBILITY GUIDELINES

In order to participate in the Program, the employer must agree to define the enrollment requirements on their annual Group Master Application and then apply these requirements in a non-discriminatory fashion for all employees in determining their eligibility, enrollment, waiting period, and contribution. These requirements can be changed at renewal. If your group, as a result of an acquisition, merger, or other circumstance, wishes to add a new group or expand the group of eligible employees to the plan, please contact your producer (broker) as soon as possible.

Eligible employees are those who have completed the waiting period, sometimes known as a probationary or introductory period, with the employer **and** have worked at least an average of 20 or more hours per week.

Each employer will note minimum hours for benefits on the Group Master Application, but the minimum must be at least twenty (20) hours. The employer must be reporting Federal Income Tax Information to the IRS. All other persons enrolled on the plan must be canceled at the time they cease to work the required number of hours, unless the employee is on leave pursuant to the Family Medical Leave Act or another legally required benefited leave. Retired employees **are not eligible**. Employees must be actively employed with the employer.

Eligibility of Owners, Partners, and Corporate Officers.

Owners, partners, and corporate officers of an employer will be considered eligible for the insurance only if they work the required number of hours or more per week. Spouses are not eligible (as subscribers) unless they are bona fide employees working the minimum hours required. However, the spouse may qualify as a dependent under the plan. Persons providing professional services, such as attorneys, accountants, etc., are not eligible unless they are bona fide employees of the firm. The employer must provide for workers' compensation coverage for all eligible employees not otherwise specifically excluded from such coverage.

DEPENDENT ELIGIBILITY GUIDELINES

The employer is not required to contribute toward the dependent cost. Dependent participation is optional.

Eligible dependents include:

- The lawful spouse or registered domestic partner (RDP) of the subscriber, unless legally separated. However, if the spouse or RDP is an owner, partner or corporate officer of the employer who meets the requirements in "Subscriber Eligibility," the spouse can only enroll as a subscriber.
- The domestic partner of the subscriber**.** The Benefit Program and AIMS require, as a condition of enrollment, proof of a domestic partner arrangement. Completion of the Affidavit of Qualifying Domestic Partnership for non-married individuals is required. The form can be found in the forms section of the www.aimstpa.com **.** Enrollment procedures for domestic partners are the same as for spouses. An enrollment form is required.
- **PLEASE NOTE:** Because federal law does not recognize domestic partnerships, even when employer-sponsored plans cover such partners, federal COBRA rights do not apply to domestic partners.

- The natural or adopted child of a subscriber's spouse or domestic partner, as defined in this document. "Placed for adoption" means assumption and retention, by the subscriber, of a legal obligation for total or partial support of a child in anticipation of adoption of such child, a legally placed ward of the subscriber or spouse living permanently in the home of the subscriber. Foster children are not eligible for coverage.

ENROLLMENT GUIDELINES

Employer Enrollment Guidelines

Please refer to the "How to Enroll" section of this document for instructions on new group submission, renewal, employee and dependent enrollment process requirements.

The employer must complete an annual Group Master Application and agree to the terms, conditions, and limitations of coverage as set forth in the insurer's contracts. The employer's request for coverage through the Employee Benefit Program must be accepted by the program prior to the coverage effective date.

See "Benefit Election Guidelines" section for requirements on plan benefits to be elected by the employer for employees.

The employer selects the hours an employee must work per week in order to be eligible for benefits. This must be no less than twenty (20) hours per week.

The employer selects the benefit waiting period, sometimes called a probationary or introductory period. Benefit waiting period is a period of time between the employee's date of hire and the date coverage becomes effective under the plan. New groups must specify their intention with regard to the waiting period for employees transferring from a part-time to a full-time status. The employer may either apply the employee's date of hire retroactively to their original date of hire, thus, eliminating the waiting period OR; the period would apply following the date of transfer, no matter how long the employee has worked with the company as a part-time employee.

All waiting periods are stated as "First of the month following" – Date of hire, 30 days, 60 days, etc. Please note as of January 1, 2014 waiting periods cannot exceed 90 calendar days and thus, the maximum waiting period must end on the first of the month following 60 days after the date of hire. An "orientation period" of up to one month can be elected providing it is a reasonable and bona fide employment-based orientation period, the waiting period would begin on the first day after the orientation period.

Waiting periods may not be waived except in the event an employee is re-hired within 6 months, then the waiting period is waived. Employers should not make the waiver of waiting period a term of employment. When the participating employer selects a waiting period, it applies to all coverage under the program. All eligible employees, who do not enroll for coverage, must complete the enrollment form and waive coverage.

During the open enrollment period employers may change their Probationary Periods and number of hours by submitting a written request to AIMS.

The Employer must include all other work site locations where enrolled employees may be located. Out of state employees will have coverage based on the network in the state they are located.

Employee and Dependent Enrollment Guidelines

To become covered under this plan, an employee must first complete an application for themselves and include each family member they wish to cover. For employees, coverage begins on the first day of the next month after the application has been accepted by AIMS and they have completed any probationary period required. For dependents that are eligible, and are included on the subscriber's application, coverage begins on the subscriber's effective date.

If a subscriber has a child who has sustained a disability rendering him or her physically or mentally incapable of self-support, that child may be eligible for coverage even though he or she is over 26 years old. To be eligible, the child must be unmarried and principally dependent on the subscriber for support. The incapacity must have arisen before the child's 26th birthday.

The subscriber must provide the medical carrier with a written physician's statement that confirms these conditions existed continuously prior to the child's 26th birthday. Documentation of the child's medical condition must be reviewed and approved by medical carrier. Periodic review by the medical consultant will also be required on an ongoing basis except in cases where the disability is certified to be permanent.

Employees must provide salary information on an annual basis when electing life and disability benefits that premiums are billed based on salary.

Any deductibles and out of pocket satisfied under the prior carrier for the current calendar year may be credited submittal of a report from the prior carrier or a copy of the members last "Explanation of Benefits" from the prior carrier. The deductible and out of pocket carry-over only applies when the entire group is transferring from another carrier. **The "Explanation of Benefits" from the prior carrier must be submitted within three (3) months of the employer's effective date.**

When a Member Moves to Hawaii

If an active employee moves to Hawaii, he or she is no longer eligible for coverage. A temporary move of four weeks is permitted.

The State of Hawaii requires that benefits for active employees living in Hawaii (regardless of where the group is located) be administered according to Hawaiian law. This applies to active employees only and does not apply to COBRA enrollees.

Newborn and Adopted Child Enrollment

For the subscriber's natural newborn child, coverage will be retroactive to the date of birth provided AIMS receives the subscriber's application for the new dependent's coverage within sixty (60) days following birth.

For the subscriber's adopted child, coverage will be retroactive to the date of placement for adoption or the date the subscriber assumed total or partial legal obligation for the child's support in anticipation of adoption. AIMS must receive the subscriber's application for the new dependent's coverage, within sixty (60) days, following placement or the subscriber's assumption of legal obligation for the child's support.

Special Enrollment Rights

If a participant declines enrollment for themselves or their dependents (including spouse or domestic partner) because of other health insurance coverage, or if the eligible employee's or dependent's prior coverage was under Medicaid or a children's health insurance program (CHIP) and such coverage was terminated due to loss of eligibility, they may – in the future – be able to enroll in this plan, provided that they request enrollment within 60 days after the other coverage ends.

In addition, if they have a new dependent as a result of marriage, birth, adoption, or placement for adoption, they then may be able to enroll themselves (or their dependents) provided that they request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

In order to have Special Enrollment Rights:

- Participant must have previously declined coverage in writing.
- Participant must notify administration within 60 days of event and submit Enrollment/Change form.
- Participant must have a qualified event such as:
  - Loss of coverage
    - Effective 1st of the month following loss of coverage.
  - Marriage
    - Effective 1st of the month following marriage date.
  - Birth
    - Effective on the date of birth.
  - Death
    - Effective the first of the month following date of death.
  - Divorce
    - Effective first of the month following divorce decree date.
  - Adoption
    - Effective on the date of adoption, or the date in which the child(ren) are placed with the employee for adoption.

Participants can then enroll themselves (if not previously enrolled) and their dependents in available coverage.

Effective Dates

Effective dates begin the first day of a month following the addition of a new employee or dependent, and the last day of the month for a cancellation. Rates and coverage cannot be pro-rated.

NEWBORN ENROLLMENT –

Medical plan coverage according to the ERIN Act:

- Newborns are covered under mother's plan for 21 days following birth. Dependent enrollment In Trust plans is effective on 22nd day. Premium is charged first of month following effective date. **Member must submit an enrollment form if child is to be covered under the Trust plan after the expiration of coverage under the Erin Act. Enrollment form must be submitted prior to the end of coverage through the Erin Act.**

Please note: The examples below are followed in all the following circumstances:

- Only mother is covered under Trust medical plan, father has coverage through his employer, decision is made to enroll the baby on the mother's plan
- Only father is covered under Trust medical plan; mother has coverage through her employer, but decision is made to enroll the baby on the father's plan
- Both father and mother are covered under Trust medical plan

Examples:

DOB is 9/5/19 – ERIN Act coverage through 9/26/19. Dependent coverage begins 9/27/19 and premium is charged effective 10/1/19.

