POLICIES & PROCEDURES

Dear Elevanta Health Employer Participant:

We appreciate your business and look forward to continuing to serve you and your employees. We hope that you find the information below helpful. This notice will cover the following topics:

- Invoicing
- Invoice Corrections
- Returned Payment Fee
- New Hires
- Terminations
- COBRA / COBRA Penalties
- Cancellations/Changes to Policy
- Qualifying Events
- Medical Support Orders
- Maximum Age Dependents
- Access Fee/Membership Fee
- Insurance Cards
- Claims
- Elevanta Health Reporting Fee / ACA & DOL Filings

INVOICING

Elevanta Health bills in advance. Your monthly invoice will be uploaded to your Criterion profile during the third week of each month for the upcoming month. We will send an email notification when the invoice is made available to you so that you can retrieve it at your convenience. We urge you to review the invoice as soon as possible and bring any discrepancies to our immediate attention.

The total amount shown on your Final Invoice will be automatically drafted from your account (using the banking information on file) on the **first business day** of each month unless notified otherwise (subject to change for holidays or office closings). Please allow a few additional days for processing time as it may vary depending on your financial institution.

As stated in your Program Participation Agreement,

> ***"Member agrees to pay all premium statements as billed by means of electronic funds transfer, with the understanding that appropriate adjustments (credits and debits) shall be made on future statements. Credits for retroactive terminations of coverage shall be given for up to thirty (30) days following the termination of coverage effective date."***

Once the Invoice is sent, any outstanding changes that need to be made will be made on the next month's invoice.

CORRECTIONS ON YOUR INVOICE

In order to see any corrections reflected on your invoice, please notify us by the 10th of the month. Any corrections requested after the 10th of the month will be reflected on the next month's invoice.

Please allow 48-72 hours for review of your email request. If you do not receive a response within that timeframe, please call us immediately.

We must be notified of any discrepancies within 30 days of receipt of your final invoice or adjustments **may not** be possible.

In order to avoid return payment fees, please notify us immediately if your banking information changes.

RETURNED PAYMENT FEE

There will be a **$75 service charge** to any account with **Return Payments**, plus a charge of **2%** of that month's premium for a first-time offense. If there is a second occurrence the service charge will double to $150 plus 2% of the month's premium; third occurrence will result in a $250 fee plus 2%. Should a company have 4 occurrences in one plan year, the company will be terminated.

As stated in paragraph two of the Program Participation Agreement signed by all franchisees: ***"Member acknowledges and agrees that it is Member's sole responsibility to make payment of all premiums on the due date, if premium payments are not paid when due, coverage will be terminated, and employees will be notified."***

NEW HIRES

New hires should be entered directly into Criterion HCM by the company HR Administrator if the new hire is signing up for benefits. How-To Instructions and a tutorial video are available to HR Administrators, in their Criterion HCM profile. Elevanta Health Benefits team is also available to host a tutorial on how to add new hires or newly eligible employees. New hires do not need to be entered into Criterion HCM if they are declining benefits. Please download a Declination form from your HR Administrator profile in Criterion for eligible employees that wish to decline coverage.

Once a new hire/newly eligible employee is added in the system, and the Elevanta Benefits Team is notified of the new addition, Elevanta will open an enrollment portal. Each employee will be invited to sign up for benefits via an invitation email sent from Elevanta. The portal will remain open for 5 business days.

A medical questionnaire (for those enrolling in medical) will be required for all new enrollees or when dependents are added (not required for newborn unless diagnosed with medical condition). All enrollment materials will be located in the HR Administrator profile and it will be the responsibility of the HR Administrator to provide any enrollment materials to your eligible employees going forward.

If an employee calls to inquire about pricing, we will advise the employee to contact their employer for rate information.

TERMINATIONS

Terminations should be entered directly into Criterion HCM by the company HR Administrator. How-To Instructions and a tutorial video are available to HR Administrators, in their Criterion HCM profile. Elevanta Health Benefits team is also available to host a tutorial on how to terminate employees.

Terminations are to be submitted by the 10th of each month in order to be processed in time for the upcoming month's invoice. Please refrain from submitting terminations earlier than 30 days before the employee's last day. COBRA packets are then sent directly to the employee using the email address provided to Elevanta Health in the employee's Criterion HCM profile. If no email is available, the COBRA packet will be mailed via USPS. To ensure your termination is processed and approved please notify Elevanta Health upon completion of the termination submission.

