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6155 Almaden Expressway, Suite 210, San Jose CA 95120
408-268-9700

www.rogersbenefit.com

Carrier Notices for the week of 08-27-10

Aetna

- **Important changes to health benefits plans for 10-1-10 effective dates**

8-4-10

  - Announcing upcoming plan changes for new and renewing groups with 2-50 eligible employees effective as of 10-1-10
    - Overview of upcoming changes
    - Aetna is changing their health benefits plan designs to comply with new federal laws
    - Aetna is making it easier for your clients to choose plan designs by simplifying the plan designs that they make available
    - Aetna is making other changes to better manage rising health care costs
  - Health Care Reform Plan Changes (*effective 1st plan year on or after 9-23-10)*
    - Dependent children can now enroll in an Aetna medical or dental plan up to age 26. If state law requires coverage of dependents age 26 and older, the plan will continue to cover those dependents
    - Coverage for enrollees up to age 19 will include services needed to treat pre-existing conditions
    - Plan designs will have no overall dollar limit on how much Aetna will pay over a member's lifetime
    - Aetna members won't pay anything for certain preventive care delivered from network providers
  - Competitive Product Solutions for California
    - As of 10-1-10, Aetna will be launching a refreshed product portfolio allowing Aetna to serve your CA Small Group clients' more efficiently and simplify their plan choices. Aetna's new streamlined portfolio of products will give your customers the ability to select from different plan designs at a variety of price points
    - These changes are part of Aetna's continuing effort to provide your clients access to high-quality, affordable health coverage. Changes in plan designs may result in reduced coverage for some services. Aetna recommends you

and your clients carefully review their plan documentation to understand which of these changes may apply to their plans

- Plans with Benefit Changes
  - MC $10,000 100/50
  - MC HSA* $2000 80/50
  - MC HSA* $3000 90/50
  - MC HSA* $3500 80/50

  As of 10-1-10, all of the HSA plans in the Small Group Portfolio will be True Integrated Family (TIF) deductible and coinsurance plans. With a TIF plan the Individual Deductible or Out-of-Pocket maximum can only be met when a member is enrolled for self only coverage with no dependent coverage. The Family Deductible or Out-of-Pocket maximum can be met by a combination of family members or by any single individual within the family. Once the Family Deductible or Out-of-Pocket maximum is met, all family members will be considered as having met their deductible or Out-of-Pocket maximum for the remainder of the calendar year
- Deleted Plans
  - Vitalidad HMO $5
  - Vitalidad Plus HMO $20/$5
  - Vitalidad Plus HMO $40/$10
  - HSA $3300 80/50
  - EPO $500 80
  - PPO $750
- What to expect
  - In-force customer plan design(s) will stay in effect until current policy periods end. At that time, the plan design will be updated for health care reform or provided an alternate plan design to renew into that best meets the needs of their employees
  - Aetna will send a renewal packet before the current plan period ends. At that time, if your clients currently offer one or more of the benefits plan designs Aetna will not be offering, Aetna will provide information on the alternative plan design that most closely resembles the in-force plan design as well as other Aetna plan designs that are available
  - If Aetna does not hear from existing plan sponsors prior to their renewal date, Aetna will automatically switch them to the Aetna plan design that they believe most closely matches their existing plan
- You should also be aware that the Federal government recently released regulations related to grandfathering of health plans in existence on 3-23-10. Changes in benefit design and contribution strategy may affect grandfathering. Renewal offerings may not preserve grandfathering

• Aetna announces new agreement with CVS Caremark *7-28-10*

- Aetna is entering into a 12-year strategic agreement with CVS Caremark that will result in enhanced value to your customers and their members. This arrangement will allow Aetna to provide customers with high-value, integrated pharmacy plans that are driven by total cost and quality management, clinical superiority, a holistic, member-centric experience and market-leading products
- Aetna's objective in this strategic agreement was to find a like-minded organization that is focused on clinical outcomes, consumer engagement and driving financial value for their customers and members. CVS Caremark shares similar values, and supports Aetna's goal of providing quality outcomes with lower cost for members
- Under the agreement, Aetna will retain and operate its mail order and specialty pharmacy businesses, with CVS Caremark providing the administration of selected functions for Aetna's retail pharmacy network contracting and claims administration,

as well as mail order fulfillment and customer service, specialty pharmacy order fulfillment and inventory purchasing and management

- Aetna will continue to own and manage its PBM organization, including:
  - Clinical program development;
  - Sales and account management;
  - Pricing and underwriting;
  - Manufacturer relations;
  - Rebate contracting and administration
  - Clinical protocols and oversight of medical policies, plan design, formulary;
  - Continued ownership and operation of their mail-order and specialty pharmacies
  - Integrated care management programs, including clinical management of their specialty pharmacy operation
- Through this agreement, Aetna will enhance its competitive position as a premier provider of PBM services while delivering superior service capabilities, innovative product offerings and greater value to its customers and members
- CVS Caremark, working closely with Aetna, will offer:
  - Handle pharmacy claim administration functions
  - Contracting for, and administration of, Aetna's retail pharmacy network
  - Robust operating platforms, which will create substantial efficiency and improvements in reporting and member experience
- Aetna's mail order and specialty pharmacies will benefit from CVS Caremark's best-in-class fulfillment and administrative capabilities
- Together, Aetna and CVS Caremark will be positioned to help optimize care management, resulting in improved health care quality for members through early diagnosis, therapy engagement, improved medication adherence and closing gaps in care, all at a lower cost
- There will be no immediate changes for your customers with Aetna pharmacy benefits. CVS Caremark services will be phased in to Aetna's pharmacy programs. Aetna expects to obtain all regulatory approvals before the expected commencement date at the beginning of 2011
- Aetna is committed to a successful service enhancement implementation process. As Aetna looks forward to putting into operation the exciting benefits of this arrangement, they will continue to share the strategy and timeline of their activities as details evolve into 2011
- The press release and other information about the agreement are available on Aetna's website (www.aetna.com). Please rest assured that there will be no impact to current services of your small group customers

- **Aetna products now available on Healthcare.gov web portal** *7-27-10*

  - As part of the Patient Protection and Affordable Care Act, The U.S. Department of Health and Human Services (HHS) unveiled Healthcare.gov July 1. The new website provides individuals and small businesses health insurance coverage options in 50 states and the District of Columbia
  - www.HealthCare.gov is a central database of health coverage options, combining information about public programs with information from private carriers. It displays plan options available for consumers, life situations and local communities
  - Within the site's *Find Insurance Options* tab, consumers enter their demographic details, household characteristics and dependencies, health condition, reason for requiring health benefits, disability status, zip code, and if they are an individual or small business employer. The portal then processes and responds with zip-code specific plan design options available from public programs and private carriers

- It also provides five categories of plan details: services covered, doctor locator, drug benefits, price estimates, and a phone number and website to contact the plan carrier. Additionally, the website serves as a one-stop informational tool as HHS implements the Affordable Care Act. While the July 1 launch was an initial release, additional plan information will be added by October 1, 2010
- Further updates by HHS will be applied as necessary. Visit http://www.healthcare.gov/improve.html for questions related to the future growth of the new www.HealthCare.gov site
- You may also visit http://www.hhs.gov/news/press/2010pres/07/20100701e.html for additional details about the new HHS website