DOB is 9/18/19 – Erin Act coverage through 10/9/19. Dependent coverage begins 10/10/19 and premium is charged effective 11/1/19.

Dental and Vision coverage does not fall under ERIN Act. Enrollment is first of the month following date of birth.

Eligibility Audits

Employers are responsible for keeping accurate and complete records of plan beneficiaries relating to eligibility, enrollment, payroll deductions, hours worked, premium payments, and other records necessary to administer the benefit plan.

The Program and its plan sponsors, have the right to request, inspect or audit the employer's records or the records of any third-party entity engaged by the employer to administer portions of the employer's business related to the information necessary to administer the benefit plan at any time during the employer's regular business hours. The Benefit Trust reserves the right to terminate coverage or decline renewal if an employer (or their agent) fails to provide audit information in a timely or accurate manner.

Employer Benefit Election Guidelines

Certain carrier guidelines must be followed when electing plan options.

- Compulsory benefits (required when electing medical)
  - Medical plan and Prescription Drug plan
  - $15,000 Basic Life and AD&D
- Buy-up benefits
  - Dental
  - Vision
  - Buy-up Basic Life and AD&D options
    - Option A - Additional $15,000 for an overall $30,000 benefit
    - Option B - Additional $35,000 for an overall $50,000 benefit
    - Option C - 1x Annual Salary to a maximum of $100,000 for employers

        - Option D - 2x Annual Salary to a maximum of $200,000 for employers
        - Dependent Basic Life
    - Short-term Disability
        - Option A - 60% salary to $100 a week maximum (core benefit)
        - Option C - 60% salary to $235 a week maximum (must purchase Option A to elect this benefit, $235 maximum is combined and not in addition to Option A)
        - Option 1 – 60% to $750 weekly maximum
        - Option 2 – 60% to $2500 weekly maximum
        - Option 3 – 60% to $1250 weekly maximum
    - Long-term Disability
        - Option A - 60% salary to $3,000 fully integrated with social security a month maximum
        - Option 1 – 60% to $4000 monthly maximum
        - Option 2 – 60% to $8000 monthly maximum
    - Voluntary (Supplemental) Life and AD&D
- Stand-Alone Options
    - Dental benefits can be offered on a stand-alone basis for groups with 10 or more enrolling employees
    - Vision benefits can be offered on a stand-alone basis for groups with 10 or more enrolling employees.
    - No life benefits will be offered on a stand-alone basis -voluntary life can be offered as a stand alone
    - Disability Plans are non-contributory 100% of all eligible employees must enroll, regardless of Medical enrollment

Regence Blue Shield/Asuris Northwest Health

BENEFIT PLAN GUIDELINES

- Rates are guaranteed through the end of the Trusts plan year for individual employers except in the case of:
    - Government mandated benefit change.
    - New or revised government taxes imposed.
    - An amendment of the benefit plan or contracts.
    - Addition or deletion of a subsidiary, corporate division, or affiliated companies.
    - Any change in employer contribution, employee eligibility, or probationary period.
    - Enrollment change of 10% in any single month or a 25% in any three consecutive months.
    - COBRA enrollment exceeds 10% of the total membership.
- Employers must not have any other medical or prescription plans, other than that provided through the Benefit Program.
- Plan election is effective from the initial election to renewal election. No plan changes will be permitted off anniversary.
- All medical plans include a Prescription Drug Plan.

CONSUMER DRIVEN HEALTH PLANS

Health Savings Account (HSA)

- The HSA plan cannot be offered alongside a medical plan underwritten by another carrier.
- Employer must contribute an equal percentage of the employee cost for both the CDHP and non-CDHP plans when dual choice offerings are elected (see Dual Choice Guidelines).
- The rates to not include any transaction and/or administrative fees charged directly by the HSA administrator.
- The HSA product is only available in the carrier's service area.

Health Reimbursement Account (HRA)

- Any medical plan can be paired with the HRA of the employer's choice
- The employer contribution to the HRA fund cannot exceed 50% of the medical plan deductible.

MULTIPLE PLAN CHOICE GUIDELINES

- If a group has ten or more enrolling employees, the Employer can select up to any two medical plans to offer their employees. Triple plan choice is available to groups with 51 or more enrolled employees.

Delta Dental of Washington

- If employer of ten or fewer subscribers offers both medical and dental the employee enrollment must be the same for both plans.
- Requires 75% participation of eligible employees for employers **dental only.**
- Employers with 10 or more enrolling employees may purchase a stand-alone dental plan.
- All new employers enrolling in dental will be billed on a tiered rate basis.
- Employers may choose a $1000 or $2000 calendar year maximum benefit for either plan.
- Employers, with 10 or more enrolling employees, may choose either an Adult/Dependent or Children only Orthodontia Rider.

Vision Service Plan Hardware Plans

- Requires 75% participation of eligible employees.

The Standard Life Insurance Company Plans

BASIC LIFE AND AD&D

- The compulsory basic life and AD&D benefit of $15,000 is required for all member companies with medical. Premiums for this benefit are built into the overall medical rate billed. This benefit is required to elect buy-up options.
- All employees will be enrolled on this benefit and must supply current salary information on an annual basis or at time of salary changes.

- Employers may elect buy-up options of an additional $15,000 to an overall $30,000 (Option 1) benefit or an additional $35,000 to an overall $50,000 benefit (Option 2).
- Employers may elect buy-up options of 1 time (Option 3) to a maximum of $100,000 or 2 times (Option 4) to a maximum of $200,000 annual salary for employees.

DEPENDENT LIFE

- Employee enrollment must match medical.
- Only those employees with dependents enrolled in medical coverage will be billed for the benefit.
- Employers are not required to purchase voluntary employee life in order to purchase dependent life.
- No evidence of insurability requirements.

GROUP SHORT TERM DISABILITY (STD)

- Requires 100% participation of eligible employees.
- All employees will be enrolled on this benefit and must supply current salary information on an annual basis or at time of salary changes.

GROUP LONG TERM DISABILITY (LTD)

- Requires 100% participation of eligible employees.
- **All employees will be enrolled on this benefit and must supply current salary information** on an annual basis or at time of salary changes.

VOLUNTARY (SUPPLEMENTAL) LIFE AND AD&D

- Employer must elect to offer this benefit to its employees.
- Requires no less than 20% of the eligible employees to enroll.
- Evidence of Insurability will be required for any amounts over the Guaranteed Issue amount of $25,000.
- Spouse benefit amount will be half the amount of the employee benefit and the spouse premiums are based on the employee's age.
- Dependent children benefit is $10,000.

How to Enroll and Renew

NEW GROUP SUBMISSIONS

The employer's Producer is to submit new group paperwork to the Benefit Resource Hub (HUB) by the 15th of the month prior to the effective date to ensure eligibility is loaded on the carriers' systems prior to the first of the month effective date.

Required materials must be submitted complete and include all of the following (no partial submissions will be accepted):

- First Months Premium Payment
  - Make check payable to the appropriate Trust listed at the bottom of the final page of the Group Master Application.
- Group Master Application
  - The Group Master Application must be signed by both the group and the producer.

- Proof of Ownership
    - Owner-only groups would require proof of ownership/tax documentation for all owners/officers/partners enrolling.

Type	Required Documentation
Corporations	• In business <1 year: Articles of Incorporation listing all enrolling officers' names • In business > 1 year: S-Corps: IRS Schedule K-1 (Form 1120s) for all enrolling Owners/Officers • C-Corps: IRS Form 1120 (pages 1&2) which includes "Schedule E"
Partnership/LLP	• In business < 1 year: Partnership Agreement signed by all partners • In business > 1 year: IRS Schedule K-1 (Form 1065) for all enrolling partners or a Partnership Agreement signed by all partners
Limited Liability Company (LLC)	• In business < 1 year: LLC Agreement signed by all managers/members parties • In business > 1 year: LLC Agreement signed by all managers/members/parties or copies of appropriate tax returns (follow the guidelines for a Partnership or Sole Proprietorship based on how the LLC was formed)
Sole Proprietorship	• In business < 1 year: Business License • In business > 1 year: IRS Schedule C (Form 1040)
Common Ownership	• Groups attorney or CPA must complete a form regarding Common Ownership

Enrollment & Waiver Forms

- Use the enrollment form to waive coverage by marking appropriate boxes provided.
- Due to CMS requirements, Social Security Numbers for all Employees and their dependents must be included. No "dummy" numbers will be accepted, and the group will not be processed until all are present.
- When COBRA carry-over enrollees are eligible, the COBRA Carry-Over Election Form must be completed by each COBRA participant electing coverage. The form must be submitted in a timely manner to prevent delays.

Deductible Credits can be applied with proof of Deductible payment through the latest EOB.

Sponsoring Association Membership Application or proof of membership and where applicable, payment for dues – with check made payable to the Association.

