Dear ACEC Life/Health Trust Member:

Welcome! Thank you for choosing the ACEC Life/Health Trust for your employee benefit needs. We appreciate the opportunity to serve you.

When you purchased coverage through the Trust, you gained the advantage of group buying power and flexible plans specifically designed by engineers, for engineers. More than 2,000 firms comprise a buying force of over 30,000 engineering employees.

Your plan is underwritten by Trustmark Insurance Company (Trustmark) a leading health and life insurer. Trustmark has been providing insurance plans and benefit services for over 90 years. Its long standing commitment to freedom of choice, unparalleled access to care, personal service and active cost management make Trustmark one of today’s principal providers of health insurance protection.

You also gained the advantage of service from an industry leader, HealthPlan Services. HealthPlan Services (HPS) has a proven track record of successful benefits administration. For more than 30 years HPS has provided unbelievable service and cutting edge technology.

The ACEC Life/Health Trust, underwritten by Trustmark and administrated by HPS, provides you with the coverage you need with the service you deserve. As we work together for you in the months to come, I’m confident you will be impressed with our commitment and our attention to detail. Once again, thank you for choosing the ACEC Life/Health Trust.

Sincerely,

Jeff Bak
President/CEO

This guide is meant to be an aid in administering the ACEC Life/Health Trust Plan. It does not modify or supercede the provisions of the master policy. For more information see the policy issued to American Council of Engineering Companies Trust Fund.

In addition to this guide, the Administrator will send bulletins on changes in coverage, administrative procedures and governmental regulations. It is suggested that you keep these bulletins with the Administrative Guide.
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HealthPlan Services wants to make it easy for member firms and their employees to keep up-to-date on their insurance benefits. So we developed an interactive web site to provide access to real-time data 24/7—no waiting—www.acec.healthplan.com.

Our exclusive on-line features provide enhanced service, including the ability for member firms to:

- Enroll your employees online
- Check billing status and history
- Terminate employees from coverage plans
- Check employee eligibility
- Order ID cards
- Download forms/supplies
- Contact HPS…and more

And covered employees have the ability to:

- Check the status of claims
- Review eligibility
- Download forms
- Look up providers
- Contact HPS…and more

Password Protection Ensures Privacy
Accessing confidential information on the secured pages of the web site requires an ID and password to log on. The firms login ID is your case number located on your premium statements. Your password will be on your 1st premium bill. It is located at the bottom of your billing statement.

To log in, employers may go to www.acec.healthplan.com, click the "Employers" button and enter their ID and password. Employees click the "Employees" button to log in. Users may change their passwords by clicking the "change my password" button.
PARTICIPATION REQUIREMENTS
for comprehensive medical, dental, life, long-term disability and weekly disability income*
(REQUIREMENTS MAY VARY BY STATE)

Firms where the employer pays less than 100% of the premium are designated contributory. Firms where the employer pays 100% of the premium are designated non-contributory.

If coverage is contributory, the following minimum participation is required:

<table>
<thead>
<tr>
<th>Number of Employees</th>
<th>Firm Size</th>
<th>Required to Participate</th>
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<tbody>
<tr>
<td>1-3 employees</td>
<td>All employees</td>
<td></td>
</tr>
<tr>
<td>4 employees</td>
<td>3 employees</td>
<td></td>
</tr>
<tr>
<td>5 employees</td>
<td>4 employees</td>
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<td>6 employees</td>
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<td>7 employees</td>
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<tr>
<td>8 employees</td>
<td>6 employees</td>
<td></td>
</tr>
<tr>
<td>9 employees</td>
<td>7 employees</td>
<td></td>
</tr>
<tr>
<td>10+ employees</td>
<td>75% of employees</td>
<td></td>
</tr>
</tbody>
</table>

- If coverage is non-contributory, 100% employee participation is required.
- Participation does not include eligible employees covered under another employer’s health benefit plan with similar benefits, if a waiver of coverage is signed.
- EERP: 100% of all eligible employees in the classification elected by the member employers must participate.
- There is no minimum participation requirement for hospital indemnity, optional additional survivor income and optional term life insurance.

[CONTRIBUTIONS]
The minimum required employer contribution is 50% of the total premium.

SELECTION OF OPTIONAL PLAN COVERAGES**
The following plans are available to the firm, but once a firm elects to enroll for a plan the following requirements are applicable to participating employees.

Life and disability may be subject to evidence of insurability. Contact HealthPlan Services for further details.

At least one principal of the firm must enroll and maintain coverage in order for the firm to participate in the plan.*

[EMPLOYEE DEPENDENT ELIGIBILITY]

PLAN I—LIFE INSURANCE – Firms with less than 10 employees may offer no more than a $50,000 Maximum Benefit Schedule. A firm may select life only coverage

PLAN II—DISABILITY INCOME – Firms may select Disability income and life only coverage. In order for a firm to apply for long-term disability, the firm must apply for weekly disability income.