- **Aetna Small Business Group Update – September 1, 2010** *7-20-10*

  - Rating Updates:
    - Current rates apply for September
    - Fourth quarter rating action will be communicated shortly
  - Underwriting Changes:
    - Certificate of Qualification – this document is required to be filed by any company who conducts business in CA but are domiciled in another state. The Certificate of Qualification (or Certificate of Foreign Corporation) **had** been required on all new business. Effective immediately, any business appearing on the California Business Portal in an 'active' status will no longer need to submit the Certificate of Qualification**.** This form was not used to verify eligibility of owners/officers not appearing on the Quarterly Wage & Tax Statement. Verification of owners/officers eligibility still requires the Proof of Eligibility and supporting documentation, if the owners are not listed on the Quarterly Wage & Tax Statement
    - Groups submitted with DBA: A certificate of fictitious name is recognition that a person or entity is doing business under a name other than the person/entity's own name. When a company is "Doing Business As", a copy of the DBA certificate or fictitious name certificate should be provided. The absence of a fictitious name certificate could impact the name Aetna would use on the group contract but does not necessarily meant it cannot be issued as a DBA. If other documentation can be provided such as the DBA name on the Quarterly Wage & Tax Statement, or on some other official form, the group may be issued as the DBA. (If the DBA name is only included on the initial premium check or bill roster, do not include it as a DBA name.)
    - Waiver requirements: State legislation requires a waiver to be on file for any employee declining coverage. *(Page 1 & 5 of the application are required for waiver of coverage.)*
      - Employees declining group coverage must submit a waiver
      - Kaiser Wrap: Aetna no longer accepts Kaiser billing statement to account for employees not enrolling in Aetna coverage. Waivers for any eligible employees not electing Aetna coverage is required
      - Spouses working for the same employer will NOT be required to submit a waiver if one elects to enroll as a dependent under the spouse
    - Aetna PEO Guidelines: As of 5/1, Aetna's guidelines in relation to employers leaving, or utilizing the services of, a PEO have changed.
      - When a group is leaving or receives services from a PEO that is looking to secure coverage with Aetna Small Group, Aetna no longer needs a letter of intent. As long as the PEO provides payroll specific to Aetna's small group and Aetna can determine if it is a small group

even though the small group may be reported under the PEO Tax ID, this is acceptable

- What this means is that an employer who is with a PEO can be written with Aetna directly by providing payroll to justify this as a small group, and that payroll can be from the PEO on the PEO's TIN. However, it will have to be specific to the employer group being written. Based on this, Aetna will no longer need a letter with intent to term, or the requirement of the initial payroll to be on the employer's TIN
- Groups having payroll under the PEO TIN will need to provide documentation to legitimize the group as a small employer through the necessary corporate docs (if there are 2 owners for 50% of the calendar quarter calendar year) to be considered GI. If the group's GI status cannot be secured based on the existence of 2 owners/ee's outside of the PEO, then Aetna would review the group based on health questions and utilization, and the group can be declined. *(Groups coming from PEO are not eligible for the RAF Promotion.)*

- Licensing & Appointment is online!
  - Any broker or agency needing to be set up with Aetna will need to submit online via Aetna's ProducerWorld site. Hardcopies (paper agreements) are no longer being accepted. Here is the link to get directly to the online application: https://pangea.geninfo.com/Aetna/Apply/, or you can access through ProducerWorld
- Medical Benefit Updates:
  - Effective 9-1-10, Aetna will no longer offer 100% HSA plans. For small group, Aetna's one 100% HSA plan will change from MC HDHP HSA $3000 100/50 ***to*** MC HDHP $3000 90/50 plan
  - There is no change to the rating for September
  - Existing groups and members will be provided the new plan upon renewal, beginning with September renewals
- Network Updates (we're only referencing updates for No CA. If you want updates for So CA or Central Valley, please call our Office for details):
  - Physicians Integrated Medical Group in San Francisco is closing effective 7-1-10. This closing impacts all carriers. Aetna will transfer PCPs and their members to Hills Physician Medical Group, Brown & Toland Medical Group or Marin IPA. Letters were sent to impacted members on 5-25-10

ASSURANT *(Formerly Fortis Benefits)*

- **Assurant Exits Market in CA and WA** *7-19-10*

  - Assurant Health Group Markets has been reviewing the market opportunities for their fully insured small group plans for a number of months to ensure they focus their efforts on the states and markets where they can be most successful and maintain a competitive presence and strong future
  - After careful and thorough consideration of all health care delivery, financing, administrative and regulatory issues in the fully insured small group space, as well as current sales volumes, Assurant has made the decision to exit the fully **insured group medical and ancillary business** in the following seven states: California, Colorado, Maine, New Hampshire, New Mexico, Vermont and Washington.

Streamlining the number of states Assurant will do business in will further assist in reducing operational costs and better position Assurant for long-term success. This decision reflects Assurant's renewed commitment to selling small group employer health insurance in states where they remain

- This does not impact Individual Medical or Health access business
- This change applies to the legal entities of John Alden, Time Insurance, Union Security Insurance Company (business administered through Assurant Health) and will include the termination of the existing fully insured small group medical and ancillary business as well as the removal of fully insured small group new business software in these states. New business applications for these states will not be accepted into the Underwriting Department after Friday, August 6, 2010
- Most states require a 180-day notification to both the employers and the employees. Therefore, letters will be sent the week of 7-19 to terminate the business as of December 31, 2010 in states that allow a date certain termination. In states that require both a 180-day notice and termination on renewal, Assurant will send a communication at this time indicating to the groups that they will terminate on their first renewal after December 31, 2010 (WA to start first renewal after 2/1/2011 because letters are being sent by July 30, 2010). Groups terminating at renewal will be sent a second correspondence closer to their renewal date as well. The agent will be sent a copy of the letter that is being sent to the employer

Blue Shield

- **October 2010 Updates Summary** *8-16-10*

    - Average quarterly rate changes for Northern & Southern CA
        - HMO +5.5%
        - POS +2.2%
        - PPO (non-HSA) +4.4%
        - HSA +2.7%
        - Ancillary No rate increase
    - Benefit Changes
        - There will be a $250 deductible for brand-name prescription drugs for the Shield Spectrum PPO Plan 1000 Value and 1500 Value. The maximum plan payment brand name drug benefit per member per calendar year has been removed from these plans
        - Vision Basic and Vision Basic Plus plans (rider plans) will not be available as riders for new business. Identical coverage and pricing is offered in the Vision Standard and Vision Plus plans
    - New RAF programs
        - Blue Shield is replacing their current RAF programs with one simplified and enhanced RAF program for new groups:
            - Clients with 6+ enrolling employees qualify for a .90 RAF guarantee
                - Renewal RAF of 1.05 qualifies
                - No health statements and no employer questionnaires needed
            - Groups with 10+ enrolling employees, with no prior coverage also can qualify for a .90 RAF guarantee
                - No health statements and no employer questionnaires needed
            - Groups with fewer than 6 enrolling employees are automatically issued a 1.1 RAF
                - Health statements no longer required