RENEWING GROUP SUBMISSIONS

All renewing groups are required to complete the renewing year's group master application.

All renewal information is sent to the employer's designated credentialed producer 45-60 days prior to the renewal date. The producer is responsible for contacting the group regarding the new rates and any benefit changes.

The packet includes a letter explaining any benefit and administrative changes to the plans, the renewal rates for all plans and benefits. A new Group Master Application is required for all renewing groups. This is regardless of any plan or benefit changes. Open enrollment is the month before the renewal date (i.e. the open enrollment for January would be the month of December.)

Renewals must be returned to the Program Manager no later than twenty (20) days before the renewal date.

COMPLETING FORMS FOR ENROLLMENT

All updated forms can be found at www.aimstpa.com in the, "Forms Library". Forms are clearly labeled with the year in the title in which the enrollment is taking place. Expired forms will not be accepted under any circumstance.

EMPLOYEE ENROLLMENT AND CHANGE FORM

(Required for new groups, new employees, changes to current enrollment and terminations.)

No other enrollment forms will be used except the specific AIMS Enrollment & Change Form, unless prior approval is received from AIMS. **Please contact AIMS regarding alternate enrollment forms or enrollment via EDI transmission**. Employers must complete the form accurately and legibly. Enrollments with errors, ambiguities and/or illegible information will take longer to process and are more likely to cause errors. Forms with any missing information, such as date of birth, date of hire or enrollment reason will not be processed and will be returned.

To be completed by the Group Benefit Administrator:

Section 1 - Group Information

Group name as indicated on the Group Master Application

- Effective date of the enrollment or change to be designated by this form
- Date of hire of the employee
- Rate of Pay for all benefits that premium is determined based on salary information
- Mark purpose of the form and applicable fields
- Enter the employee's worksite state (Section 2), if other than Washington State, where medical services may be rendered.

To be completed by the Employee:

Section 2 - Employee Information

- Name, Marital Status, Gender, Date of Birth (Required for enrollment for both employee and dependents), SSN (Due to CMS requirements, Social Security Numbers for all Employees and their dependents must be included. No "dummy" numbers will be accepted, and the enrollment form will not be processed until all are provided), home addresses
- Enter the employees' worksite state if other than Washington state, where medical services may be rendered.

Section 3 - Enrollment Information

- Choose whether to elect or waive from the medical plan and indicate the name of the plan chosen
- Choose whether to elect or waive from the dental plan and indicate plan chosen (if employee is enrolling in the medical, the dental must also be elected if offered by the employer with less than 11 employees).
- Choose whether to elect or waive from the Vision plan and indicate plan chosen.
- Voluntary employee and dependent life and AD&D are to be chosen if the employer has chosen to offer the benefits to the employees. Specify the amount of coverage for Voluntary (Supplemental) Life and AD&D
- List all enrolling parties within the family and mark Add or Drop
- Also mark Medical and/or Dental. The SSN and Date of birth is required for all dependents, if incomplete the enrollment will not be processed.

Section 4 - Designation of Beneficiary

- Complete information

Section 5 - Read disclaimer and sign and date the form and provide your email address

DOMESTIC PARTNERSHIP
See Page 7 for details.

How to Terminate Coverage

HOW TO TERMINATE COVERAGE FOR AN EMPLOYEE:
Use the Trust's Employee Enrollment & Change Form:

- Mark the box next to "Termination" near the top of the form in Section 1.
- Fill in the "Last Day Worked", "Last Day Compensated" and "Date Coverage Ends" in Section 1 and indicate voluntary or involuntary.
- Put the employee's actual last day of work in the Date of Termination and note the qualifying event in the "Reason Section".
- Enter all of the employee information in Section 2.
- Sign the Employer signature box and date it.
- You do not need an employee signature when an employee terminates employment.
- You also can send an email to AIMS@AIIN.com from company email with employees last day worked and term date for insurance.

TO TERMINATE COVERAGE FOR A DEPENDENT ONLY:
Use the Trust's Employee Enrollment & Change Form:

- Enter the last day of the last month of coverage in the effective date box in Section 1
- Mark the box next to "Change" near the top of the form in Section 1.
- Choose "Remove dependents" and fill in the "Date" and "Reason" fields immediately following.
- Enter the employee information in Section 2.

- Enter the dependent information in Section 3, marking the "Drop" box to the left of the dependent name.
- The employee must sign the left box on the last page. The group administrator should sign the right box on the last page.

Please note: if you terminate coverage for a dependent, you cannot re-enroll them in coverage without a qualifying event or open enrollment period.

WHEN COVERAGE ENDS

Coverage Termination

Coverage will end without notice, on the last day of the month for which premiums have been paid, when any of the following events occur:

- The contract between the Program and the insurance carrier is terminated.
- The next month for which premium is not paid when due.
- The employee dies or is otherwise no longer eligible as an employee (for example, the employee's employment terminates).
- The participating employer ceases to meet the Program's continued participation requirements.
- The participating employer notifies their Producer that it no longer wishes to participate in the Trust. Such notice must be received prior to the next premium due date, otherwise the participating employer will be charged for an additional month's premium.

For a spouse/dependents:

- When his or her marriage to the employee is annulled.
- When he or she becomes legally separated or divorced from the employee.
- For a domestic partner, when his or her domestic partnership relationship with the subscriber is ended.
- For a child when he or she no longer meets the requirements for dependent coverage.
- Employee can voluntarily cancel spouse and children at any time.

Employees who are rehired within six (6) months of termination will not have to re-satisfy their probationary benefits period.

It is the responsibility of the employee to notify the participating employer when an enrolled dependent is no longer eligible to be covered as a dependent under the Program. **The participating employer must then notify the AIMS within thirty (30) days of the date the participating employer was notified of such event. Retroactive adds and terminations are only available for 30 days from the date of effective date to notification to the carrier, not when received by AIMS.** Based on legal notification deadlines relative to COBRA following a termination, we are unable to make exceptions to this deadline. **Note: the group will be responsible for all premiums incurred due to the late notification of terminations.**

LEAVE OF ABSENCE

Coverage for a subscriber and enrolled dependents may be continued for up to ninety (90) days when the employer grants the subscriber a leave of absence and subscription charges continue to be paid.

AIMS will bill group for premium on their regular monthly billing. Employer must remit premium when remitting premium for active group. It is up to the employer to collect premiums form employee.

The ninety (90) day leave of absence period counts toward the maximum COBRA continuation period, except as prohibited by the Family and Medical Leave Act of 1993 or other laws which mandate benefit coverage during leave.

Employees wishing to continue coverage under group plan after 90 days must complete COBRA application upon receipt.

COBRA Administration

OVERVIEW OF COBRA LAW

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce and other life events.

Qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost to the plan.

COBRA applies to group medical, dental, vision and EAP benefits. COBRA does not apply to benefits that are not group health plan benefits (i.e. LTD, STD, AD&D.)

COBRA ADMINISTRATION

All member companies are automatically enrolled in AIMS COBRA Administration program free of charge, regardless of the size of the group. Contact AIMS for more information about COBRA services.

COBRA ELECTION

Qualified Beneficiaries have sixty (60) days from the later of the date of the qualifying event letter or the date benefits are terminated to inform the Trust COBRA Administrator of their desire to continue coverage. Once notified, the Trust COBRA Administrator will see that the Qualified Beneficiaries receive the necessary COBRA applications required by each Insurer. The completed applications needs to be mailed to the specific trust at Associated Industries, 1206 N Lincoln Ste 200, Spokane, WA 99201.

If the person requesting continued coverage is deemed “ineligible” for COBRA, the unavailability of COBRA notice shall be sent within fourteen (14) days from the date the person expresses their desire to continue.

Please note: Federal COBRA rights are available for spouses. However, because federal law does not recognize domestic partnerships, even when employer-sponsored plans cover such partners, federal COBRA rights do not apply to domestic partners.

Termination - AIMS must receive an Enrollment and Change Form for the termination of the employee from the group administrator.

COBRA Enrollment - Within the allowed 60 days from the termination, AIMS must receive an Enrollment and Change Form for the electing COBRA beneficiary.

COBRA Rollover - COBRA beneficiaries electing to continue with the COBRA when a group transfers into the Trust must complete an AIMS COBRA Carryover form. For immediate enrollment, COBRA premium must be included in the first month's premium check. Enrollment will not be processed until COBRA premium is received.

MONTHLY PREMIUMS

COBRA Beneficiaries will be charged the group rate, less miscellaneous group charges such as basic life and AD&D, plus an administration charge of 2%of premiums). COBRA Premiums are not changed other than at the annual insurance renewal, a change in Dependents or if a COBRA Beneficiary is determined by Social Security Administration to be "Disabled."

If a COBRA Beneficiary is deemed disabled, the Trust COBRA Administrator **may** charge an increased administration fee of 2%, although the COBRA premium may be increased (at the employer's discretion) as allowed by law. Upon receiving renewal rates, the COBRA Administrator will notify the COBRA Beneficiaries of the new premiums. The COBRA Administrator does this, annually, during the renewal period, as AIMS is notified of plan and rates elected by each participating company for the coming year.