**** PLEASE BE AWARE: Termination dates cannot be altered** unless payroll records and a signed

affidavit are provided as proof that the original date was incorrect. Any credit due will be given on the following month's invoice.

The Coverage End Date for all qualifying event (**terminations**) should be entered using the last day that the employee worked or the day that the employee's benefits should end.

If an employee's last day worked is 3/31/2021, then the Coverage End Date should reflect 3/31/2021, this means that the employee's benefits will no longer be active as of 12:01AM, on 4/1/2021.

Employers will not be charged for any termination that occurs on or before the 14th of the month. However, terminations that occur on or after the 15th of the month will be billed for the full month of premiums.

COBRA

Per ERISA requirement, COBRA packets are sent to all terminated employees within **14** days of receiving notice from the HR Administrator. COBRA packets are sent directly to the employee using the email address provided to Elevanta Health in the employee's Criterion HCM profile. If no email is available, the COBRA packet will be mailed via USPS. Charges will appear on your monthly invoice for any terminated employee that elects to have continuation of coverage. The COBRA member will send all payments directly to Elevanta Health within their 30-day grace period. Elevanta Health will reimburse you for those billed employees via ACH deposit to your account within one week of your ACH draft. If a payment is not received from the employee, then you will see a credit on the following month's invoice.

COBRA PENALTIES

COBRA is legislation primarily directed at employers. Thus, **employers**, and not their insurers or third-party administrators, are primarily liable for COBRA violations. If sued or audited by the regulators, an employer must be able to prove that it has properly complied with COBRA's rules, or else be subject to substantial penalties, up to and including the payment of claims for the aggrieved individual.

All employers, including those with only a few COBRA Qualifying Events a year, should not be lulled into a false sense of security just because they have not had any COBRA problems. Many employers are surprised when they are sued for non-compliance with COBRA, often not even realizing they were out of compliance.

What Are the Penalties?

- **Internal Revenue Service Penalty**
  - $100-per-day nondeductible excise tax per violation. If more than one qualified beneficiary is in the family, the IRS excise tax is $200 per day.
  - If a violation is not corrected, the noncompliance period ends six months after the last day of the applicable maximum COBRA coverage period — generally 18 or 36 months.
- **ERISA Penalty**
  - Failure to provide the required COBRA notices in a timely fashion can result in a daily assessed penalty of up to $110 per day, per violation when COBRA is the subject of a lawsuit.
  - This penalty can be levied per each qualified beneficiary with no family maximum. Therefore, if there were four qualified beneficiaries in a family that the employer neglected to notify, a judge could fine the employer up to $440 per day.
- **Payment of Claims**
  - The employer would be required to pay the qualified beneficiary's claims. The employer must "make the person whole" by placing the qualified beneficiary in the exact financial condition they would have been in if they had elected the most favorable coverage considering the expenses incurred.
- **Damages –** Levied by the judge in a COBRA lawsuit.
- **DOL Audit –** The plan could be subject to an audit by the U.S. Department of Labor, which could bring a lawsuit against an employer; and/or the qualified beneficiary can sue an employer for failure to comply with COBRA.

CANCELLATION / CHANGES TO POLICY

Because we are a group insurance plan, we are governed by the federal guidelines covering the Cafeteria 125 Plan. This information is outlined in the enrollment packet that is made available to all of your new hires.

Members are only allowed to cancel or make changes once a year during open enrollment unless it is an IRS-recognized qualifying event. Please refer to the Qualifying Event section for additional information.

QUALIFYING EVENTS:

Section 125 of the IRS code allows for certain benefit premiums / contributions to be deducted from employee's pay on a pre-tax basis, which reduces their tax liability. The following are examples of qualifying events:

- Change in marital status, including marriage, divorce, or annulment;
- Birth of a child
- Termination or commencement of spouse's employment;
- A reduction or increase in hours of employment by the employee, spouse or dependent, including a switch between part-time and full-time employment, a strike or a lockout;
- Significant change in health coverage of the employee or spouse attributable to the spouse's employment;
- Commencement or return from an unpaid leave of absence in excess of two calendar weeks by the employee or spouse;
- Change in child's status to satisfy or cease to satisfy plan requirements for unmarried dependents;
- Entitlement to Medicare or Medicaid;
- Plan's receipt of a court order, such as a qualified medical child support (QMCSO) requiring coverage of an employee's child;

For a full, detailed list of qualifying events, please contact Elevanta Health Benefits Team.