PLAN III—COMPREHENSIVE MEDICAL INSURANCE – Dependent coverage is optional by employee.

PLAN IV—DENTAL INSURANCE – Dependent coverage is optional by employee.

** NOTE: Once a firm has enrolled in the plan, the employer must continue to meet each plan’s participation requirements. Coverage for employee and dependent(s) may be subject to satisfactory evidence of insurability and/or medical underwriting.

Requirements vary by state; please refer to Certificate of Insurance
EMPLOYEE/PRINCIPAL – all employees and principals of Participating Employers are eligible for the Life/Health Trust benefits. An employee or principal is considered eligible if he/she is working a normal work week of at least 20 hours and:

a) Is on the Participating Employer’s regular payroll; and
b) Is performing his or her employment duties and
c) Is physically able to perform the basic and essential duties of his/her employment at the Employer’s regular place of business or worksite.

Employment duties performed at home or while confined in a hospital or institution cannot be used to satisfy this definition.

DEPENDENT – a person qualifies as an eligible dependent if he/she is the employee’s:

- Legal spouse;
- Unmarried child under age 19;
- Unmarried child age 19-25* years old as long as he/she is a full-time student at an accredited educational institution. However, a student otherwise qualified as a dependent may interrupt the course of study for a period not to exceed 120 days, with coverage continuing during such period. Coverage will terminate at the end of 120 day interruption, upon graduation or when he/she no longer qualifies as a full-time student. COBRA is available in this situation; or

- Unmarried child who, because of a handicap condition that occurred before the attainment of the limiting age, is incapable of self-sustaining employment and is dependent on his/her parents or other care providers for lifetime care and supervision.

The word "child" as used above, refers to the employee’s natural child, a stepchild, a legally adopted child, a foster child, or a child pursuant to a court issued qualified medical support order and any other child who is related to the employee by blood or marriage, or is a child for whom the employee is legally appointed to serve as guardian or custodian and meets all of the following conditions:

a) Resides with the employee in a parent-child relationship and is primarily dependent on the employee for support and maintenance; and
b) Provides evidence of insurability which is satisfactory to Trustmark; and
c) Who is under 19 years of age and is unmarried.

If a dependent’s coverage as a child who is mentally or physically incapable of earning a living is due to terminate because of the child’s age, Trustmark will continue coverage. However, proof of the child’s disability should be submitted within 31 days of the requested date coverage would otherwise terminate.

[ELIGIBLE ENROLLMENT]

EMPLOYEE – all employees actively working at least 20 hours per week for the Participant Employer are automatically eligible for coverage on the firm’s effective date of enrollment. Any employee joining the firm after the firm’s effective date will be eligible for coverage after 30 days of continuous active full-time employment.

Once a firm has decided on the waiting period for new employees, all employees must be enrolled in accordance with the established waiting period.

The waiting period may vary for key employees (Senior Executives or Principals), provided HealthPlan Services receives a written notice from an authorized firm representative prior to or on the employee’s first day of active full-time employment. Please note, if HealthPlan Services does not receive a written notice within the required time period, the notice cannot be honored and the regular waiting period for insurance will be applicable.

Requirements vary by state; please refer to Certificate of Insurance
[ENROLLMENT OF NEW EMPLOYEES]

To apply for coverage, a new employee must complete an enrollment form and forward the form to HealthPlan Services immediately. Employee applications can be found on the web under employers at www.acec.healthplan.com. Coverage cannot become effective until a completed group insurance enrollment form has been received by HealthPlan Services.

HealthPlan Services may send a personal health statement to be completed by the applicant. Trustmark will review the returned application, and additional medical records may be requested before making a determination on the application. If approved, Trustmark will determine the effective date of insurance.

If the enrollment form is received by HealthPlan Services more than 31 days after the date the employee becomes eligible for insurance, he/she will be excluded from coverage. However, a Late Enrollee will again become eligible to enroll during the Annual Open Enrollment, and the Pre-existing Condition Limitation provision shall apply.

The enrollment form should only be used for new employees who have not been previously insured under the ACEC Life/Health Plan. Please use the "ACEC Enrollment Application" for transfer, reinstatement and changes in status.

COMPLETING THE ENROLLMENT FORM

a) The employee should provide his or her name, sex, date of birth, social security number, marital status, dependents’ names and dates of birth and relationship of beneficiary, and the employee and dependent coverage(s) requested (if such insurance is available under the employer’s plan). The employee must sign and date the application.

NOTE: If the employee and/or dependents had prior creditable coverage, proof of the creditable coverage must be submitted along with the enrollment application.

b) The EMPLOYER is responsible for completing the following information on the application: occupation, wages, dates employed, name of participating employer and location. The employer should also check the employee section of the application to make sure that all of the spaces are completed correctly.

NO INSURANCE CAN BECOME EFFECTIVE WITHOUT THIS INFORMATION. "DATE EMPLOYED" IS OF PARTICULAR IMPORTANCE.