If the individual deemed disabled elects not to continue during the eleven month extension, the remaining family unit should be charged the standard administration fee (and not the 50% for disabled COBRA Beneficiaries.)

MONTHLY PREMIUM TIER CALCULATION

COBRA Rates under the Plan are as follows:

- Employee only or Dependent only (Spouse or Child) will be billed the Employee only rate.
- Employee & Spouse will be billed the Employee/Spouse rate.
- Employee & Child(ren) will be billed the Employee/Child(ren) rate.
- Employee, Spouse and Child(ren) will be billed the Employee/Spouse/Child(ren) rate.
- Spouse & Dependent Child(ren) separate from the participating employee will be billed the Employee/Child(ren) rate.
- Dependent Children (2 or more together) separate from the participating employee will be billed the Employee/Child(ren) rate.

PREMIUM DUE DATE

COBRA Beneficiaries must make timely premium payments to continue under the Company's group plan. There are two (2) different grace periods that will be offered to COBRA Beneficiaries prior to termination from any plan.

- **Initial Grace Period** - Upon notifying the COBRA Administrator of their desire to continue, the COBRA Beneficiary will have a **forty-five (45) day** grace period (commencing on the later of the date the COBRA Administrator was notified of the continuation or the date premiums are due to the Insurer) to make their first premium payment.
- **Subsequent Grace Period** - For all remaining COBRA premium payments, the COBRA Beneficiary will have a **thirty (30) day** grace period.

In the event a Beneficiary's premium is short by an "insignificant amount," a notice will be sent requiring the additional premium or the Trust COBRA Administrator may deem the payment as paid-in-full. The Trust never deems any short payment as "paid-in-full."

The COBRA Administrator will use the postmark date as the determination if a payment is made in a timely fashion.

TERMINATION FROM COBRA

The COBRA Administrator shall terminate COBRA Continuation Coverage upon one or more of the following events:

Insurance Plan Termination - If a participating Member company (or the Trust, itself) terminates a group insurance plan for active employees, COBRA Beneficiaries will be notified and terminated from that plan only. If the participating Member Company offers a new similar type of Insurance Plan ***or*** decides to go with a new carrier, the COBRA Administrator will inform the COBRA Beneficiaries of their right to transfer their COBRA coverage to the new plan directly through the participating company. **The COBRA Administrator is no longer responsible for premium, eligibility or COBRA obligations for the affected COBRA Beneficiary.**

Nonpayment of COBRA Premiums - COBRA Beneficiaries will be terminated for nonpayment of premiums if premiums are not postmarked within the applicable 45-day (initial) or 30-day (subsequent) grace period.

Coverage Under Another Group Plan - For COBRA Beneficiaries that obtain similar coverage under another group plan, the Administrator will notify the COBRA Beneficiary of their termination from the Company's Insurance Plan.

Prior to termination, the Administrator will review with the Beneficiary, the new group plan's preexisting condition limitations (if applicable.) If the COBRA Beneficiary's new group plan does not cover a preexisting condition (if applicable), the COBRA Beneficiary may continue coverage until the end of the COBRA term. Note that group health plans are prohibited from imposing any preexisting condition exclusions for plan years beginning on or after January 1, 2014, and thus, the provisions of this paragraph are only applicable on or before December 31, 2014.

Medicare Entitlement - Once a COBRA Beneficiary becomes entitled to Medicare **(Part A &/or B),** the Administrator may terminate COBRA Continuation Coverage. NOTE: For purposes of COBRA Administration, Part A of Medicare is as valid an enrollment as Part B, per ERISA rulings and DOL recommendations.

Prior to termination, the Administrator shall contact the COBRA Beneficiary and establish a date of termination so that there will be no lapse in coverage. Dependents already enrolled on COBRA, at the time of enrollment in the COBRA plan, may continue to the end of their COBRA term.

Insurance Company's Service Area - If a COBRA Beneficiary is enrolled in an insurance plan that requires members to reside in a specific geographical area and they move from that area, the Administrator shall notify the COBRA Beneficiary and terminate coverage. If another similar plan is available in that area, the Administrator can offer the plan to the COBRA Beneficiary. This is not, generally, used as the medical and dental carriers have national networks.

Coverage may be terminated "for cause" due to fraudulent claims or other activities in which a similarly situated active employee would be terminated. Any "for cause" termination will be conveyed to the Administrator by the carrier.

If a disabled COBRA Beneficiary is deemed to no longer be disabled during the eleven-month extension, the entire family unit may be terminated. It is the beneficiary's responsibility to notify the Administrator of this cessation of disability and, if it is within the 11-month period, coverage under the COBRA plan will then terminate.

End of COBRA Term - Once the COBRA Beneficiary has reached the end of their COBRA time frame (either 18, 29 or 36 months), the Trust COBRA Administrator will send a termination notice. The COBRA Beneficiary has the right to convert to an individual plan (where available) that has no preexisting condition limitations. The Trust COBRA Administrator will provide a "Certificate of Coverage" detailing the completion of COBRA.

COBRA Beneficiaries have the right to a hearing if they disagree with any termination. At the COBRA Beneficiary's request, the Administrator will set up a hearing and have the appropriate Company managers attend to review the termination and decide on its validity.

COBRA DOCUMENTATION

The Administrator will document every qualifying event, every qualified beneficiary electing COBRA, the selected plans and plan changes, and premium payments. Reports will be completed on a monthly basis, filed and **maintained for a minimum of seven (7) years.**

Files shall be maintained for all qualified beneficiaries and will include copies of all COBRA-related notifications, correspondence, applications and election notices.

NOTICES

General Notice of Continuation Coverage

The **General Notice must be provided to each new employee and his or her spouse within 90 days** following the date the employee or the spouse, as applicable, first becomes eligible for coverage under the employer's group health plan (or, for a new plan, the General Notice must be distributed within 90 days following the adoption of the new plan.)

The General Notice may be distributed to employees by means of electronic media. However, because the General Notice must be provided to each employee's spouse, it should be mailed to the last known address of each employee's spouse. Providing the General Notice to the spouse by mailing is an important step to avoiding future COBRA issues, especially in the event of a subsequent legal separation or divorce.

Therefore, the better form of distribution of the General Notice may be a mailing or other physical delivery to the employee's home if the spouse also lives at the same address. In such a case, only one notice must be provided. Also, if the employee adds the spouse to the health plan after the date on which the employee is first covered, a COBRA notice must be sent to the spouse at that later date. This notice to a newly added spouse is easy to overlook and can result in liability to the employer for failure to timely provide the COBRA notice.

Employer's Notice Requirements

The employer must notify AIMS as the plan administrator of certain qualifying events if the COBRA responsibilities are outsourced and an outside administrator provides COBRA services for the plan. The employer must provide such notice to the outside plan administrator within thirty (30) days following any of these qualifying events: death of the employee, termination of service or reduction in hours of the employee, entitlement of the employee to Medicare, or for retired employees, bankruptcy of the employer.

Notice Requirements for Covered Employees and Beneficiaries

The regulations discuss the requirements for covered employees and beneficiaries to notify the plan administrator upon the occurrence of certain qualifying events, such as divorce, legal separation, a beneficiary ceasing to be covered under the plan as a dependent child, the occurrence of a second qualifying event, or notice of a Social Security determination of disability within thirty (30)days following the latest of:

- The date of the qualifying event;
- The date of the loss of coverage; ***or***
- The date on which the individual is informed, by means of the plan SPD or the general notice, of the individual's obligation to provide notice and the procedure for providing the notice.

Notice of Right to Elect Continuation Coverage

This notice must be provided by the employer or the administrator, as applicable, to the covered employee or qualified beneficiary within fourteen (14) days following notice of a qualifying event. This notice must inform the covered employee or beneficiary that he or she has a right to elect COBRA continuation coverage.

Notice of Unavailability of Continuation Coverage

The Notice of Unavailability of Continuation Coverage must be provided when the employer or administrator receives a notice of the occurrence of a qualifying event or a second qualifying event and then determines that the individual whose coverage is affected by the event is not eligible for the continuation coverage requested.

In such a situation, the administrator or employer must provide to the individual an explanation of why the individual is not eligible for the coverage. The notice must be provided within the same time period as applies to the Notice of Right to Elect Continuation Coverage.

Notice of Termination of Continuation Coverage

The Notice of Termination of Continuation Coverage is required if the continuation coverage terminates earlier than the maximum continuation period available. The notice must be written in a manner calculated to be understood by the average plan participant and must identify the

reason that the continuation coverage is terminating early, the date the continuation coverage will end and any rights the covered employee or qualified beneficiary may have to elect an alternative group or individual coverage, such as a conversion right.

The regulations do not specify a time frame for providing the Notice of Termination of Continuation Coverage other than it must be provided as soon as practicable following the administrator's determination that the continuation coverage will terminate.

Although the DOL regulations do not require a notice of the end of continuation coverage in the normal course, there is a requirement in the Internal Revenue Code to notify the covered individual of any right to convert to individual coverage.

