TRI-COUNTY SCHOOLS INSURANCE GROUP

EMPLOYEE BENEFITS Policy No. 210

This Policy for employee benefit programs has been instituted by the Tri-County Schools Insurance Group Executive Committee for the purpose of controlling adverse selection against Tri-County Schools Insurance Group plans and of defining those policies which influence rate setting.

I. Employee Groups

The same rate structure, i.e., composite or tiered must be used for all employees in a group.

The term "Employee Group" in these regulations is defined as follows:

a. Any group defined under existing applicable collective bargaining law.

b. The Board, Superintendent, Management Employees, Confidential Employees, Classified Employees, Certificated Employees and Retirees will always be considered individual Employee Groups even if there are no organized bargaining groups.

c. Retired employees follow the group to which they would belong if they were active employees.

II. Coverage

a. Effective Date of Coverage

Eligible employees are covered under the Plan as determined by the written policies of the Employer, but not any sooner than the first day of the month following the date of employment.

Examples: Date of Employment December 25th - Effective January 1st
Date of Employment December 1st - Effective January 1st

b. Continuous Coverage:

Employers shall not allow an employee to opt out during the summer and enroll again in the fall in the medical, dental and/or vision plans.

c. Full-time Employees:

A full-time employee shall be determined as defined in the Employer's collective bargaining agreement or the Employer's employment contract.

d. Less Than Full-time Employees:

New less than full-time employees have 31 days to enroll (from the date they become eligible). However, once enrolled in the program, no employee can opt out of the program and later re-enroll without meeting criteria (see "Break in Coverage"), unless conditions of employment change.

An "employment change" occurs when an employee's hours or work-year change sufficiently to affect the amount of premiums self-paid by the employee or changes the employee from an ineligible to an eligible status.

An employee who enrolls must enroll in all programs (medical, dental, vision, life) in which their employee group participates.

Less than full-time eligible employees may elect not to participate in benefits. Such election (waiver of benefits) must be in writing.

e. Retirees:

Continued coverage for eligible retired employees is at the option of each Employer. Contributions may be retiree or Employer paid but collection is the responsibility of the Employer. Retirees and covered spouses must secure Medicare Parts A and B if eligible. Retirees or their dependents that discontinue coverage cannot re-enroll in any plan even during open enrollment. The "Break in Coverage" regulations do not apply.

Retired employees are considered part of the employee group they were in just prior to retirement for benefit eligibility.

Retirees will be placed on the tiered rate structure upon retirement, unless the retirees employer requires the composite rate for retirees with two or more eligible dependents and the composite rate is used for the retirees former active group.

Retirees may select medical coverage only or all offered benefits. Retirees may not select dental or vision coverage without medical coverage.

f. Board Members:

Coverage for board members is at the option of each Employer.

New board members have 31 days to elect coverage.

Board members may elect not to participate in benefits. Such election (waiver of benefits) must be in writing. Once enrolled in the program, no board member can opt out of the program and later re-enroll without conditions (see "Break in Coverage").

g. Non-Employee

Coverage cannot be extended to non-employees. Individuals must meet the IRS definition of an employee and must be on the Employer's payroll. Individuals cannot be on a contract for services that is not paid through the normal Employer payroll.

h. Leave Policy

When someone is on an approved leave of absence from a member Employer, they may opt out of all benefits. If they elect to continue benefits at their or the Employers expense, they must continue to participate in all of the plans in which their employee group is enrolled, e.g., they cannot opt out of vision and elect medical and dental.

III. Break in Coverage

A break in coverage occurs whenever an employee remains employed by the Employer, but coverage under the Plan terminates for either the employee or dependents.

After a break in coverage, except under an approved leave of absence, an employee and/or dependent(s) may only re-enroll in the Plans during the annual open enrollment, unless there is a status change.

IV. Employer Contributions

Each Employer is responsible for a contribution to the program fund equal to the rate set for the medical plan selected or in the case of those full-time employees that waive coverage, a minimum assessment to support the program fund as actuarially determined.

V. Dental and Vision Program Eligibility

Employees and eligible dependents must be enrolled in one of TCSIG's medical plans in order for the employee, retiree and their eligible dependents to qualify for eligibility in TCSIG's dental and vision programs.

Employees and eligible dependents must file written application with the Employer for

coverage within thirty-one (31) days of becoming eligible for coverage. Employees, dependents or retirees that do not enroll with thirty-one (31) days of becoming eligible or discontinue dental or vision program coverage cannot re-enroll in the dental or vision programs. The break in coverage provisions in TCSIG's Policy 210 do not apply. The dental and vision programs do not provide for open enrollment.

All employees in an employee group must be in the same plan. If an employee group elects to change plans, they must remain in that plan for two years. The two year provision does not apply if an employee group elects a plan which increases their benefit. Request to change plans must be received by June 1st and are effective on July 1st.

VI. Competing Plans

Employers may not offer and/or maintain competing medical/dental/vision plans within an employee group. If an Employer offers a non-TCSIG plan to any members of a employee group, the entire employee group must be withdrawn from the competing TCSIG plan.

TCSIG reserves the right to contract with "open" and/or "closed" panel HMOs as TCSIG offerings. If an HMO is offered by TCSIG, then Employers cannot offer a different, competing HMO to employee groups.

VII. Rate Structure Changes

Employers choosing to change rate structures shall be required to notify TCSIG by December 31st for the change to become effective by the beginning of the next fiscal year, July 1st, i.e., composite rate to tiered rate.

In the event of a new hire in a single person group after the notification deadline of December 31st, the Employer may request a rate structure change for the single person employee group. The effective date of the change will be subject to TCSIG administrative requirements.

In the event of special circumstances, including but not limited to the ratification of a collective bargaining agreement between an Employer member and their bargaining units, a change in rate structure may be approved after the December 31st deadline. The effective date of the change will be subject to TCSIG administrative requirements.

VIII. Rate setting Criteria

The actuary shall develop recommended rates by pooling all plans' experience and applying a relative value factor. The actuarial study shall also indicate the recommended rates on a plan by plan basis.