APPLICATIONS FOR OPTIONAL TERM LIFE AND OPTIONAL SURVIVOR INCOME

The following must be submitted to HealthPlan Services for all insureds applying for optional benefits:

- Completed enrollment form
- Completed evidence of insurability form

Trustmark will notify HealthPlan Services of acceptance or rejection of the application. Further medical information, such as completed medical questionnaires or medical records may be required by Trustmark to make a determination.

DEPENDENT - dependent insurance coverage, if elected, at the time of the employee’s initial enrollment, will become effective on the same date as the employee’s insurance. For dependents first acquired after the effective date of the employee’s coverage:

a) If the enrollment forms are completed within 31 days of the Dependent’s eligibility date, insurance will be effective on the Dependent’s eligibility date.

b) If the enrollment forms are completed more than 31 days after the Dependent’s eligibility date, coverage will be effective the date enrollment forms are approved by Us; or

c) If the Dependent is a Late Enrollee, he/she will be excluded from coverage. However, a Late Enrollee will again become eligible during the Annual Open Enrollment, and the Pre-existing Condition Limitation provision shall apply.

NOTE: Eligibility, Enrollment, and Pre-Existing Condition Limitations are contained in the Certificate of Insurance.

Requirements vary by state; please refer to Certificate of Insurance.
[OPEN ENROLLMENT]

Open enrollment will take place once a year for 30 days prior to your renewal date.

[LATE ENROLLMENT]

If an employee submits an application for enrollment more than 31 days after the initial eligibility date, or submits an application for dependent coverage more than 31 days after the dependent become eligible, they will be excluded from coverage. However a Late Enrollee will again become eligible to enroll during the Annual Open Enrollment, and the Pre-existing Condition Limitation provision shall apply. A person shall not be considered a Late Enrollee if:

- the person was covered under Qualifying Coverage at the time of initial eligibility;
- had other group health insurance coverage, which was terminated because he was no longer eligible due to death, divorce, legal separation, termination of employment, or reduction in the number of hours of employment;
- had other group health insurance coverage, which was terminated because his employer stopped contributing to the plan;
- was covered under COBRA benefits, which have expired;
- requested enrollment within 30 days after termination of the Qualifying Coverage;
- the Participant Employer offers multiple health benefit plans and the person elects a different plan during an open enrollment period; or
- a court has ordered the Employee to provide coverage for a dependent under his/her employee health benefit plan and request for enrollment is made within 30 days after the issuance of the order.

If approved by Trustmark, the Late Enrollee will be subject to the Plan’s Pre-Existing Condition Limitation, and:

a) With respect to Dental Insurance, coverage will be provided on a restricted basis; payment for Class B Dental Expense, including Orthodontia, shall be 25%, rather than 50%, for expenses incurred within two years of such individual’s effective date of coverage.

b) With respect to Hospital Indemnity and Life and Disability Income and EERP:

- Hospital Indemnity Plan and EERP – available only during "Open Enrollment".
- Life and Disability Income – enrollment is subject to satisfactory evidence of insurability.

[SPECIAL ENROLLMENTS]

If employees decline enrollment because of other health insurance coverage, they may, in the future, be able to enroll themselves or dependents in this plan, provided that they request enrollment within 30 days after the other coverage ends. In addition, if employees add new dependents as a result of marriage, birth, adoption or placement for adoption, they may be able to enroll themselves and dependents, provided that they request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Special note for Newborn children: Comprehensive Medical Benefits are effective from the moment of birth for a newborn dependent child and benefits continue for 31 days. The employee must notify the member employer or HPS of the birth within 31 days to continue coverage for the child and any required premium must be paid when due. An enrollment card will need to be completed.

Requirements vary by state; please refer to Certificate of Insurance.
[PAYMENT OF PREMIUM]

Premium statements are mailed on the 10th business day of the month; the statement represents the premium for the ensuing month and is DUE IN FULL ON THE FIRST OF THE MONTH FOLLOWING.

If payment is not received in full in the office of HealthPlan Services by the end of the billed month, a reminder is sent on the 9th of the following month. If premium is not received by the 10th of following month, the premium statement will include the delinquent month’s premium and the current month’s premium due at the end of the month. If premium payment is not received at the end of the following month the account becomes delinquent and COVERAGE IS SUBJECT TO TERMINATION FOR NON PAYMENT. (See example below)

FOR EXAMPLE:
The premium statement for the month of March will be mailed on February 10th. If premium payment is not received by March 1st, coverage will be delinquent. A reminder will be sent on March 10th for the March premium. On March 10th, a premium statement for the delinquent month of March and April premium payments will be mailed with payment due on April 1st. If March premium is not received by April 1st, coverage will terminate for non payment.

Premium debits and credits for individual employees can be made for a portion of the month. If an employee completes the waiting period in the middle of the month, then coverage is effective on that date. Their premium charge from the effective date to the first day of the following month. Premium will be prorated for employees that start mid-month. Coverage for employees terminated mid-month — premium is paid through the last day of the month.