IRS mandated Qualifying Events are required in order to make any changes to an employee's coverage outside of our annual May 1st Open Enrollment period. **Please note: We must receive written notification of Qualifying Events along with supporting documentation* containing the date of the event within 30 days of the event**. The benefit effective date for any qualifying event will be the date of the event. Qualifying event changes that are not received within 30 days will not be processed.

EXAMPLE: If the qualifying event is the birth of a child, and the child is born on 5/10/2021; We would need notification in writing from the employer, a birth confirmation or discharge papers showing the date of birth and child's name from the employee within 30 days of the child's date of birth. Benefit changes would become retroactively effective 5/10/2021. This also means that you will be back billed for changes to the policy on your next invoice.

If you are uncertain of what information is needed, please contact us immediately.

MEDICAL SUPPORT ORDERS

Medical Court Orders should be sent to Elevanta Health immediately upon receipt. Failure to comply with the court mandated order is a violation and as a result you could be liable. Elevanta Health will need the following information to process all medical support orders:

- **Notification in writing** - Indicating the date the employee became eligible for coverage (although this is court ordered the employee must still be eligible for the insurance).
  ****Please note:** The effective date of coverage for Medical Support Orders is determined by the Date of Notice on the Medical Support Order or the Eligibility date determined by Employer's waiting period.
- **Medical Questionnaire** - If the member refuses to complete a Medical Questionnaire, you as the HR personnel at your company can complete, sign and date the questionnaire on the employee's behalf.
- **Medical Support Order** – Please submit the Plan Administrator Document in its entirety to Elevanta Health.

As the "Plan Administrator", Elevanta Health will complete all sections that pertain to the health insurance.

We will return the Plan Administrator section of the medical support court order to the HR Administrator once coverage elections have been processed for you to submit to the issuing agency.

*The employee must also be enrolled with benefit coverage in order to enroll the child(ren). Participants will be enrolled in all products specified within the court document.

MAXIMUM AGE DEPENDENTS

Dependents can remain on a parent's policy until the last day of the month of their 26th birthday.

ACCESS FEE / MEMBERSHIP FEE

All companies must join Elevanta, LLC as an Associate Member in order to be eligible to participate in the Elevanta Health program. The yearly Membership Fee / Annual Dues associated with this membership is $100 per location, not to exceed $1,000. Membership renews on January 1 each year and fees will be drafted via ACH. As an Associate Member, your company will be eligible for all of the following member services:

- Health Plans
  - Major Medical
  - MEC
  - Dental
  - Vision
  - Basic Term Life Insurance
  - Supplemental Life and/or Accidental Death and Dismemberment Insurance
  - Short and Long Term Life (Quotes available upon request)
  - Teladoc
  - Livongo (Diabetes Management Program)
  - All COBRA services provided
- Payroll Solutions
- PayCard Solutions
- Retirement Programs
- Business Insurance Services

INSURANCE CARDS

Please note, your employees will receive a card from CBA Blue for their medical and dental benefits. **Vision coverage is provided by United Healthcare Spectera, however, they do not issue cards**. Your employees will only need to provide their social security number to their provider, and this will allow them to access their information in United Healthcare's system. Employees may also log onto United Healthcare's vision website at www.myuhcvision.com to establish a profile and view your current benefits. You can also contact customer service at 1-800-638-3120 for assistance.

CLAIMS

Any member with questions regarding medical or dental claims should contact BCBS customer service at 1-888-222- 9206, or United Healthcare at 1-800-638-3120 for vision claims. The member will need to provide the date of service
and the amount of the claim.