This conversion right notice must be provided within 180 days prior to the date the continuation coverage is scheduled to end. In addition, state law may require a notice to be provided of the regularly scheduled end of continuation coverage.

NOTICE DELIVERY REQUIREMENTS

The regulations provide guidance on the form of delivery of the various notices. Notice may be provided to the employee and spouse by mailing the notice, addressed to the employee and spouse, at the employee's home if, based on the most recent information available to the employer, the employee and spouse live at the same address.

The administrator may provide notice to dependent children who are qualified beneficiaries by providing notice to the employee or the spouse, if, based on the most recent information available, the dependent children live at the same address as the individual to whom the notice is provided.

Notices may be delivered in any manner generally accepted by the DOL for delivery of other ERISA-required notices, including the use of electronic media. However, while delivery to the employee by electronic media, for example, via the employee's email at his or her worksite, will suffice for notice to the employee and to any dependent children living with the employee, such delivery will not meet the notice requirements for delivery to the spouse.

Unless the employer or administrator has the spouse's email address and can confirm that the spouse received the relevant COBRA notice by email, a mailing by U.S. mail or some other form of written delivery still must be used for notices that are required to be provided to the spouse.

OTHER COBRA ADMINISTRATION OPTIONS

Employers who maintain a reputable third-party administrator for COBRA purposes may apply for an exception to Trust administered COBRA. This is in the sole discretion of the Plan and the Trust retains the right to reject such a request or rescind such an agreement at any time, should the selected TPA not meet Trust or legal requirements.

All communications, enrollment updates, eligibility changes and premium payment must be directed to Associated Industries Management Services only. Change requests or payments made directly to the carriers will delay enrollment and cause disruption in COBRA beneficiaries' coverage.

COBRA ELECTION

When notified by the employer, member terminations will be processed by AIMS (no notifications or forms will be sent to the termed employee.) AIMS COBRA Enrollment Forms must be sent by

the Third-party COBRA Administrator to the terminated employee (no alternate forms can be accepted.) Please submit completed COBRA Enrollment Forms in an accurate and timely fashion. Copies of the COBRA election forms must be sent to the COBRA Administrator. AIMS will ensure enrollment information is forwarded to the appropriate carrier(s.)

OPEN ENROLLMENT

When employer groups renew, AIMS will provide the Third-party COBRA Administrator an updated COBRA Employer Specification Worksheet. In the event new plan selections are required, the COBRA Enrollment Forms must be submitted to AIMS in a timely manner.

MONTHLY PREMIUM PAYMENT

AIMS will bill the Third-party COBRA Administrator directly for COBRA beneficiaries. Invoices will be provided to the group, listing all active COBRA participants and the premium due. The invoice is generated on the 15th of the month for the next coverage month. Should there be any questions on the invoice, contact us at 800-274-5309.

In the event premium payment is not received by AIMS by the due date, coverage will be terminated and notice will be sent to the Third-party COBRA Administrator. No reinstatements will be allowed after the third request.

AIMS COBRA CONTACT INFORMATION

Contact us at 800-274-5309 or to access a list detailing AIMS staff contacts, visit our website http://www.aimstpa.com/

Understanding Your AIMS Invoice

Invoices are generated on the 15th of each month for the next month's coverage. Your benefits are on a pre-paid program.

GROUP INVOICE SUMMARY

The Group Invoice Summary page lists your current monthly premium amount, premium and billing information for prior months and any past due amounts. Also reflected are credit or charge adjustments for late additions/terminations and balance due amounts for each, if applicable. These are reflected on the second line of your summary, (Payments and Adjustments posted since previous Invoice Summary) and detail can be found on the Payments and Adjustments page of your bill (see page 31). Note: If you paid your prior invoice in full, but had retroactive business, then you will see an amount posted as Balance Forward. **Please pay the total amount due as shown on the statement page, payment options available are ACH Payment, Payment Portal, EFT**. Any adjustments will be reflected on your next invoice. **Premium payments are due the 1st of each month for the current month. If payment is not received by the 10th, coverage may be retroactively terminated to the paid through date.** A reasonable late fee of 12% per annum will be charged for payments not received by the 10th of the month due. In the event a non-sufficient funds check is received, a $30.00 fee will be charged to your account.

Group Invoice Summary

Invoice Period: September 1 - 30, 2010
Invoice Number: 44790
Invoice Date: August 20, 2010
Page 1 of 1

Sample Company
Sample Street

Sample City, WA 99999

Balance from Previous Invoice Summary	6,367.88
Payments and Adjustments posted since previous Invoice Summary	-6,367.88
Balance Forward	.00

Employee Name	L4-SSN	Policy Number	Current Premium Billed
LastName,First	3984	741143	927.67
LastName,First	2763	741143	927.67
LastName,First	3734	741143	306.14
LastName,First	3948	741143	927.67
LastName,First	1758	741143	927.67
LastName,First	3975	741143	927.67
LastName,First	2570	741143	306.14
LastName,First	8265	741143	306.14
LastName,First	9237	741143	635.87
LastName,First	0702	741143	306.14
LastName,First	9246	741143	306.14
LastName,First	7233	741143	927.67
LastName,First	2272	741143	572.29
Total Current Premium			8,304.88
Balance Forward			.00

Total Amount Due September 1, 2010 8,304.88

*COBRA

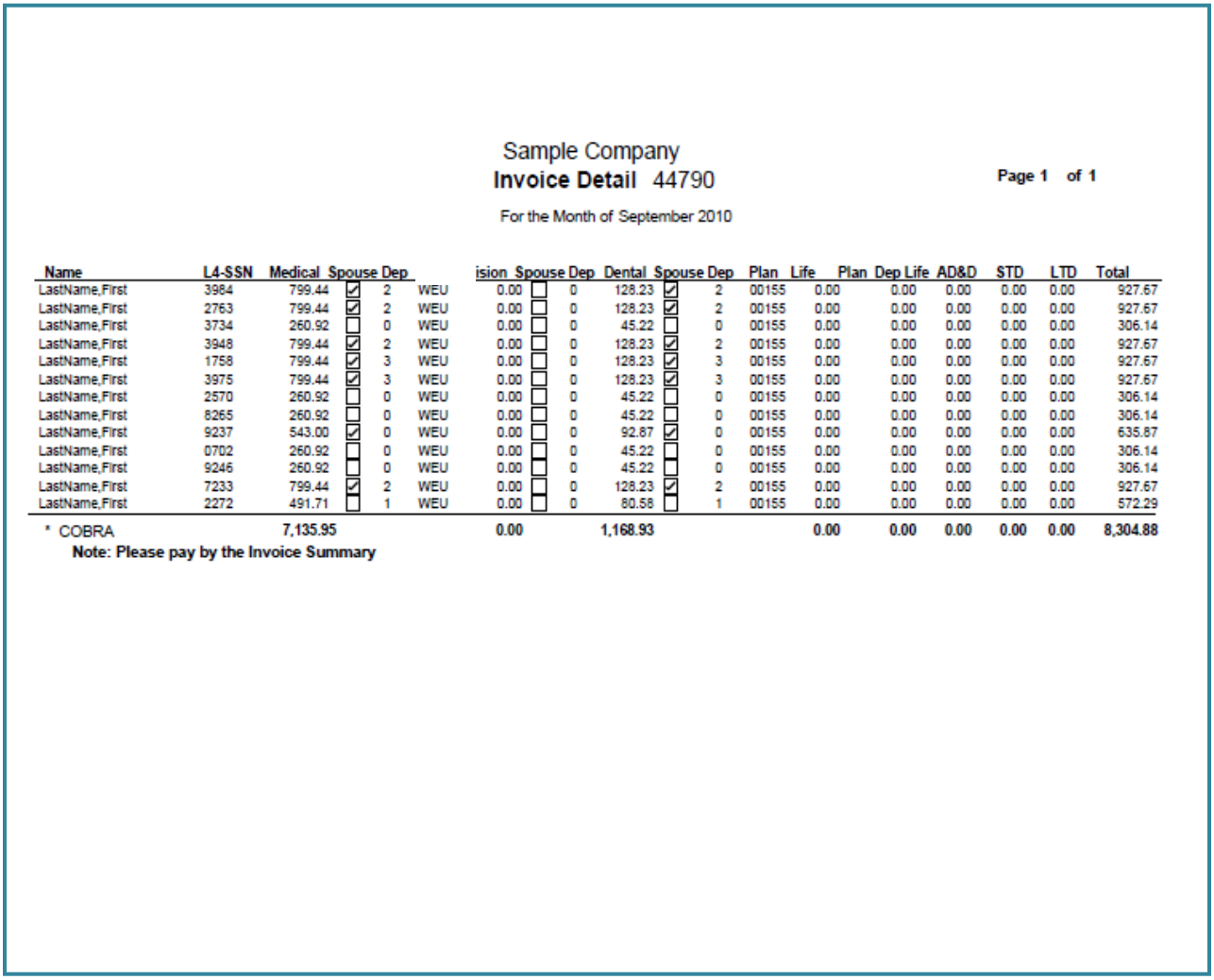
* Please Note *

Your invoice is due and payable the first of the month. Unpaid accounts as of the tenth of the month are subject to cancellation according to contracts with the insurance carriers. Please pay your invoice as billed. Failure to pay as billed may result in a delay of posting your payment. Thank you.