NOTE: A firm that is terminated for non-payment of premium is not eligible for automatic reinstatement. Medical underwriting for rating each participant may be required and reinstatement is subject to approval of the Trustees.

Requirements vary by state; please refer to Certificate of Insurance

The address for premium payment is:

ACEC/HealthPlan Services
P.O. Box 740518
Atlanta, GA 30374-0518

The firm’s cooperation in keeping its account current at all times is necessary for its protection and that of its associates.
[TERMINATION........WHAT HAPPENS]

An employee's insurance will terminate on the earliest of the following dates:

a) The date on which the employer ceases to be a Member Employer;
b) The date on which the policy is terminated;
c) The last day of the month for which a premium has been paid;
d) The last day of the month in which the employee is no longer eligible for coverage, plus applicable extension or continuation period.

The date last worked means the last day the employee actually entered the employer’s place of business or jobsite for actual work.

Dependent Insurance will terminate when the employee’s insurance terminates, at the end of the period which dependent coverage premiums have been made, or if the dependent ceases to be a dependent as defined plus applicable extension or continuation period.

[EXTENSION OF LIFE INSURANCE IF DISABLED]

If, while insured under the Group Life Insurance Policy, an employee becomes totally and permanently disabled, the Life Insurance and Survivor Income Insurance will continue in force during the continuance of such total disability. This benefit would end the earliest of the following:

- The date the employee is no longer totally and permanently disabled; or
- The date the employee fails to furnish due proof of continued total and permanent disability;
- The end of a 5-year period following the date the employee becomes disabled, if the total and permanent disability began on or after the employee’s 70th birthday;
- The date the employee retires; or
- The employee’s date of death

Due proof of total disability, means proof that the disability has been continuous since the employees last day of active work and is submitted after 9 months and before one year after the date the total disability began: annual proof of continued disability was submitted as requested by us; and upon the employee’s death, proof that disability continued to the date of death. Please contact HealthPlan Services for the necessary forms.

[CONVERSION OF INSURANCE BENEFITS]

To obtain information on a conversion policy, contact HealthPlan Services, giving the employee’s full name, home address and date of termination. This request for information must be made within 31 days of termination. The employee will then receive an application for conversion. The application should be forwarded to HealthPlan Services.

[CONTINUATION OF COVERAGE AT RETIREMENT]

Retirement coverage only applies to firms that elected this benefit at enrollment.

The Life Insurance and Disability Income coverage cannot be continued. Life Insurance may be converted to an individual policy with Trustmark at retirement. The Comprehensive Medical Insurance, offered by ACEC Life/Health Trust and Dental Insurance may be continued, with certain limitations, subject to the conditions below:

PRE-AGE 65 RETIREE - Limited Pre-Age 65 coverage may be available for a person who retires on or after age 55 and has satisfied the following criteria:

- Has completed 10 years of continuous service with the Member Employer participating under the plan; and
- Has been continuously insured under the ACEC Life/Health Plan for the 60 consecutive month period immediately preceding the date of retirement.

OR

AGE 65 AND OVER RETIREE - a person who retires on or after age 65, and who has satisfied the following criteria:
Has completed 10 years of continuous service with the Member Employer participating under the plan; and

Has been continuously insured under the ACEC Life/Health Plan for the 60 consecutive month period immediately preceding the date of retirement.

Coverage will terminate:

- The end of the period for which premium is paid;
- As to any dependent, the end of the month in which the Dependent ceases to qualify as a Dependent;
- The date the Member Employer terminates coverage with Us for any reason; or
- The date the Policy terminates;
- The date the retiree engages in any activity pertaining to any occupation or employment for remuneration or profit.

DEPENDENTS – coverage for dependents will continue provided they are covered prior to the date of the employee’s retirement as long as they continue to meet the Plan’s definition of an “Eligible Dependent.” No additional dependents can be added.

PREMIUM PAYMENT – the premium must be continued as part of the participating Employer’s regular plan and premium payment.

Contact HealthPlan Services for premium rates and coverage description.

Requirements vary by state; please refer to Certificate of Insurance
[COBRA]
The Consolidated Omnibus Reconciliation Act (COBRA) H.R. 3128 law, effective for the ACEC Life/Health Plan on July 1, 1986, allows certain individuals the option of continuing their group health insurance under specified conditions. This law is an EMPLOYER LAW, applicable to firms of 20 or more employees. For further information regarding specific COBRA compliance please refer to http://www.dol.gov.

[CONTINUATION OF EMPLOYER INSURANCE /REDUCTION IN HOURS WORKED]
Employees and their dependents are eligible to continue their group comprehensive medical insurance for up to 18 or 36 months, depending on the reason for termination of coverage, except that when a qualified beneficiary is determined under the Social Security Act to have been disabled within 60 days of termination of employment (or reduction in hours), and that person notifies his/her member employer of such determination within 60 days of the determination, that person is entitled to 29 (as opposed to 18) months of Continuation of Coverage. COBRA outlines how employees and family members may elect continuation coverage. It also requires employers and plans to provide timely notice.