        - Groups may apply for a lower RAF via standard underwriting and the submission of health statements
    - Program rules
        - Applies to Standalone, Dual Choice, Suite Deal and PlanSelect plans
        - New groups of 2-5 enrolling employees will automatically be written at 1.1 and health statements are no longer required. However, groups with less than 6 enrolling employees may submit health statements and go through underwriting to apply for a lower RAF. The best RAF for groups of 2-5 enrolling employees is still 1.0
        - New business with 6-14 employees not participating in a RAF program are still required to submit health statements
    - You can find a complete set of details and rules at www.blueshieldca.com/raf
- Health reform update
    - We encourage you to visit Blue Shield's Health Reform page on the Producer Connection website at www.blueshieldca.com/producer/news/health-reform to download detailed information
- Medicare Part D Status
    - The following plans are changing from Non-Creditable to Creditable
        - SS 1800/3600
        - SS 2000/4000
        - SS 2250/4500
        - SS 2500
        - SS 3000/6000
- Blue Shield has come out with new applications (employer and employee) for 10-1-10. This means the apps for 1-1-10 will no longer be accepted for groups effective 10-1-10 or later. Blue Shield will only accept the current (10-1-10) and the prior (7-1-10) versions

• Health Reform Update *8-4-10*

- Blue Shield of CA is pleased to report that additional grandfathering information is now available. Also, producers should remind clients that members who've reached their lifetime coverage limits will be allowed to re-enroll at renewal
- Grandfathering requirements finalized – Blue Shield can now confirm the Blue Shield medical plans that are eligible for 'grandfathered" status:
    - All Individual and Family Plans, except Essential(SM) Plans and Access_ HMO® - as long as the contract was in effect on or before 3-23-10, and the plan meets all grandfathering qualifications
    - All small group plans (2-50 employees) – as long as the contract was in effect on or before 3-23-10, and the plan meets all grandfathering qualifications
    - Current ASO groups and insured groups with highly-customized plans will have the option to grandfather their current plan as long as the contract was in effect on or before 3-23-10 and the plan meets all grandfathering qualifications
- Based on thorough research and analysis, the following plans will not be grandfathered as Blue Shield has concluded there will be no added value as a grandfathered plan:
    - Standard medical plans for groups with 51-299 eligible
    - Groups of 300 or more eligible employees that have standard medical plans
- Lifetime coverage limit removal
    - Members that have reached their lifetime dollar maximum will be allowed to re-enroll at renewal without a dollar value limit

        - Blue Shield is making strong efforts to locate those who have reached their benefit maximum. However, members who are aware that they have met their lifetime maximum status should contact Blue Shield immediately for re-enrollment
    - Open enrollment flyer in renewal packets
        - Renewal packets will include an *Important Health Reform Rights* flyer. Please make sure to distribute this flyer to your Blue Shield clients during open enrollment. Use the flyer as a tool to educate clients about the removal of lifetime dollar limits and the extension of coverage for dependents up to age 26
    - Blue Shield is committed to providing you with up-to-date health reform facts that you and your clients can rely on. You can count on Blue Shield's support as you continue to assist California's businesses and individuals in purchasing coverages that best fits their needs. Blue Shield thanks you for choosing to sell Blue Shield
    - Please visit Producer Connection at www.blueshieldca.com for continued health reform updates

- **Health Reform Update** *7-23-10*

    - Remind groups of the option to re-enroll dependents up to age 26
        - Group members will be allowed to re-enroll covered dependents up to age 26 for any renewals on or after October 1, 2010. The renewal materials that will be sent to employers by Blue Shield will include a written notice about this re-enrollment right that employers should provide to their employees with their open enrollment materials. The federal regulations specifically require that this notice be provided. Please remind your clients when you're talking about renewals. Members must act fast since re-enrollment is not automatic

- **Update! PEO and Small Group Underwriting Guidelines Explained** *7-23-10*

    - An increasing number of employers are outsourcing their human resources, payroll, workers' compensation, and employee benefits including health coverage, with professional employer organizations (PEOs). The PEO establishes and maintains an employer relationship with the employee and maintains a plan contract to offer health coverage for those employees. If the employer terminates its relationship with the PEO that employer may hire these individuals back as its own employees and establish its own benefits. In this situation, an employer that is otherwise eligible as a small employer group is eligible for guaranteed issue under the Small Group Act; however, certain exceptions may apply
    - Please note: One exception to guaranteed issue requirements of the Small Group Act in California is that a carrier is not required to offer a health plan contract to a small employer or eligible employee that within 12 months of application for coverage disenrolled from a plan contract offered by that carrier. Therefore, if the PEO provided coverage to these employees through a contract with Blue Shield of California or Blue Shield of California Life & Health Insurance Company, the small employer will not be eligible for guaranteed issuance from that company within 12 months of disenrolling from that plan contract

Choice Administrators®

- **Updated Quote** *8-27-10*

- *Choice*Administrators® is in the process of updating the benefits displayed in their quotes for California*Choice*®, HSA California®, Kaiser Permanente Choice Solution and California*Choice* 51+ to reflect new healthcare reform requirements effective October 1, 2010.
    - Updates to the California*Choice* quote have been made
    - The other programs will be updated soon
    - Updated benefit summaries and employee enrollment guides will be available for download from the websites in the near future

- **Medical Enrollee Over Age Dependent / Student Status Verification** *5-20-10*
    - Effective with a calendar date or effective date of June 1, 2010:
        - California*Choice*®, HSA California® , Kaiser Permanente Choice Solution and California*Choice* 51+ New & In Force Business
            - Full time student status and verification for medical / chiro / vision only enrollees are not required
            - Full time student status and verification for medical / vision only enrollees are not required
            - Full time student status and verification for medical only enrollees are not required
            - Note: Full time student status and verification are still required for dental enrollment on all program

- **EOCs Added to California*Choice* website** *1-11-10*

    - 2009 EOCs have been posted to www.calchoice.com in the Download Forms page
        - The EOC tab is visible as a top level tab on logged in pages of the broker and employer sites
        - Members do not currently have access to the EOC tab. This will be reviewed later and any changes communicated
    - 2010 EOCs will be added once Cal*Choice* has received them from all carriers
    - Reminder: Kaiser Permanente Choice Solution brokers, employers and members have access to all their program EOCs by logging in to www.kpchoicesolution.com
    - Other *CHOICE* Admin programs are not currently slated for EOC posting

- **Small Group Qualification Guidelines** *12-14-09*

    - *CHOICE* Administrators® has resumed accepting qualified small group new case submissions for groups with over 50 employees. This applies to all of their small group programs
    - The Small Group Qualification form is restored to the website's "Download Forms" page
    - Please note that further review of regulations clarified acceptability of these underwriting qualifications

Choice Administrators – HSA California

- **HSA California® 7-1-10 quoting is now available** *5-17-10*
    - Health Net PPO – please note that 4th quarter deductible carryover is not available (new or existing groups)

- **Rogers Benefit Group is pleased to announce that we are now representing *Choice* Administrators' HSA California product offering**