INVOICE DETAIL PAGE

The invoice page reflects those employees who are currently enrolled and the premium billed. It is very important to review who is listed to ensure our records reflect only those who should be enrolled. Do not make any changes on the invoice page.

Any changes in enrollment should be noted on the Billing Reconciliation Adjustment Form and followed by a completed enrollment form notifying AIMS of new enrollments or terminations. Terminations can also be communicated in an email if subscriber is terming, provide last day worked (if terming spouse or dependent we need to receive a signed enrollment/term form which can be emailed). The total current month premium is listed on the statement page and is included in the total amount due.



Sample Company

Invoice Detail 44790

Page 1 of 1

For the Month of September 2010

Name	L4-SSN	Medical	Spouse	Dep		ision	Spouse	Dep	Dental	Spouse	Dep	Plan	Life	Plan	Dep Life	AD&D	STD	LTD	Total
LastName,First	3984	799.44	☑	2	WEU	0.00	☐	0	128.23	☑	2	00155	0.00	0.00	0.00	0.00	0.00	0.00	927.67
LastName,First	2763	799.44	☑	2	WEU	0.00	☐	0	128.23	☑	2	00155	0.00	0.00	0.00	0.00	0.00	0.00	927.67
LastName,First	3734	260.92	☐	0	WEU	0.00	☐	0	45.22	☐	0	00155	0.00	0.00	0.00	0.00	0.00	0.00	306.14
LastName,First	3948	799.44	☑	2	WEU	0.00	☐	0	128.23	☑	2	00155	0.00	0.00	0.00	0.00	0.00	0.00	927.67
LastName,First	1758	799.44	☑	3	WEU	0.00	☐	0	128.23	☑	3	00155	0.00	0.00	0.00	0.00	0.00	0.00	927.67
LastName,First	3975	799.44	☑	3	WEU	0.00	☐	0	128.23	☑	3	00155	0.00	0.00	0.00	0.00	0.00	0.00	927.67
LastName,First	2570	260.92	☐	0	WEU	0.00	☐	0	45.22	☐	0	00155	0.00	0.00	0.00	0.00	0.00	0.00	306.14
LastName,First	8265	260.92	☐	0	WEU	0.00	☐	0	45.22	☐	0	00155	0.00	0.00	0.00	0.00	0.00	0.00	306.14
LastName,First	9237	543.00	☑	0	WEU	0.00	☐	0	92.87	☑	0	00155	0.00	0.00	0.00	0.00	0.00	0.00	635.87
LastName,First	0702	260.92	☐	0	WEU	0.00	☐	0	45.22	☐	0	00155	0.00	0.00	0.00	0.00	0.00	0.00	306.14
LastName,First	9246	260.92	☐	0	WEU	0.00	☐	0	45.22	☐	0	00155	0.00	0.00	0.00	0.00	0.00	0.00	306.14
LastName,First	7233	799.44	☑	2	WEU	0.00	☐	0	128.23	☑	2	00155	0.00	0.00	0.00	0.00	0.00	0.00	927.67
LastName,First	2272	491.71	☐	1	WEU	0.00	☐	0	80.58	☐	1	00155	0.00	0.00	0.00	0.00	0.00	0.00	572.29
* COBRA		7,135.95				0.00			1,168.93				0.00	0.00	0.00	0.00	0.00	0.00	8,304.88

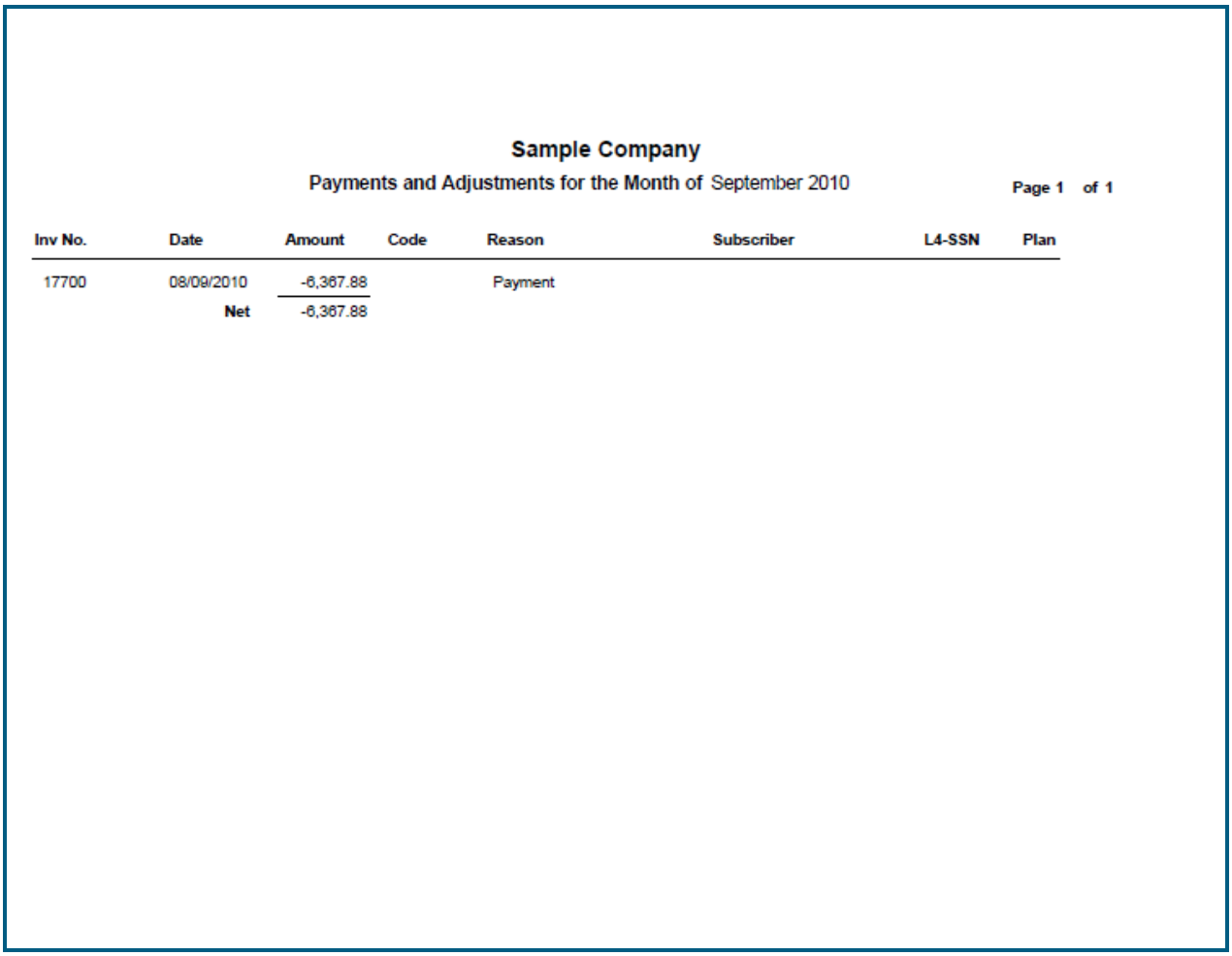
Note: Please pay by the Invoice Summary

PAYMENTS AND ADJUSTMENTS PAGE

The adjustment page reflects any retroactive additions and/or terminations processed between the prior invoice and the current invoice. These adjustments are reflected on the statement page. The balance due, if any, is reflected on the statement page as Balance Forward, and is included in the total amount.

Retro Adjustment Guidelines (Late Additions or Terminations): It is very important that enrollment changes, additions and terminations are submitted to AIMS in a timely manner. This ensures accurate billing and minimizes claims and eligibility issues with the carriers.