Employers should notify HealthPlan Services in writing as soon as an employee is terminated. If the terminated employee elects COBRA, HealthPlan Services will reinstate the elected coverages retroactive to the qualifying event upon receipt of a completed COBRA election form (without lapse in coverage).

Please send the COBRA election form to:
ACEC/ HealthPlan Services
Enrollment Services
PO Box 30357
Tampa, FL 33630-3357
or Fax to: 1-800-649-0350

[CONTINUATION OF DEPENDENT(S) INSURANCE]
Individuals are eligible to continue group health insurance which would otherwise end for up to 36 months upon occurrence of the following events:
  a) Upon the death of the covered employee.
  b) Upon divorce or legal separation from the covered employee.
  c) When active employee becomes entitled to Medicare.
  d) When a child ceases to be dependent under the terms of the policy.

INSURANCE CANNOT BE CONTINUED BEYOND ANY OF THE FOLLOWING DATES:
  a) The date the employer is no longer a Participant Employer in the ACEC Life/Health Plan.
  b) The date the premium is not paid by the individual.
  c) The date the ACEC Life/Health Plan Terminates.
  d) When the individual becomes covered under any other group health plan, unless that plan has a pre-existing limitation provision.
  e) An individual becomes entitled to Medicare benefits.

[NOTICE OF TERMINATION]
The covered employee is responsible for notifying the employer of any change in family status – separation, divorce or child becoming ineligible for dependent’s coverage. The employer is responsible to notify HealthPlan Services within 30 days of the occurrence of:
  a) Death;
  b) Termination (or ineligibility due to reduction in hours); or
  c) Medicare eligibility of the covered employee.

ELECTION PERIOD
The individual must be given an election period of at least 60 days. This period must begin no later than the date on which coverage would otherwise terminate, and extend for at least 60 days beyond the date on which COBRA election notice is provided.

An individual who elects continuation of coverage will be allowed to elect continuation of coverage on behalf of all dependent children who would otherwise terminate due to the employee’s termination of group health coverage. Evidence of insurability cannot be a condition of continuation of coverage.

When continuation is elected under this provision no other continuation coverage is available.

Requirements vary by state; please refer to Certificate of Insurance
[STATE CONTINUATION] -not mandatory in all states

Please refer to the Certificate of Insurance issued by Trustmark for the specific information that may apply.

We suggest that employers notify HealthPlan Services in writing as soon as an employee is terminated. If the terminated employee elects State Continuation, HealthPlan Services will reinstate the elected coverages retroactive to the termination date upon receipt of a completed State Continuation election form (without lapse in coverage).

Please send the State Continuation election form to:

ACEC/ HealthPlan Services
Enrollment Services
PO Box 30357
Tampa, FL 33630-3357
or Fax to:
1-800-649-0350

CONTINUATION OF COVERAGE

Individuals whose coverage is continued shall receive identical coverage provided under the group plan for similarly situated active full time employees.

PREMIUMS

The cost to continue coverage can be borne by the individual in monthly installments, but not more than 102%* of the "applicable premium" (ACEC Life/Health Plan will only charge the applicable premium), which is defined as the cost to cover a similarly situated active full-time employee or dependent (without regard to whether such cost is paid by the employer or employee). Premium required is payable to the employer. If continuation of coverage is elected after the termination date, payment for continuation of coverage during the period preceding the election must be made with 45 days of the date of the election.

*In the case of a disabled employee who is continued for the additional 11 months coverage, the cost will be 50% higher than it was in the preceding 18 months.

CONVERSION OPTION

A conversion policy shall be offered after the expiration of the continuation of coverage to individuals continued there under. This option is not available to persons eligible for Medicare. The conversion option offering period is the 30 days preceding termination of the continuation of coverage. A conversion policy need not be offered when continuation of coverage ends due to:

a) Plan termination;
b) The failure of the individual to pay premium; coverage is replaced by another group plan; or
c) Eligibility for other coverage, whether insured or uninsured.

Requirements vary by state; please refer to Certificate of Insurance
[CHANGES IN AN INSURED PERSON’S STATUS]
The following changes are to be reported to HealthPlan Services by the employer through the use of the Request for Service Form:

- Desired Change
- Change in Dependent Status
- Change of Beneficiary’s Name
- Change of Beneficiary

NOTE: AN ENROLLMENT FORM IS NOT REQUIRED FOR ANY OF THE ABOVE CHANGES.

The following changes are to be reported to HealthPlan Services by the employer through the use of the Enrollment Application Form:

- Request for Discontinuance of Insurance
  (Employee still working at firm)
- Addition of dependent(s)

CHANGE IN DEPENDENT STATUS

If the employee is requesting the addition of dependent(s) coverage, and the form is received by HealthPlan Services within 30 days from the initial date of eligibility, change in status will be effective on the date of eligibility.