    - HSA California offers an affordable, full replacement HSA portfolio and a unique opportunity for employers to define a set contribution
    - HSA California does what others don't do by allowing employees to choose from three carriers, seven plan designs and with no minimum participation rules
    - And, HSA California offers free setup and maintenance of health savings accounts through Bancorp – the third largest depositor of HSA's in the country
    - Product Features:
        - The power of choice and defined contribution – Kaiser Permanente, Health Net and Western Health Advantage
        - Ancillary benefits to complete the package – Dental, Vision and Life
        - Partnership with Bancorp Bank – allows employees convenient set up of HSA's
        - Fastest growing consumer directed concept – 30% of new benefit plans in 2008 were HSA qualified
        - Wellness programs to help members stay healthy – Health Risk Assessments, Electronic Health Records, Resources and classes
        - California RX Card – Savings of up to 75% at more than 50,000 national and regional pharmacies
        - Unique benefit plans that fit employees needs – 4 HMOs, 3 PPOs
            - Kaiser Permanente
                - HMO 2200 - deductible $2200 ind/$4400 family, $20 office visit copay (deductible waived for annual physical exam), 75% coinsurance, RX - $10 generic/$20 brand formulary
                - HMO 2600 – deductible $2600 ind/$5200 family, $30 office visit copay (deductible waived for annual physical exam), 70% coinsurance, RX - $10 generic/$30 brand formulary
            - Western Health Advantage
                - HMO 1800 – deductible $1800 ind/$3600 family, coinsurance 100%
                - HMO 2800B – deductible $2800 ind/$5600 family, $40 office visit copay (deductible waived for annual physical exam), $500 per day hospital, 100% coinsurance, RX - $10 generic/$30 brand formulary/$50 brand non-formulary
            - Health Net
                - PPO 2500 – deductible $2500 ind/$5000 family (combined network/non-network), $25 network office visit copay, 70% network coinsurance/50% non-network coinsurance, RX - $15 generic/$30 brand formulary/$50 brand non-formulary
                - PPO 3500 – deductible $3500 ind/$7000 family (combined network/non-network), $35 network office visit copay, 70% network coinsurance/50% non-network coinsurance, RX - $15 generic/$30 brand formulary/$50 brand non-formulary
                - PPO 4500 – deductible $4500 ind/$9000 family (combined network/non-network), $45 network office visit copay, 60% network coinsurance/50% non-network coinsurance, RX - $15 generic/$30 brand formulary/$50 brand non-formulary

California*Choice*®

- **California*Choice* becomes first health insurance exchange in America to reach 20 million member plateau** 8-19-10

  - California*Choice*® announced that is has become the first health insurance exchange in the nation to reach the 20 million member-month plateau, solidifying its position as the country's most successful health insurance exchange for small and mid-size employers. Founded in 1996, California*Choice* is a product of *CHOICE* Administrators®, the nation's leader in developing and administering health insurance exchanges
  - Further information may be obtained at www.choiceadmin.com

- **Cal Perks Savings through CaliforniaChoice** *8-4-10*

  - *CHOICE* Administrators® is pleased to announce Cal Perks savings through California*Choice*®!
    - Now you can offer your California*Choice*® small group clients FREE ACCESS to Cal Perks, demonstrating the value – and savings – you bring to their business
    - But the saving doesn't stop there. You can offer those same great discounts to your own employees at up to 40% off market price, saving you on the annual membership fee and helping your employees save BIG every single day
    - And because you're a valuable California*Choice* producer, California*Choice* has also made it possible for you to offer Cal Perks memberships to your non-California*Choice* groups at the same 40% off rate
  - Cal Perks lets members access hundreds of dollars in savings on entertainment, sporting events, theme parks plus products and services they use every day
  - Best of all, there's no administration for you or your clients. Members can access Cal Perks 24/7 on one easy-to-use website to explore their discounts wherever and whenever they want
  - Here's a sample of the great savings employees and clients get from Cal Perks:
    - Ranch Las Palmas Golf – 2-for-1 golf Mon-Thurs
    - Disneyland – save $17 on a 1-day adult park hopper
    - LA Kings Hockey – save 55% on select home games
    - Sam's Club - $10 gift card with membership or renewal
    - AMC Theatres - $6.50 movie admission
    - Embassy Suites Anaheim – 15% off best available rate
    - 1-800-DRY-CLEAN - $20 off your first order
    - Monterey Bay Aquarium – save $2 on each ticket
    - Gilroy Gardens – save $20.99 per ticket
    - Costco - $50 membership certificate + $50 in coupons

    Discount shown for information purposes only and are subject to change and cancellation without notice. See Cal Perks website for current discounts available
  - To access Cal Perks, your employees simply log-in to www.calchoice.com *(registration required*). Click on the 'Discounts' button and discover a great new way to save!

- **Save your clients up to 18% with NEW networks from California*Choice*®** *7-30-10*

- CaliforniaChoice now offers your new and renewing groups' access to the Anthem Blue Cross Select HMO and Health Net Silver HMO Networks. Groups with access to these networks can significantly reduce their premiums
- Contact your RBG sales representative for additional details

- **California*Choice*® now offers an integrated payroll solution** *6-2-10*

  - Now you can integrate payroll services with your clients' California*Choice* program. This means your clients' payroll team communicates directly with California*Choice*, ensuring that their information is always accurate and up-to-date. It also means:
    - Faster adds and terminations
    - Reduces retroactive adds and deletes
    - Reduces your hassle when clients make changes to payroll
  - CHOICE Administrators® Payroll Services is powered by E-chx. The partnership with E-chx guarantees they will not market or sell group insurance to your clients, so you have the security of knowing your business is protected. They offer the same great hassle-free payroll solutions for groups of all sizes, and for 20-50% less than other payroll companies
  - Brokers visiting www.calchoice.com will see a Payroll Services link on the home page. Click on this link https://www.calchoice.com/Shared/PDF/HomePayroll.pdf to view the Payroll Services brochure

California*Choice*® 51+

- **July 1 quoting for California*Choice* 51+ new business is now available** *5-11-10*

  - Due to the Mental Health Parity Act, mental health benefits in all plans have been changed for severe, non-severe and alcohol/substance abuse benefits
  - Remember, California*Choice* 51+ offers these great benefits:
    - **Employee Choice** – each employee selects from 2 health plans offering thousands of providers. They then review the 11 benefit plan designs and costs, and determine based on personal needs whether to increase their monthly payroll deduction to "buy up" to a richer plan than is covered by the employer's healthcare contribution
    - **Employer Defined Contribution** – Employers decide how much to contribute monthly to employee's healthcare costs – a fixed dollar amount or a fixed percentage of a selected benefit level. This 'healthcare allowance' puts the power of choice in the employee's hands and cost control back in the employer's
    - **Ancillary Benefits including free dental & vision** – California*Choice* 51+ offers an exciting selection of optional benefits like dental coverage, a discount vision plan, HR support and a hearing plan at no additional cost
    - **Expert sales support** – From quoting and client presentations to enrollment and renewal – you'll find what you need to help you land the client!
    - **Easy administration and single source billing** – One enrollment form, one toll-free number for questions and one bill makes enrollment and administration a breeze!