Elevanta Hours of Operation: Monday – Friday 8:30 am – 5:00 pm
Eastern Phone: (866) 696-3225
Fax: (866) 632-9373

ACA and DOL Required Filings

ELEVANTA HEALTH REPORTING FEE

Each employer participating in the Elevanta Health program is viewed as a separate self-funded plan rather than one large program. By filing your various reports as such, we are able to keep down the cost of most employers' premiums. There is a $600 administrative reporting fee for all of the various reporting done throughout the year by your Elevanta Health Team. This reporting fee has been divided evenly into twelve (12) $50 increments which will be added to your monthly invoice. For companies that have multiple entities under a common ownership, the company reporting will be prepared on an aggregate basis and the monthly administration fee will be $50 for the aggregated entities (i.e., only one $50 fee per month). **If you have multiple entities, please inform Elevanta Health of the entity you wish to serve as the primary company under which your reports will be prepared.**

FORM 5500 IRS FILING

The DOL & IRS require annual reporting, which contains information about a plan's financial conditions and operations such as paid claims and administrative costs, for certain welfare (health and dental) benefit plans. Each participating employer must file a separate Form 5500 in order to protect and support the structure of our arrangement as individual self-insured plans. Elevanta Health will gather all information from our Trust and insurance carriers to prepare these forms on your behalf. You will only be required to review and electronically sign the document via a third-party software company that we utilize. Generally, the Form 5500 must be filed by the last day of the seventh month following the close of the plan year. As your Elevanta Health plan year begins on May 1st, your Form 5500 is due each year on November 30th .

PLEASE NOTE:

- As of December 31, 2019, the **IRS** penalty imposed for late filers is $250 a day, up to a maximum penalty of $150,000 per plan year.
- As of January 15, 2020, The **DOL** penalty imposed for late filers has increased from $2,194 to $2,233 per day, for all plans under Title I of ERISA, ***with no maximum***.

SUMMARY ANNUAL REPORT (SAR)

The SAR is an ERISA required document that summarizes the information reported on the Form 5500. The SAR must be distributed to each participant and their beneficiaries receiving benefits under the plan no later than two months following the Form 5500 filing deadline of November 30th. Elevanta Health will provide the SAR to participating employers in time to meet the distribution deadline of January 31st. The SAR notifies participants that they have the right to request a copy of the statement of assets and liabilities of the plan. A copy of Form 5500 and Schedule I would fulfill this request.

PCORI FEE (IRS FORM 720)

One of the fees established under The Affordable Care Act is the Patient-Centered Outcomes Research Institute (PCORI) Fee, which helps fund research that evaluates and compares health outcomes, clinical effectiveness, and the risks and benefits of medical treatments and services. Under the ACA, ALL plan sponsors, of self-funded health care plans, are responsible for paying the PCORI Fee (regardless of whether you are an employer that must comply with the Employer Mandate). The fee began in 2012 and is due by July 31 of the calendar year immediately following the last day of the plan year. Therefore, the May 1, 2020 – April 30, 2021 plan year PCORI fees are due by **July 31, 2022**. The PCORI fee is calculated based on average number of lives (i.e. employees, spouses and dependents) covered under your plan**. For the 2020-2021 plan year, the fee is $2.66 multiplied by the average number of lives.**

PLEASE NOTE: The IRS imposes penalties if your filing is not submitted by the deadline. The ***late payment penalty*** is .5% of the tax owed after the due date, for each month the tax remains unpaid up to 25%. After the IRS issues a final notice of intent to levy, the .5% rate increases to 1% per month. The ***failure to pay penalty*** is 5% of the unpaid taxes for each month that the tax return is late. The failure to pay penalty won't exceed 25%. The maximum penalty for ***failure to file and pay*** is **47.5%** (22.5% late filing and 25% late payment) of the tax.

W-2 HEALTH INSURANCE REPORTING

The Affordable Care Act requires employers who are filing more than 250 W-2 Forms for the previous calendar year to report the cost of coverage on employees' W-2 for the current calendar year. It is required to be furnished to each employee that was enrolled in medical coverage during the year. Elevanta Health will compile and send you a listing containing your employees and the total amount of premiums that were paid out for the calendar year.

EMPLOYER REPORTING (1094 & 1095 FILING)

All employers of self-funded plans are required to submit form 1094 in compliance with the Employer Reporting Mandate. Although we do not have all of the information needed in order to complete the filing on your behalf (as most of this information would be gathered from your payroll provider), Elevanta Health compiles the information required for section III of the 1095 filing. The report will contain any employee that had medical coverage under our program for the calendar year, including any dependents, SSNs, dates of birth, and specific months of coverage.