NOTE: Comprehensive Medical Benefits are effective from the moment of birth of a child born to you for 31 days for all such benefits provided for dependents. If a separate premium is required for the child’s coverage, you must notify the member employer or us of the birth within such 31 days to continue coverage for the child and any required premium must be paid when due. An enrollment card will need to be completed.

If the request for addition of dependent(s) coverage is not received by HealthPlan Services within 31 days after the initial eligibility date, coverage may be subject to the limitations under LATE ENROLLMENT or denied entirely, according to HIPAA regulations.

[CHANGES IN AN INSURED PERSON’S LIFE AND DISABILITY CLASSIFICATION]

Any changes in the amount of insurance due to an increase in the employee’s income or other basis for determining the amount of insurance will become effective on the date on which written original notification of such change is received by HealthPlan Services.

Any change in the amounts of insurance due to a decrease in the employee’s income or other basis of insurance will become effective on the date of such change. There will be no retroactive premium credit, unless HealthPlan Services receives notification of change within one month of date of such change.

COMPANY ADDRESS CHANGE

A company officer is authorized to make the change. A written notification is required.

TERMINATION OF EMPLOYMENT

To protect the Participant Employer and the employee’s conversion right, each terminated employee, including those selecting coverage, must read and sign the "Notice of Employee Right to Convert and Termination of Employment" form, certifying that the employee understands the conversion rights as explained on that form.

Employees that terminate with a firm that has ACEC Trust insurance and start a new job at a completely separate firm not affiliated with the prior company but one that has ACEC Trust insurance will be treated as a new employees and must wait the waiting period stated by the new firm.

All Service Request Forms can be obtained through HPS. Completed forms should be mailed to:

ACEC/ HealthPlan Services
Enrollment Services Department
PO Box 30357
Tampa, FL 33630-3357

or fax to: 1-800-649-0350

Requirements vary by state; please refer to Certificate of Insurance

If you have any questions, please call 1-888-813-7099.
COVERAGE FOR INSUREDS AGE 65 AND OVER
(who are not retired)

THE BENEFIT PAYMENT UNDER THE PLAN
WILL BE REDUCED BY THE NORMAL PAYMENT
UNDER MEDICARE A AND B, EVEN IF THE
EMPLOYEE OR DEPENDENT HAS NOT APPLIED
FOR MEDICARE A AND B.

The member employer should advise the employee to
contact the nearest Social Security office to make
arrangements for the necessary coverage prior to the
employee’s or dependent 65th birthday.

A. FOR ACTIVE EMPLOYEES AGE 65 AND
OLDER WITH FIRMS WHO EMPLOY 20 OR
MORE* –
An active employee of a firm with 20 or more employ-
ees has the option to elect the regular ACEC Health
plan coverage as the primary plan for health coverage
or Medicare as primary health coverage.

If the employee chooses Medicare as primary coverage,
by law, the ACEC Life/Health Plan cannot be offered.
In this situation, employee medical coverage will termi-
nate and all eligible dependents may qualify for a con-
tinuation of coverage afforded by
COBRA/State/General continuation.

Therefore, the employee should understand the benefits
available through the ACEC Life/Health Plan and
through Medicare.

Requirements vary by state; please refer to Certificate of Insurance

B. UNDER THE TERMS OF MASTER GROUP
POLICY, THE FOLLOWING EMPLOYEE BENEFITS
WILL BE REDUCED IN ACCORDANCE WITH
THE CERTIFICATE OF COVERAGE:

- Life Insurance
- Survivor And Optional Survivor Income
  Benefits
- Weekly Disability Income and LTD except
  as stated below
- Optional Term Life Insurance
- EERP
- HIP

If the employee is insured for Long Term Disability
Income Insurance and becomes disabled after age 60,
but prior to attaining age 68, benefits will be payable
for five years or to age 70, whichever comes first (but
in no event will benefits be payable for less than two
years). If the employee becomes disabled after age 68,
benefits will be payable for two years.

Medicare is primary for retired employees age 65 and over, no
matter the Member Employer size.
If a hospital admission is recommended for an insured or covered dependent, the employee or the attending Physician must call the toll free number listed on the insurance card for Pre-Certification. That call must be made before admission or within two working days of an emergency or maternity admission. Other services that require Pre-certification:

- Skilled nursing facility admissions
- Home health care services such as home infusion and in-home physical, occupational or speech therapy
- Sub-acute medical and rehabilitation inpatient admission
- Hospice care services

The Plan Medical Reviewer will ask about the hospitalization and proposed treatment or surgery.

After reviewing the information, the Plan Medical Reviewer will do one of the three things:

1. They may determine that the admission is appropriate, certify it and assign a hospital stay;

2. They may ask for more details before giving an opinion; or

3. They may refuse to certify the proposed hospital stay. The decision to certify or not to certify confinement will be relayed to the insured, the doctor, the hospital and HealthPlan Services.