- **Free Hearing Program for Large Group Clients** *11-19-09*

  - Good news – California*Choice* 51+ now offers clients access to a free hearing program from EPIC Hearing Service Plan (HSP)

- Savings on:
  - Hearing tests
  - Hearing Aids
  - Hearing Aid Batteries
  - Ear Protection
  - Swim Plugs
  - Musician Ear Plugs
  - Hearing Aid cleaning supplies & accessories
  - Assistive Listening Devices
  - TV Ears (Amplifies & clarifies Television)
  - Telephone amplification
  - Alerting and signaling devices
- Advantages of EPIC HSP:
  - Save up to 50% on brand name hearing aids
  - All levels of technology and hearing aid styles
  - Reduced costs on services & products
  - National Network of local Ear Physicians and Audiologists
  - Toll free telephone support
  - Flexible payment plan
  - No administrative forms or paperwork to fill out

- **Free Online HR Support Now Available** *11-10-09*

  - California*Choice* 51+ now offers you 24-hour online HR Support. And, it's absolutely FREE!
  - Login to www.calchoiceplus.com, click on HR Support and find:
    - Sample Employee Handbooks, Company Policies, Job Descriptions and HR forms
    - The latest employment law news as well as details about laws that have been updated
    - Summaries of both State and Federal laws that affect employers
    - A database of questions and answers on subject ranging from benefits and compensation to labor relations and recruitment
    - Articles written by HR Professionals that will provide you with tips, information and best practices to help you better manage your business and employees
    - A glossary of commonly used HR terms and definitions
    - A compilation of tools and information specific to Leave of Absence, Hiring, Performance Management and Termination
    - Great pricing on HR posters, books and training videos
    - A subscriptions to the monthly e-newsletter HR Advisor that is designed to keep you aware of the most current HR best practices and legal changes

CIGNA

Health Net (51+)

- **Network Update** *5-5-10*

- Effective July 1, 2010, Physicians Integrated Medical Group, Inc. will no longer be a Health Net contracted provider. Most members will be transferred to follow their current PCP to either Brown and Toland Medical Groups or Hill Physicians Medical Group except for a couple of PCPs that will not be available through any other PPG
- If members have any questions or concerns, they may contact Health Net Member Services at the number listed on their ID card or they may visit www.healthnet.com and click on "contact us"

- **More Ways to Fuel Sales** *10-1-09*

  - Health Net's Starting Line-Up (SLU) Portfolio matches the demands of today's savvy buyer with a streamlined collection of their top-selling plans. Designed for mid-size employers of 51+, SLU makes it possible for your clients to provide employees with comprehensive health care coverage without breaking the bank
  - All About Simple
    - First, Health Net offers a wide variety of plan types and benefit designs. But not so may that it becomes difficult to tell them apart – or to choose
    - Next, Health Net's HMO, EOA plans and PPO insurance plans come in two designs:
      - Standard plans are more traditional with HMO and EOA flat copayments, and deductibles of $500 or less for PPO
      - Value plan options are the more economical buy-down alternatives with coinsurance for HMO and EOA, and higher deductibles ($1,000 or more) for PPO
  - The Line-Up
    - HMO/HMO Silver Network – reliability and cost savings are the hallmarks of the HMOs. Among other choices, Health Net has $30 and $40 copay options and Value plans to offer employers greater savings. All of the HMO plans come with a choice of full HMO network or Silver Network (a select subset of the full network) for additional savings, which vary by county
    - EOA/EOA Silver Network – popular and exclusive Elect Open Access (EOA) plans combine the predictability of an HMO with the flexibility to go directly to a physician or specialist for specified services in the PPO network. For additional savings, Health Net will now offer EOA with the choice of the Silver Network. EOA Silver Network savings vary by county and not all counties will see a cost differential
    - PPO – employer groups have a choice of PPO insurance plan designs in Standard and Value options. New high-deductible, non-HSA plans expand Health Net's budget friendly options even further
    - HSA-compatible PPO – HSA-compatible PPO insurance plans makes it easy for clients to take a more consumer-directed approach to the way they offer benefits. Health Net's options combine a low premium with a high deductible, along with the tax-saving potential of a Health Savings Account
  - Plus, every SLU plan comes complete with valuable extras like Decision Power, (SM) healthy discounts and self-service at www.healthnet.com
  - Health Net is confident that their SLU Portfolio, with its streamlined plan designs and smart economic options, is sure to expand your sales, no matter what the market is doing. Visit Health Net at www.healthnet.com/broker for more information and to view/download sales and marketing materials

- **Health Net's business-boosting sneak peek** *8-12-09*

  - Health Net 51+ has an exciting sneak peek at some business-boosting options for October 1st and later effective dates

- Health Net is going back to basics with their 2010 Starting Line-Up (SLU) Portfolio for your mid-size 51+ group clients. Streamlined and simplified, Health Net's refreshed portfolio combines their best-selling plans with new client-pleasing options. Plus, you can start selling 2010 SLU as early as 10-1-09 effective date for more ways to finish 2009 strong and jumpstart 2010 sales
- New EOA Silver Network: Health Net's popular and exclusive Elect Open Access (EOA) plans will soon come with a Silver Network choice
- Just like with their full network EOA plans, EOA Silver Network is part of SLU and combines the predictability of an HMO with the flexibility to go directly to a specialist for specified professional services in Health Net's PPO network. EOA Silver Network plans are a great cost-saving choice for employers 51+ in Los Angeles, Orange and San Francisco counties (EOA Silver Network savings vary by county)
- Vision plan enhancements, also effective on 10-1, is Health Net's new contact lens fit and follow-up exam benefit, which gives members more dollars toward their contact allowance and less to pay out-of-pocket for their overall contact lens expenses. Plus, now medically necessary contact lenses are paid in full when provided in-network, and Health Net has added JCPenney® Optical and additional Sears OpticalSM location for greater convenience
- Look for more details in the coming weeks

- **Medicare Secondary Payer Mandatory Insurer Reporting: What SBG and MM Need to Know** *8-20-09*

  - The Medicare Secondary Payer Mandatory Insurer Reporting (MSP-MIR) requirement of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) includes a Group Health Plan (GHP) requirement that obliges health plans to report certain information to the Centers for Medicare & Medicaid Services (CMS). CMS is the federal agency that regulates the Medicare program
  - The purpose of this reporting process is to enable CMS to more effectively pay for the health insurance benefits of Medicare beneficiaries who have coverage under group health plan arrangements
  - In order to comply with the his mandatory request, Health Net needs some data from their small business & mid-market group customers that Health Net has not previously collected
  - Group Data Needed:
    - Group legal name, if different than the name noted in their current Health Net Group Service Agreement
    - Tax Identification Number (TIN)
    - Total number of employees company wide – includes full-time and part-time employees – in the range that applies: 1-19, 20-99 or 100 or more
  - Social Security Number Collection – the MSP-MIR requirement also specifies that Health net provide Social Security Numbers* for members who meet any one of the following criteria:
    - Active employees and dependents who are age 45-64;
    - Members 65 and older who have coverage based on their own – or a spouse's – current employment status;
    - All group members of any age who are receiving kidney dialysis or have had a kidney transplant; and
    - All active employees and dependents who are under age 45 and who are known to be entitled to Medicare
  - What Health Net is doing:

        - Health Net will be sending a mailing to their customers the week of 8-17 requesting the group data and missing Social Security Numbers for covered dependents age 45 and older
        - In addition, brokers will receive a notice about the mailing to employer groups
    - Customers simply fill in the form and return it directly to Health Net in a pre-paid envelope on or before 9-15-09
    - Going forward, both Subscriber and Dependent SSNs will remain required fields on the enrollment forms. To assure continued compliance with this reporting requirement and to minimize future requests for missing data, Health Net is asking groups and brokers for their help. Prior to sending enrollment forms to Health Net, they are being asked to ensure the SSNs are included – particularly for members and dependents age 45 and older

*State laws that restrict the collection of SSNs do not apply in this case. Provisions of the federal Medicare as Secondary Payer (MSP) or Medicare Modernization Act (MMA) regulations or the "permitted use" provisions of the HIPAA privacy rules allow the collection and use of SSNs to help providers and insurers manage their operations. For more information about MSP reporting, please see the CMS website: http://www.cms.hhs.gov/MandatoryInsRep/

Humana

- **New small business bonus when you sell specialty benefits products**

7-9-10

    - You can earn up to a $5,000 bonus for placing small group Humana specialty benefits plans with effective dates of coverage between July 1, 2010 and Jan. 31, 2011. Bonus applies to groups with 2-99 eligible employees. Here's how to qualify:
        - $5,000 for placing 40 or more lines of coverage
        - $3,000 for placing 30 lines of coverage
        - $2,000 for placing 20 lines of coverage
    - Humana's suite of specialty benefits products include dental, vision, disability, life and workplace voluntary benefits. Your clients can save on their rates when they add multiple products
    - Bonus rules and regulations:
        - Humana believes that agents should fully disclose to the insured or applicant the programs under which they are compensated including base commissions, bonuses, incentives or other forms of remuneration for which the agent is eligible for the sale or renewal of insurance products
        - Humana determines each case's effective date of coverage and eligibility for this promotion
        - Bonuses will be charged back for qualifying coverages that terminate before their first anniversary
        - The transfer of an in-force Humana coverage or placement of a renewal does not qualify for the agent for payment under this promotion
        - An agent of record may earn up to one bonus payment under this promotion
        - The number of cases and coverages placed during this promotion is measured according to agent of record listed on the employer group application, and production across agents of record will not be combined for the purposes of this promotion
        - Individual products are excluded from this promotion, except for those issued as part of a Workplace Voluntary Benefit offering
        - Cases split into subgroups to segment business units or locations are combined as one case to determine eligibility for this promotion

        - In cases where commissions are split between two or more producers, the case count is prorated according to the commission split percentages
        - All of the provisions of the Group Producing Agent or Agency Contract and Producer Partnership Plan apply to this bonus promotion
        - Humana may modify or terminate this promotion at any time without notice
        - Humana is the final arbiter of any issues related to this promotion
        - Bonus will be paid by the end of April, 2011

- **HumanaDental – Change in how late entrants are handled** *1-25-10*
    - Starting January 25, 2010, any late applicant attempting to enroll on a Humana NPOS/Open Access HMO or DHMO/PPO with an open enrollment provision and, who enrolls outside of the open enrollment period, will receive a letter denying enrollment. The letter will inform the employee they cannot enroll on their employer's group plan outside the open enrollment time period
    - In addition, a carbon copy of the letter will also be sent to the employer informing them of the denial. Finally, no ID card will be issued if the individual does not enroll within the open enrollment
    - This will provide better service to Humana's customers and align with their commitment to their guiding principle of "Guidance when you need it the most"

- **Offering a dental plan promotes good overall health** *1-2010*
    - HumanaDental plans now feature:
        - No waiting periods on major services for voluntary groups with 10 or more enrolled employees
        - New Preventive Plus coinsurance option: preventive services covered at 100%; some basic services covered at 80%
        - $2,000 adult/child orthodontic rider and $2,000 child orthodontic rider
        - $1,250 annual maximum
        - Composite fillings and implants for groups with 10 or more enrolled employees
        - Open enrollment option
        - Adult/child orthodontic coverage for groups with 25 or more enrolled employees
    - The dental enhancements are available for Jan. 1 quotes and effective dates of coverage starting Feb. 1, 2010
    - Also available is the PA100 DHMO plan. Plan benefits include:
        - Optional cosmetic rider which offers coverage for elective services as well as teeth whitening
        - Pedodontic coverage until the age of 8
        - No charge for consultations (D9310)
        - Same porcelain crown copay for molar and non-molars

- **New dental products available in select states** *12-2009*
    - Humana's 2009 dental product portfolio includes the introduction of new plan and benefit options. The new dental portfolio is now available for quoting with effective dates of coverage starting January 1, 2010 in California
    - Plan features:
        - Variety of deductible, annual maximum options
        - Implant, composite filling and orthodontia riders

        - Out-of-network reimbursement options
        - Open enrollment option available
    - Updates to the 2009 products include:
        - No waiting periods on major services for voluntary for groups with 10 or more enrolled employees
        - Extended annual maximum option (members reaching their annual maximum automatically receive an additional 30% coinsurance on preventive, basic and major services … implants and orthodontia excluded. This option is available for PPO and Traditional Preferred plans)
        - Adult/child orthodontic coverage for voluntary groups with 25 or more enrolled employees
        - $2,000 adult/child orthodontic rider on all PPO and Traditional Preferred plans
        - $1,250 annual maximum

Kaiser Permanente Choice Solution

- **7-1-10 quoting is now available** *5-13-10*

    - Underwriting Updates
        - Groups moving to or from a Kaiser Permanente plan – groups can only change from a Kaiser Permanente plan to a Kaiser Permanente Choice Solution plan or vice versa at their anniversary date
        - Dependent proof of student status
            - In force Kaiser Permanente Choice Solution members: proof of student status for medical dependents is not required. Medical dependent coverage will auto terminate on the last day of the month following 26th birthday
            - New business Kaiser Permanente Choice Solution members: new business and new hire medical enrollee applications without dependent proof of student status are accepted. If the dependent is enrolling in dental, proof of student status is required
            - This does not change the requirements for Kaiser Permanente Choice Solution dental plans for new business or in force membership
    - Updated RAF Guidelines
        - The following information defines what Risk Adjustment Factor (RAF) is applied to the rates quoted:
            - Groups with 2-5 employees are always quoted 1.10
            - Groups with 6-50 employees are quoted with the 1.00 RAF before the final RAF is applied in underwriting
            - Note: Life only employees and COBRA members are not included in the overall employee count
        - The following defines how the RAF is applied during underwriting for groups who do not currently have existing coverage with Kaiser Permanente or California*Choice*® within 12 months of the effective:
            - 2-5 enrolled employees – 1.10
            - 6-15 enrolled employees – 1.00
            - 16-50 enrolled employees - .90
            - Note: Life only employees and COBRA members are not included in the overall employee count