All enrollment additions, changes or terminations must be reported to AIMS within30 days of the intended effective date. Notices received outside this timeframe will not be



Sample Company

Payments and Adjustments for the Month of September 2010

Page 1 of 1

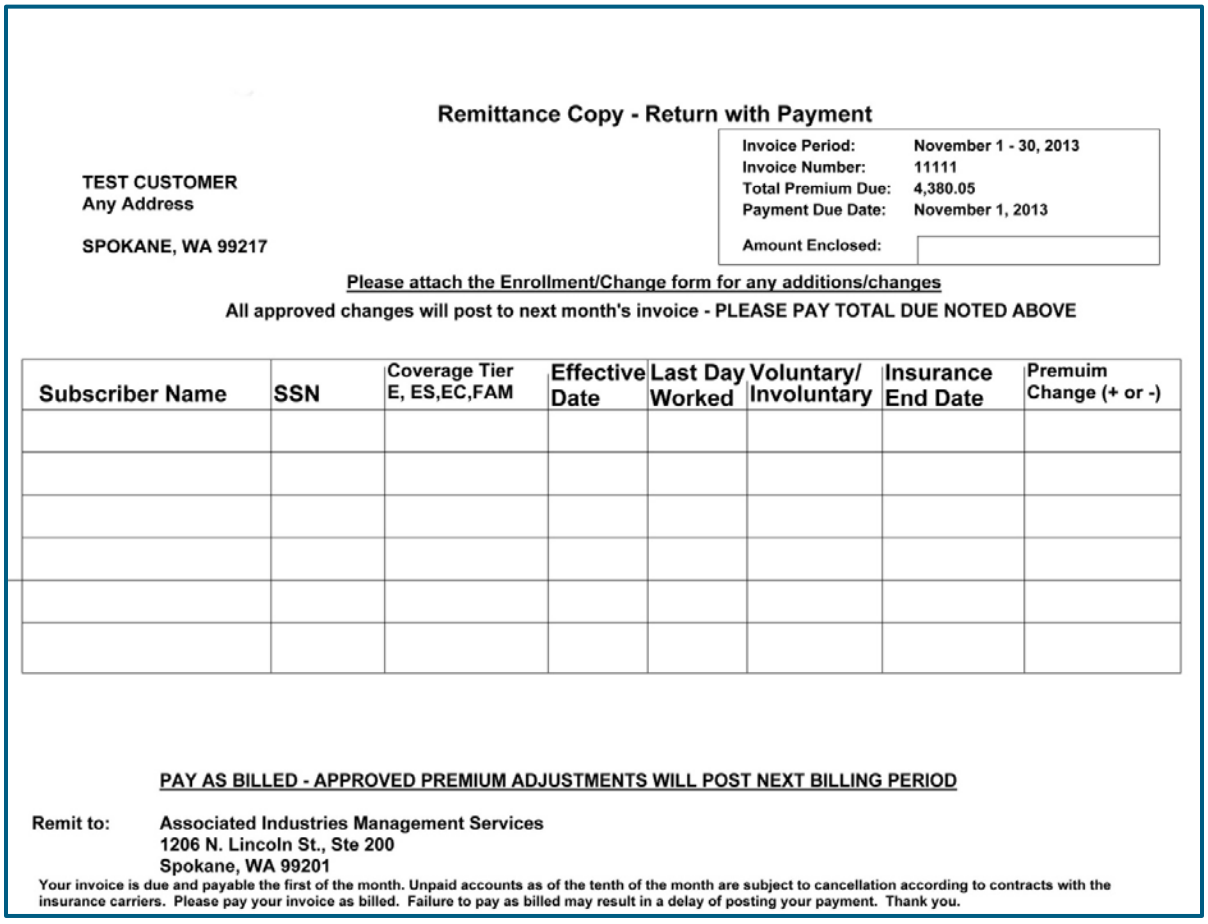
Inv No.	Date	Amount	Code	Reason	Subscriber	L4-SSN	Plan
17700	08/09/2010	-6,367.88		Payment			
	Net	-6,367.88					

processed as requested and may result in additional premium owed.

REMITTANCE COPY

When submitting your monthly premium payment, please include with your payment a completed copy of the Remittance Form (sample below) that comes with your Invoice.

Please return this page with your payment. In the event the invoice is not paid as billed, please note any changes that modify the amount of the invoice and payment, and include the



Remittance Copy - Return with Payment

Invoice Period:	November 1 - 30, 2013
Invoice Number:	11111
Total Premium Due:	4,380.05
Payment Due Date:	November 1, 2013
Amount Enclosed:	

TEST CUSTOMER
Any Address

SPOKANE, WA 99217

Please attach the Enrollment/Change form for any additions/changes

All approved changes will post to next month's invoice - PLEASE PAY TOTAL DUE NOTED ABOVE

Subscriber Name	SSN	Coverage Tier E, ES,EC,FAM	Effective Date	Last Day Worked	Voluntary/ Involuntary	Insurance End Date	Premuim Change (+ or -)

PAY AS BILLED - APPROVED PREMIUM ADJUSTMENTS WILL POST NEXT BILLING PERIOD

Remit to: Associated Industries Management Services
1206 N. Lincoln St., Ste 200
Spokane, WA 99201

Your invoice is due and payable the first of the month. Unpaid accounts as of the tenth of the month are subject to cancellation according to contracts with the insurance carriers. Please pay your invoice as billed. Failure to pay as billed may result in a delay of posting your payment. Thank you.

appropriate enrollment or termination form.

ELIGIBILITY TIMING AND PROCESSING

Medical Eligibility is sent to Regence/Asuris Health electronically on a daily basis.

Dental Eligibility is sent to Delta Dental of Washington electronically on a thrice weekly basis.

Vision Eligibility is sent to VSP electronically on a thrice weekly basis.

The Member Enrollment and Change Forms can be sent via:

Email to aims@aiin.com
Fax to 509.328.6832 or

US Mail: Associated Industries Management Services, 1206 N. Lincoln, Suite 200, Spokane WA 99201

Applicable Laws

HIPAA PRIVACY RULES

AIMS and its insurance carriers are subject to all federal privacy restrictions effective April 14, 2003. Procedures are in place to process protected health information as required.

Please note: Due to the restrictive nature of these federal requirements, Administration Office and carrier personnel will not be able to respond to unauthorized inquiries and requests for information.

FMLA ADMINISTRATION

The FMLA generally applies to employers that employed fifty (50) or more employees during each of the twenty (20) or more calendar work weeks in the current or preceding calendar year. Employees must have worked for the employer for at least 12 months; have at least 1250 hours of service for the employer in the 12 months immediately preceding leave and must work at a location where the employer has at least 50 employees within 75 miles. Under this provision, eligible employees may receive up to twelve (12) weeks of leave during a twelve (12) month period, as provided by FMLA, under the following circumstances:

- The birth of an employee's child
- The placement of a child with the employee for adoption or foster care
- Care for the employee's seriously ill spouse, parent or child
- The employee's own serious physical or mental health condition. Any qualifying exigency arising out of the fact that a spouse, son, daughter, or parent is a military member on covered active duty or call to covered active duty status.
- An eligible employee may also take up to 26 workweeks of leave during a "single 12-month period" to care for a covered servicemember with a serious injury or illness, when the employee is the spouse, son, daughter, parent, or next of kin of the servicemember.
- Benefits must be continued for employees on FMLA leave as if he/she had continued to work. Please contact your legal counsel or producer for more information.

MEDICARE SECONDARY PAYER (MSP) RULES

The Benefit Program will be primary over Medicare coverage for active employees and dependents.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

The Benefit Program will comply with any court ordered enrollment of a child for benefits, whether it be as a result of divorce or governmental requirements. Copy of order must accompany enrollment form.

USERRA ADMINISTRATION

USERRA (Uniformed Services Employment and Re-Employment Rights Act) has provisions that allow an employee, who is called up to military service, the right to continue coverage for up to eighteen (18) months by paying the monthly premiums.

For further information on USERRA, please contact your legal counsel or producer.

Frequently Asked Questions

QUALIFYING EVENT FAQS

What Is a Qualifying Event?

It is an event that qualifies an employee or a dependent for a change in coverage. Some common examples are loss of other coverage, marriage, birth/adoption, or change in employment status. Below is a chart of qualifying events and what action is allowed. Please note if an employee or dependent voluntarily terminates their individual coverage on the Exchange, it is not considered a qualifying event.

Table of Authorized Change of Election Events
Change in Legal Marital Status or Number of Dependents: Marriage, Domestic Partnership, Divorce, Legal Separation, Annulment, Death of Spouse or Dependent, New Child (birth, adoption or placed for adoption)
Gain or Loss of Employment: Going from Full-Time to Part-Time or Part-Time to Full-Time Change in Work Schedule Due to Strike or Lockout Resulting in a Loss of Eligibility Return from or Commencement of Unpaid Leave of Absence Gain/Loss of Coverage under Participant or Dependent's Health Plan Change of Employment Status Impacting Eligibility for Health Plan
Dependent Satisfies, or Ceases to Satisfy, Requirements for Dependents
Change in Residence or Work Site That Affects Eligibility
Judgment, Decree or Order resulting in the Plan Receiving a Qualified Medical Child Support Order
Employee/Dependent Medicare or Medicaid Eligibility Change
Employee Entitled to Special Enrollment Rights under HIPAA
A Change in Status Occurs that Entitles an Employee, Spouse or Dependent to COBRA Coverage

INCOMPLETE FORMS FAQS

Will I Be Notified If I Send In an Incomplete Form?

Generally, yes. AIMS will attempt to contact you if you have not completed a form or if there are discrepancies. If AIMS is unable to contact you; incomplete forms will be returned with a letter explaining why the form could not be processed.

What Are Some Common Pitfalls?

Effective date: Please consult the "How to Enroll" section for information on effective dates. If you have questions about your probationary period or what the effective date should be, the AIMS team will be happy to help you and answer any questions you may have.

Illegible handwriting: If handwriting is hard to read it is more likely to cause an error, resulting in coverage problems. Please ensure all forms are completed legibly or typed.