If admission is certified, the Plan Medical Reviewer will contact the doctor on the day after the scheduled admission to confirm admission and on the day before expected discharge. If continued care is medically necessary, an extended stay is assigned, provided the insured or his/her physician, at anytime prior to discharge, requests the extension.

Should the insured bypass the Plan Medical Reviewer program, or the Plan Medical Reviewer and the attending physician cannot reach an agreement, reduced benefits will be paid.

TO INSURE THE PROPER NETWORK PLEASE REFER TO THE TOLL FREE NUMBER LISTED ON THE ID CARD FOR NETWORK INFORMATION AND PRE-ADMISSION PHONE NUMBERS.

Requirements vary by state; please refer to Certificate of Insurance.
LOCATE A NETWORK PROVIDER

NETWORK CLAIMS ADDRESSES, PRE-CERTIFICATION PHONE NUMBER AND HOW TO LOCATE A PROVIDER

The following directory contains information on those providers that participate in the ACEC provider Network and is for reference only.

Depending on your health plan, the provider you select may not be available due to plan design. You should encourage your employees to contact the provider’s office to confirm that the provider is accepting new patients, to verify the location of the provider’s office, and to confirm participation in your Network.

Additionally, employees should contact their health plan administrator or your firm’s group insurance representative to verify benefits and eligibility information.

ACEC/HealthPlan Services, Inc (PHCSMD)
PO Box 44109
Las Vegas, NV 89116
Pre-Certification Phone number: 1-800-454-5073
To locate a provider you can call 800-454-5073

ACEC/HealthPlan Services, Inc (PHCSOA)
PO Box 44109
Las Vegas, NV 89116
Pre-Certification Phone number: 1-800-454-5073
To locate a provider you can call 1-888-884-7427

Accountable Health Care of America
PO Box 90613
Arlington, TX 76006
Pre-Certification Phone Number: 1-800-454-5073
To locate a provider you can call 800-613-1124

AHC of WI
PO Box 981
Brookfield, WI 53008-0981
Pre-Certification Phone number: 1-800-454-5073
To locate a participating provider you can call 800-952-8661

Alliance PPO
PO Box 934
Frederick, MD 21705-0934
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 800-342-3289

AMCO (Arkansas Managed Care Organization)
PO Box 8219
Little Rock, AR 72221-8219
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 800-278-8470

American Life Care
1100 Poydras St, Suite 2600
New Orleans, LA 70163
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 800-749-2298

Arizona Foundation for Medical Care
PO Box 2909
Phoenix, AZ 85062-2909
Pre-Certification Phone number: 800-454-5073
(outside of Maricopa County) or 602-252-4042
To locate a provider you can call 800-624-4277
(outside of Maricopa County) or 602-252-4042

BeechStreet
PO Box 57015
Irvine, CA 92619-7015
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 800-432-1776

Devon Health Services
1100 First Ave, Suite 100
King of Prussia, PA 19406
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 888-225-8932

HealthLink
PO Box 419104
St Louis, MO 63141-9104
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 800-624-2356

HealthSmart
PO Box 53010
Lubbock, TX 79453-3010
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 800-687-0500

MedCo (Southcare)
PO Box 8530
Kansas City, MO 64114
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 800-395-2545
Medcost Preferred
PO Box 25307
Winston-Salem, NC 27114-5307
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 1-800-824-7406

Medical Mutual of Ohio
PO Box 94648
Cleveland, OH 44101-4648
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 800-601-9208

Mississippi Physicians Care Network
PO Box 1530
Ridgeland, MS 39158-1530
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 800-931-8533

Multiplan
PO Box 44105
Las Vegas, NV 89116
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 800-672-2140

PPOM
PO Box 2720
Farmington Hills, MI 48333
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 800-831-1166

Preferred Community Choice
PO Box 3270
Tulsa, OK 74101-3270
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 800-884-4776

Preferred Health Professionals
PO Box 25938
Shawnee Mission, KS 66225-5938
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 800-544-3014

Preferred One
PO Box 1527
Minneapolis, MN 55440-1527
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 800-451-9597

ProAmerica
PO Box 90603
Arlington, TX 76006
Pre-Certification Phone number: 1-800-454-5073
To locate a provider you can call 800-523-3669

Sloans Lake Managed Care
PO Box 241322
Denver, CO 80224-9322
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 303-691-2200

Sagamore
P.O. Box 6051
Indianapolis, IN 46206-6051
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 800-382-8414

Midland Choice
PO Box 247017
Omaha, NE 68124-7018
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 800-605-8259

CCN
POB 5190
Tampa, FL 33675-5190
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 800-226-5116

Alliance PPOI
PO Box 934
Frederick, MD 21705-0934
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 800-342-3289