- For groups who currently have existing coverage with Kaiser Permanente, California*Choice*® or any association or trust plan that offers Kaiser Permanente within 12 months of the effective date:
    - The RAF applied will be the same as the most recent RAF assigned by Kaiser Permanente or California*Choice*
- The following defines how the RAF is applied during underwriting for groups who currently have existing coverage with Kaiser Permanente or California*Choice* within 12 months of the effective date and which experience a growth in Kaiser Permanente membership on the effective date (e.g. due to displacing a second carrier):
    - 1-15 employees currently enrolled in Kaiser Permanente, less than 5 added through Kaiser Permanente Choice Solution: Final RAF applied during Underwriting = 1.10
    - 1-15 employees currently enrolled in Kaiser Permanente, 5 or more employees added through Kaiser Permanente Choice Solution, 6+ total number of employees enrolled in Kaiser Permanente Choice Solution: Final RAF applied during Underwriting = 1.05
    - 16+ employees currently enrolled in Kaiser Permanente, increase of 30% or more employees added through Kaiser Permanente Choice Solution, 21+ total number of employees enrolled in Kaiser Permanente Choice Solution: Final RAF applied during Underwriting = Prior RAF less 0.05 (final RAF cannot be lower than .90)
    - Note: Life only employees and COBRA members are not included in the overall employee count. For a reduction in RAF to apply to groups with base subscribers of 16+, the prior RAF must have been 1.05 or less

- **Kaiser Permanente Choice Solution – Better Than Ever** *2-2-10*
    - KPCS packages high-quality health benefits into a single program that's easy to administer, satisfies everyone's needs and is priced for every budget
    - With KPCS, you're offering your clients:
        - A selection of 10 plans (HMO, PPO, POS and HSA-qualified plan options
        - Discount vision benefits – clients save 20% on eyeglasses, sunglasses and contact lenses
        - Kaiser Permanente's renowned Complete Care wellness program
        - Dental through Delta Dental®
        - Life with AIG
        - Section 125 benefits through CONEXIS
        - 12-month rate guarantee
        - One consolidated monthly invoice that includes all lines of coverage
    - 2010 Updated Plan Designs
        - KPCS has updated their HSA-Qualified plans with new copays and deductibles
    - Visit www.kpchoicesolution.com for additional details

- **KPCS RAF Guidelines Update** *1-8-10*
    - The following Kaiser Permanente Choice Solution (KPCS) guideline is updated:
        - For groups with 6-40 employees currently enrolled in Kaiser Permanente, if the group adds less than 10 employees through Kaiser Permanente Choice Solution, KPCS will match the most recently assigned Kaiser Permanente RAF

- Previously if a group had a KP RAF of 0.95 or 1.05, KPCS rounded the RAF to 1.00. KPCS will no longer round but will apply the actual .95 or 1.05 RAF
- Please note the following:
  - Quotes already processed for February may be re-processed and the updated RAF Guidelines page will appear in the new PDF
  - Quotes will continue to process with only 1.0 and 1.10 RAFs, as determined by census size

MetLife

• MetLife Voluntary PPO Dental Plans *6-2-10*

- The market for voluntary dental has grown dramatically over the past few years. The growth is primarily due to the following:
  - Dental insurance is one of the most highly desired employee benefits, yet many employers are either unable to unwilling to incur the cost of an employer sponsored dental plan
  - Voluntary dental enables employers to include dental insurance as part of their total employee benefit package, yet shifts some or all of the cost to their employees
  - Employees are increasingly accepting cost sharing in some of their benefit choices including dental
- Key advantages of MetLife's PPO dental plan:
  - Offered as Employer Paid or Voluntary (no prior coverage needed)
  - No waiting periods
  - No DE-6 required
  - Dual-Option Plans available (SafeGuard a Company of MetLifeDHMO & MetLife PPO) receive a consolidated billing statement
  - Stand Alone PPO – minimum of 7 enrolled. Dual-Option – minimum of 7 enrolled (5 on PPO plan and 2 on DHMO plan)
  - All Plans including orthodontia coverage are Adult/Child and do not require proof of prior coverage and only require 7 minimum enrolled
  - Composite or "white" fillings included for all teeth
  - Implant coverage included under major services (for groups of 10+ enrolled)
  - Deep discounts provided for non-covered services (ex: Adult Orthodontia), when performed by a network provider
  - MetLife-s VisionCare – Discount Program which consists of discounts on vision care, related equipment and LASIK eye surgery, included for all employees and their dependents
  - MetLife's PPO network with over 132,00 points of access nationwide. View the on-line directory of dentists at www.metlife.com/dental
- MetLife is easier. Plans also include the following value-added benefits:
  - MetLink – MetLife's on-line benefit administration platform, providing, among other things, "real-time" enrollment and list billing functionality
  - MyBenefits – MetLife's on-line employee benefits portal designed to give employees the information and tools they need to help service their own benefits needs
  - Census Enrollment is available in lieu of employee enrollment forms
- Why MetLife?

- A MetLife dental PPO plan will provide your employees and your organization with several enhancements
    - MetLife is the largest administrator of dental benefit plans among all single commercial carriers (2008 MetLife Market Research, based on enrolled lives as of 12-31-07, providing dental plan administration for more than 21 million people)
    - MetLife's brand name is one that employees know and trust – 9 out of 10 plan participants would recommend MetLife's dental coverage to a friend (2007 MetLife Plan Participant Satisfaction Survey, results based on participating active employees. Based on responses from those who participated in and responded to the survey)
    - Financial strength and reputation: Consistently receive high rating for their financial strength (A+, AM Best MetLife's current ratings as of October 2008. MetLife Auto & Home companies are only ranked by A.M. Best and may differ from that of MetLife's. As of October 2008, they are ranked A (Excellent)) and claims-paying ability
    - MetLife's Preferred Dentist Program (PDP) Group dental insurance programs featuring the MetLife PDP are underwritten by Metropolitan Life Insurance Company, New York, N.Y., has a network of more than 132,000 carefully credentialed general and specialty dentist locations nationwide. All PDP dentists agree to accept MetLife's negotiated fees (typically 10-35% less than the average fee charged – average discounts in CA is 32%); even non-covered services and services provided after the annual maximum has been exceeded – offering participants more value

PacifiCare/UnitedHealthcare

- **UHC has extended their RAF program to 9-30-10** *5-11-10*
    - For effective dates through 9-30-10
    - Groups with 6-50 enrolling employees:
        - Guaranteed .90 for groups with prior carrier RAF of 1.06 or better
    - Eligible Business:
        - CalCOBRA/COBRA enrollees do not count toward group size
        - Groups that receive a 10-point RAF increase on their renewal with another carrier do not qualify for this RAF program
        - Groups with more than 30% of COBRA/Cal-COBRA enrollees are not eligible for this RAF program
        - Groups enrolling with UHC and/or PacifiCare plans July 1, 2010 – September 30, 2010 effective dates
        - Groups must meet Small Business eligibility requirements (AB1672)
        - Carve-out groups are not eligible for RAF Guarantee Program
        - New groups must present a prior carrier small group renewal that reflects a renewal date within three months of the new business effective date with UHC or PacifiCare plans
        - Groups must apply for the RAF promotion prior to underwriting approval. A copy of the current carrier renewal reflecting the RAF/renewal census and documentation from its current carrier disclosing the amount of the RAF change must be included with the group's initial submission to underwriting
        - Groups previously submitted and approved under standard underwriting guidelines will not be reconsidered or rerated under the RAF program