Mailing address: Employees should include their street address (including Apt. or Unit #), city, state, and zip code in the "Employee Information" section. Employees frequently write their street address but neglect to include Apt., Unit #, city, state, or zip code.

Signature: Both the employee and employer need to sign the enrollment form.

Outdated Forms: Please check the AIMS website for the most up-to-date forms. Forms are located in the Forms Library in the "Employers" section of the website: www.aimstpa.com.

MISCELLANEOUS FAQS

What Is Open Enrollment?

Open enrollment is the month before the plan renews. During this period, employees may add and drop coverage with no other qualifying event. Employers may also change the coverage that is offered. To find out which month your group renews, consult your Group Master Application or your producer.

Where Do I Find…

Enrollment Forms

Forms can be found here: www.aimstpa.com

Benefit Booklets

Employers may obtain copies of the medical benefit booklets on the www.aimstpa.com
Participants may obtain copies by logging on to Regence or Asuris.

I Do Not Understand What my Plan Offers. Whom Can I Call to Get Further Clarification?

For information relating to what types of services are covered, reimbursement, and claims, please contact customer service at the insurer or your Producer.

My Renewal?

Specific questions about your renewal, including definition of terms and the difference between options should be directed to your Producer. Renewal information is provided by directly to your Producer. If you believe you should have received renewal paperwork and have not yet received it, please contact your Producer.

NEW GROUPS FAQS

How Do I Verify That My Member Enrollment & Change Form Has Been Processed?

When submitting your enrollment forms, please send them to aims@aiin.com and you will receive a message verifying that your enrollment form has been received. To verify the accuracy of the enrollment information, please review your monthly premium invoice. In the event of an urgent inquiry, please contact AIMS for enrollment questions. AIMS will be able to confirm if enrollment has been processed and the effective date of coverage.

Enrollments/Changes?

Please send enrollment/change questions to AIMS. Enrollment requests should be submitted prior to the 15th of the month in order to be reflected on the following month's billing. Enrollment forms can be emailed to aims@aiin.com or faxed to 509.328.6832.

Claims?

Questions about claims should be directed to the insurer. Please note that neither AIMS nor the Program Manager adjudicate claims nor do they have any information about pending, denied, or approved claims.

Credit For Deductible Paid To Prior Provider?

This question would be handled by the insurer.

Certificate of Prior Coverage?

If you need a Certificate of Prior Coverage, please contact the insurer of that coverage. In general, Certificates of Prior Coverage will be sent to employee's homes directly after the termination of coverage for a qualified plan.

I Sent an Enrollment, But My Employee Has Not Received an ID Card. How Can I Make Sure They Enrolled?

AIMS communicates enrollment information with the insurers daily. Identification cards may take an additional 12-14 business days to be printed and mailed. If you have not received a card, please contact AIMS to verify enrollment.

How Can I Transition an Employee From Part-Time To Full-Time Employment?

Fill out an Enrollment and Change Form as you would for a new employee, including both the original date of hire and the date of transition from part-time to full-time employment. Please note the event next to each date. Check your Group Master Application for information regarding probationary periods for part-time to full-time transitions.

BILLING FAQS

I Know My Payment is going to be Late. Whom Do I Call?

Contact AIMS. You may want to ask about setting your firm up for EFT payments on a monthly basis , or we now have an option to make payments through the payment portal.

My Check Was Returned for Non-Sufficient Funds. What Is Going to Happen to Our Coverage?

A $30 fee will be charged for NSF checks. Replacement funds must be paid by Cashier's Check within 10 business days of notice in order to retain coverage.

Is There a Grace Period?

Premium invoices are generated the 15th of the month for the next month's coverage and are due by the 1st of each month. There is a grace period of 10 days. In the event payment is not received by the 10th, your coverage can be terminated. Any claims incurred between the 1st and the termination date will be the individual's responsibility

I Sent In a Change and It Is Not Reflected on My Invoice. Why?

Your request was probably received after generating the billing statement. Please contact AIMS to confirm the change.

When Do I Need To Submit Changes to Ensure That They Are on My Next Invoice?

Prior to the 15th each month.

I Have a New Employee That Should Have Coverage This Month, But I Have Already Paid This Month's Bill. What Should I Do? What Is the Effect on the Employee's Coverage?

Send in the Member Enrollment and Change form as soon as possible. Email it to aims@aiin.com for processing. Adjustments for the prior months invoice will appear in the Adjustment Section of the next billing statement.

I Believe My Invoice Is Incorrect. What Should I Do?

Contact AIMS.

I Did Not Receive an Invoice This Month.

Invoices are available on Payment Portal or you can contact AIMS. You may sign up to have your monthly invoice emailed to you. This will eliminate all the mail time and give you more time to review your invoice.

How Do I Change the Billing/Administrative Contact or Address for the Group?

Send written confirmation to AIMS by sending an email to aims@aiin.com.

What Is My Balance Forward? I Thought I Paid My Bill Last Month. Why Is a Balance Forward Showing Up?

This usually is reflective of an amount left over from the previous month. Review the adjustment page of your bill for retroactive charges or credits posted after your last invoice was generated. If you still have questions, contact AIMS for further information.

How Do I Request a Billing Adjustment?

Contact AIMS. (See page 5 for contact information.)

What Is My Group Number?

This is a number assigned to you by the insurer to identify your company. If you are unsure of your group number feel free to contact AIMS and we will be happy to provide that information to you.

What Is a Retroactive Adjustment?

This is an adjustment for a prior month that effects that month's billing figures.

What Is an Effective Date?

Date employee or dependent is enrolled in health insurance coverage.

What Is a Hire Date?

This is the first day that an employee actually worked for your company.

What Is a Termination Date?

This is the last day an employee worked for your company. In some instances, an employee will be terminated following a period of absenteeism. In this case, the last day that the employee worked is the termination date.

Glossary of Terms

CARRIER:
Term used to describe the insurance company.

CLAIM:
Service rendered to the participant that is sent to the insurance company for payment.

COBRA:
The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal regulation requiring certain employers to allow eligible employees and eligible family members to continue group health care coverage when specific events occur that would normally result in loss of coverage.

COBRA DISABILITY EXTENSION:
An 11-month extension (not to exceed a total of 29 months of coverage) provided to a qualified beneficiary who is currently on COBRA under an 18-month qualifying event term. This extension is granted to qualified beneficiaries who have been deemed disabled by the Social Security Administration. The disability date, as determined by the Social Security Administration, must exist either prior to the COBRA qualifying event or at any time during the first 60 days of COBRA coverage.

To take advantage of the extension, the qualified beneficiary must inform AIMS in writing of the determination before the expiration of the 18 months of COBRA and within 60 days of receiving their SSD award letter. The extension would be granted to the qualified beneficiaries covered under COBRA, not just to the individual that was deemed disabled. Premiums may increase to 150 percent of the active premium during the COBRA disability period.

EFFECTIVE DATE:
The date coverage begins.

HIPAA:
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides expanded rights and protections for participants and beneficiaries in group health plans. Understanding this amendment is important to your decisions about future health coverage. If you find a new job that offers health coverage, or if you are eligible for coverage under a family member's employment-based plan, HIPAA includes protections for coverage under group health plans.

INITIAL RIGHTS NOTIFICATION:
Federal law requires that certain information about COBRA be provided to employees and their spouses at the time the employee is hired. This information is included in an Initial Rights Notification letter and/or your Summary Plan Description booklet.

LIMIT EXCLUSIONS FOR PRE-EXISTING CONDITIONS:
These prohibit discrimination against employees and dependents based on their health status.

PAID THROUGH DATE:
The date your coverage will terminate if you do not make subsequent payments.

PHI - PROTECTED HEALTH INFORMATION:
Protected health information (PHI) under HIPAA means individually identifiable health information. “Identifiable” refers not only to data that is explicitly linked to a particular individual (i.e.: that is identified information); it also includes health information with data items, which reasonably could be expected to allow individual identification.

QUALIFYING BENEFICIARY (QB):
Generally, a qualifying beneficiary is any individual who, on the day before a qualifying event, is covered under a group health plan maintained by the employer of a covered employee by virtue of being:

1. The covered employee;
2. The spouse of the covered employee; or
3. The dependent child of the covered employee. Exceptions include certain nonresident aliens.

QUALIFYING EVENT (QE):
A qualifying event is any one of the following events that would result in the loss of health insurance coverage:

4. The death of the covered employee;
5. The termination (other than for reasons of gross misconduct) of a covered employee's employment;
6. A reduction in a covered employee's hours of employment;
7. The divorce or legal separation of a covered employee from the employee's spouse;
8. A dependent of a covered employee when that employee becomes entitled to Medicare benefits;
9. A dependent child ceasing to be a dependent child of the covered employee under the terms of the group health plan; and
10. With respect to certain retirees and their dependents, bankruptcy proceedings of an employer under Title 11 of the U.S. Code, commencing on or after July 1, 1986.

USERRA:
The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) provides for the continuation of health plan coverage for up to 18 months for those persons on military leave. Because this overlaps with COBRA, there is no functional difference between COBRA and USERRA.