WPPA
1102 S. Hillside
ATTN: Jodi Smith
Witchita, KS 67211
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 800-801-9772

First Choice of the Midwest
P.O. Box 5078
Sioux Falls, SD 57117-5070
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 800-246-9949
4-Most
4Most-Trustmark/6056
PO Box 7060
Middletown, NY  10940
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 888-258-6477

Mississippi Health Ventures dba HealthLink [North MS HealthLink]
Acclaim Repricing
808 Varsity Dr.
Tupelo, MS 38881
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 800-453-7536

TN Healthcare
MMS
PO Box 22389
Nashville, TN  37203-2389
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 888-297-1864

Indiana Health
P.O. Box 20570
Indianapolis, IN 46220
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 888-446-6670

Premier Health Systems
P.O. Box 1640
Columbia, SC 29202-1640
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 800-773-1445

Medical Network of Maine
MedNet
PO Box 15440
Portland ME  04112
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 800-556-1144

Interwest
Trustmark/ACEC
PO Box 8629
Missoula, MT 59807
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 877-542-1912

10% Healthcare Finest Network
HFN
PO Box 3428
Oak Brook, IL 60523-3428
Network WebMD: #36335
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 800-295-5444

20% Healthcare Finest Network
HFN
PO Box 3428
Oak Brook, IL 60523-3428
Network WebMD: #36335
Pre-Certification Phone number: 800-454-5073
To locate a provider you can call 800-295-5444
[SHARED SAVINGS]

Shared Savings is a program for discounts on out of network services. If a BCE Emergis Provider is used for out-of-network services, a discount may be applied. This may result in savings to your out-of-pocket expenses.

[COORDINATION OF BENEFITS]

Benefits will be adjusted so that the total benefits payable under all Plans is no more than 100 percent of the Allowable Expense. Benefits ‘payable’ under other Plans include benefits that would be paid if You made claim.

If benefits paid under this Plan are reduced because of coordination, each benefit will be reduced proportionately. The amount of the reduction will be a benefit credit for the same claim. The credit may be used to pay that portion of Allowable Expense which would otherwise not be paid by any Plan.

The credit may only be used to pay that portion of a charge which is incurred during the same Year as the credit. Total benefits paid will not exceed the total payable in the absence of coordination. Only the amount actually paid will be charged against any benefit maximum.

[CLAIMS PROCESS FOR LIFE AND LTD]

Life and LTD claims are sent to:
HealthPlan Services
P O Box 3098
Tampa, FL 33630-3098

Upon receipt of notification of a death or LTD claim, HPS will send a letter with forms to the firm, employee, etc. That letter will indicate what is needed to file the claim.

Once appropriate information is received at HPS, it will be reviewed and then sent overnight to Trustmark. Upon review from Trustmark-a check is sent to HPS via overnight and we then forward it with a letter via certified mail to the claimant.

[HOW TO FILE A CLAIM FOR MEDICAL EXPENSE BENEFIT]

The Standard HFCA and UB92 forms are considered a valid claim form and should be used to submit all claims. Balance due statements are not considered a valid claim form. To ensure timely handling all fields on the standard forms should be completed in full and signed by the physician rendering the services.

[WHERE TO FILE A PHCS PPO CLAIM]

Claims should be sent to:
ACEC Claims
PO Box 44109
Las Vegas, Nevada 89116

[WHERE TO FILE A PPO CLAIM]

Claims are to be sent directly to the member’s PPO network when services are rendered by a participating provider. Name and address of member’s PPO Network is available on the ID Cards.

[HOW TO FILE A NON PPO CLAIM] (out-of-network)

Claims should have a stamp or other type of notification that the provider is non-participant with the member’s PPO network to ensure timely handling of non PPO claims.

Claims are to be mailed to:
PO Box 44109
Las Vegas, Nevada 89116
[WHEN TO FILE A CLAIM]
HPS must receive written notice of a claim within 90 days after a covered loss occurs or begins or as soon thereafter as reasonably possible. When the Benefits provide for periodic payment for a continuing loss, written proof of the loss must be given to HPS within 90 days after the end of each period.

Except for absence of legal capacity, no claim for benefits will be accepted after 18 months from the date the loss occurred or began. If the claim is for Life Benefits, a certified copy of the death certificate must be submitted along with the claim form.

[CLAIMS FOR WEEKLY DISABILITY INCOME BENEFITS]

Notification of short-term disability claim begins with one of the following:

- Disability claim form is mailed and/or faxed to HPS
- A call from an employer, employee, agent or family requesting disability claim form is received. Form will be sent same day to claimant.

*Claims are not considered submitted until receipt of disability claim form by mail and/or fax and signed and dated by employee, employer, doctor(s).

If claim is received with all information needed, claim will be processed within 30 days of receipt.

If claim is submitted, but found to be incomplete, claim will be denied. HPS cannot process until additional information is received.

Requirements vary by state; please refer to Certificate of Insurance.