        - Groups coming from a large group contract that are now AB1672 eligible can qualify for the RAF promotion if they can prov9ide a large group renewal of less than a 20% increase within three moths of their requested effective date
        - CalChoice, Kaiser Permanente Choice Solution, HSA California, Contractor's Choice, existing UHC or PacifiCare groups, Non-Guaranteed Issue and Association Group cases are not eligible
    - New groups with 2-5 enrolling employees are not eligible for this RAF Guarantee Program
    - Please contact us for further details

- **UHC to fill coverage gap for graduating college students** *4-19-10*

    - UHC will work with your clients that wish to extend the health coverage that graduating college students currently have under their parents' plans. UHC is taking this step ahead of a new federal health reform provision that will require dependent coverage up to age 26
    - As part of the Patient Protection and Affordable Care Act, young adults will be able to stay on their parents' employer-offered or individual family health plans up until age 26. However, this extension does not begin to take effective until 9-23-10, leaving some graduating students temporarily without coverage
    - UHC wants students to graduate into a secure future, not the ranks of the uninsured. UHC saw an issue with this possible gap in coverage and are the first health insurance company taking action ahead of the new requirements
    - This offer to extend coverage applies to students who currently are covered under their parents' fully insured plans through UHC, as well as those covered under UHC's Golden Rule individual family health plans. UHC will work closely with you and your fully insured clients to carry out the extension of coverage and to make sure these young adults have health coverage available to them. UHC will also work with self-funded customers to determine if they are going to offer this benefit to graduating seniors. Individual health plans from Golden Rule Insurance already allow all dependents to stay on the plan until age 26, so no action is necessary for those health plan enrollees
    - Accelerating the dependent coverage extension timeline for graduating student enrollees is another tangible step UHC is taking to help translate the new, complex health reform directives into workable reality

- **UHC Small Business quoting options are changing** *4-15-10*

    - Effective May 31, 2010, UHC will no longer provide a quoting tool through HealthConnect but will offer several alternative ways that you can quote UHC to prospective and existing clients:
        - Go directly through a General Agent
        - Contact the UHC quoting team directly by e-mailing caquote@uhc.com and they will delivery your quote within 24 hours
        - Visit www.unitedeservices.com or www.uhctogether.com/casb and obtain a quote from the self-service quoting tool
        - Work directly with HealthConnect. You can transfer all your history through the HealthConnect portal on an individual basis or through a General Agent who works with HealthConnect. UHC will still provide benefits and rates through the HealthConnect portal

- **New RAF Promo** *2-16-10*

- For April 1, 2010 – June 30, 2010 effective dates
- Groups with 6-50 enrolling employees:
  - Guaranteed .90 for groups with prior carrier RAF of 1.06 or better
  - The prior carrier renewal must be the original, not a revised renewal
  - Groups with enrollment in more than one carrier must meet requirements. Group's current renewal census must match enrolling employees in UHC and/or PacifiCare. Individual health statements are required from enrolling employees not included on the renewal census
- Please contact us for further details

Principal

- **Sign up to get the latest dental industry news via e-mail** *8-27-10*

  - Keep up with dental industry trends and legislative changes by signing up for the National Association of Dental Plans (NADP) SmartBrief weekly e-mail news brief
  - The NADP SmartBrief provides information that is handpicked by knowledgeable editors and summarized with links to original sources
  - Follow these easy steps to sign up:
    1. Go to http://www.smartbrief.com/nadp/?campaign=principal
    2. Enter your e-mail in the box
    3. Click the *Sign Up Now* button
  - NADP is the largest non-profit, national trade association focused exclusively on the entire dental benefits industry, i.e. dental HMOs, dental PPOs, discount dental plans and dental indemnity products
  - Principal Life Insurance Company is a longtime NADP member, participating on committees and contributing data for industry reports

- **Notices being sent soon to possible discriminatory insured medical plans** *8-24-10*

  - As stated in Section 2716 of the Patient Protection and Affordable Care Act (PPACA), effective for plan years beginning on or after Sept. 23, 2010, the nondiscrimination rules of IRC Section 105(h) will now apply to fully insured medical-non-grandfathered plans
  - Self-funded medical plans are already subject to these requirements. In a self-funded plan, highly compensated individuals who receive discriminatory benefits are subject to taxes on the value of the benefits
  - For purposes of PPACA, a discriminatory insured medical plan is defined as one that fails to satisfy the requirements of section 105(h)(2) relating to discrimination in favor of highly compensated individuals. These plans are sometimes also knows as "carve-outs"
  - Principal Life will send policyholders who may have a discriminatory plan as described above a letter this week. The letter encourages the policyholder to contact their tax counsel or accountant, because if the coverage they provide through Principal Life does discriminate in favor of highly compensated individuals, they may have to pay substantial penalties
  - Additional information has been posted to Principal eFP for brokers who have a login

- **Age reduction in eligible members to comply with Medicare, Medicaid and SCHIP Extension Act of 2007 requirements** *8-20-10*

- Effective January 1, 2011, Principal Life Insurance Company is required to submit active medical employees and dependents age 45 and above to comply with the Medicare, Medicaid and State Children's Health Insurance program (SCHIP) Extension Act of 2007. Currently the age limit is 55 and above
- Principal Life is required to report to the Center for Medicare and Medicaid Services (CMS):
  - The total number of employees for their employer groups
  - Employer Tax Identification Number (TIN)
  - Social Security Number (SSN) or Medicare Health Insurance Claim Number (HICN) for certain employees and their dependents
- As a company, Principal Life has already reached out to their employer groups several times requesting their group size, TIN and SSN/HICN. However, with the age reduction to age 45, Principal Life must contact them again to collect SSN/HICN for members and dependents age 45 and above
- Principal Life will send a letter, which is similar to the letter used in 2008, to all impacted employers on 8-23-10. If the employer does not respond, Principal Life will send a follow-up letter on 11-4-10

• 2010 Health Care Reform Benefit Changes *8-12-10*

- You are probably starting to receive questions from existing groups that are about to renew on 10-1 or from new groups that are enrolling for 10-1 about why Principal information doesn't have the updated health care reform information. Principal is aware of this. Here is some approved language you can use to respond to these questions:

  The Patient Protection and Affordable Care Act (PPACA) will change certain coverage provisions for new and renewing Principal Life Insurance Company groups on or after September 23, 2010. Principal is currently making system changes to their quoting tools that will transfer on September 10, 2010. While the proposal output or benefit summary does not reflect all the PPACA changes, be assured that Principal Life will be compliant prior to when the new regulations become effective. However, the pricing information Principal is providing you does include any cost increases for design changes as a result of new Health Care Reform rules