



Federal and State Regulation Benefit Notices and Rights

Federal and state legislation requires notification of certain regulations and rights. It is important you (and applicable dependents) understand your (their) rights to which you and any applicable dependents are entitled. For a list and to view these notices, reference may be made to our website: www.employersresource.com, then go to "Employee Service Center", then "Additional Employee Benefits", then scroll down to "Compliance". Additionally, we have provided a paper copy of such notices, which follows, and we will subsequently remind you (and your dependents) through payroll reminders, periodic mailings and new employee material. If you are unable to view this information, or would like additional copies, please contact the Employers Resource Benefits Department at: 866-214-9506.

Notices Enclosed and Posted on The Employers Resource Website

- 1) NOTICE OF PRIVACY PRACTICES**
 - 2) NOTICE OF RIGHT TO CONTINUATION COVERAGE UNDER COBRA**
 - 3) SPECIAL ENROLLMENT RIGHTS**
 - 4) PRE-EXISTING CONDITIONS EXCLUSION NOTICE**
 - 5) WOMEN'S HEALTH AND CANCER RIGHTS**
 - 6) NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT**
 - 7) SUMMARY ANNUAL REPORT**
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Notices to follow in order (front and back printing)



Federal and State Regulation Benefit Notices and Rights

1) SUMMARY NOTICE OF PRIVACY PRACTICES

(Effective April 14, 2003 and since restated)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices (Notice) applies to Employers Resource Benefit Trust (Trust), Employers Resource Management Company (ERM), Employers Resource of America, Inc. (ERA) and Integrative Health Consultants (IHC). Wherever the term “we” or “us” or “our” appears in this Notice, the term means the Trust and/or ERM, ERA or IHC as the context may require. Federal and state governments have adopted regulations designed to protect the privacy of your protected health information. As part of these requirements, we are required to send you this Notice describing our responsibilities and your rights under these regulations. Please review this Notice carefully.

Your privacy and the protection of your protected health information have always been important to us. We consider protected health information to be confidential and we protect the privacy of that information in accordance with federal and state privacy laws, as well as our own company privacy policies. We take those responsibilities seriously and remain dedicated to protecting your protected health information as we continue to meet your insurance needs.

DEFINITION OF PROTECTED HEALTH INFORMATION (PHI)

This Notice describes how we may use and disclose your “protected health information” or PHI. PHI is any information created or received by a health care provider, health plan, employer, or health care clearinghouse that relates to your past, present, or future physical or mental health or condition, or provision of or payment for health care. PHI is information that identifies the individual or may reasonably be used to identify the individual. The term PHI includes all individually-identifiable protected health information transmitted or maintained by the group health plan regardless of whether it is in oral, written, or electronic form.

HOW WE USE AND DISCLOSE PHI

In order to provide you with coverage, we need PHI about you and we may obtain that information from many different sources—particularly your employer or benefits plan sponsor, other insurers, HMOs, third-party administrators, and health care providers.

In administering your benefits, we are permitted by law to use and disclose your PHI for certain purposes without your written authorization. This Notice does not list every permitted use or disclosure we may make. However, all the ways we are permitted to use or disclose PHI will fall within one of the categories below.

- 1. Treatment Purposes:** We may disclose PHI to a health care provider for the health care provider’s treatment purposes, although it is more likely a health care provider would receive your PHI from another health care provider than from us. Treatment refers to the provision, coordination, or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers.
- 2. Payment Purposes:** We may use your PHI to process any requests for coverage and claims for benefits you make and we may review PHI included with claims to reimburse providers for treatment and services. Additionally, we may disclose PHI to another group health plan or to a health care provider for payment purposes. Payment refers to actions to make coverage determinations and payments, including billing, claims management, plan reimbursement, utilization review, and pre-authorizations.
- 3. Health Care Operations Purposes:** We may use PHI for health care operations and may disclose PHI to another group health plan, a health care provider, a medical group, or a hospital for health care operations purposes of our health plans, or for certain health care operations purposes of the other entities.

Other operational activities requiring use and disclosure include: administration of reinsurance and stop loss; underwriting and rating; detection and investigation of fraud; administration of pharmaceutical programs and payments; transfer of policies or contracts from and to other health plans; facilitation of a sale, transfer, merger, or consolidation of all or part of the Trust/ERM/ERA/IHC with another entity (including due diligence related to such activity); and other general administrative activities, including data and information systems management and customer service.

- 4. Health Plan Sponsor (the Trust) Purposes:** The Trust may disclose PHI to ERM/ERA or IHC only if the company has amended its plan documents as required by the HIPAA Privacy Rule, certified to the Trust that it will maintain confidentiality, and has established certain safeguards and firewalls to restrict the use of PHI to plan purposes and deter non-permissible purposes. Any disclosures to the Trust must be for purposes of payment or administering the Trust. An example would be for claims appeals to the Trust’s Administrator. The Trust may also disclose enrollment/disrollment information to ERM/ERA or IHC, for enrollment or disenrollment purposes only, and may disclose “summary PHI” to ERM/ERA or IHC to obtain premium bids or modify or terminate the Trust.
- 5. Other Covered Entities Purposes:** We may disclose PHI to other covered entities, or business associates of those entities for treatment, payment, and certain health care operations purposes. For example, in order to have certain expenses reimbursed, we may disclose PHI to other health plans maintained by your employer if it has been arranged for us to do so.



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ADDITIONAL REASONS FOR DISCLOSURE

We may use or disclose PHI about you when providing you with treatment alternatives, treatment reminders, or other health-related benefits and services. We also may disclose such information in support of:

- **Plan Administration**—to your employer, only after we have been informed that appropriate language has been included in your employer's plan documents, or when summary data is disclosed to assist in bidding or amending a group health plan.
- **Research**—to researchers, provided measures are taken to protect your privacy.
- **Business Associates**—to persons who provide related services to us and also assure us they will protect the information.
- **Industry Regulation**—to state insurance departments, boards of pharmacy, U.S. Food and Drug Administration, U.S. Department of Labor, and other government agencies that regulate us.
- **Law Enforcement**—to federal, state, and local law enforcement officials as required by law.
- **Legal Proceedings**—in response to a court order or other lawful process.
- **Public Welfare**—to address matters of public interest as required or permitted by law (e.g., child abuse and neglect, threats to public health and safety, and national security).

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

In all situations other than those described above, we will ask for your written authorization before using or disclosing PHI about you. If you have given us an authorization, you may revoke it at any time so long as we have not already acted on the authorization.

YOUR LEGAL RIGHTS

Federal privacy regulations give you the right to make certain requests regarding PHI about yourself. You may ask us to:

- **Communicate** with you in a certain way or at a certain location. For example, if you are covered as an adult dependent, you might want us to send PHI to an address different from your participant. We will accommodate all reasonable requests.
- **Restrict** the way we use or disclose your PHI in connection with health care operations, payment, and treatment. You also have the right to ask us to restrict disclosures to persons involved in your health care. We will consider, but may not agree to, such requests.
- **Inspect and Obtain** a copy of information that is contained in your medical records and other records maintained and used in making enrollment, payment, claims adjudication, medical management, and other decisions. We may ask you to make your request in writing, may charge a reasonable fee for producing and mailing the copies, and, in certain cases, may deny the request.
- **Amend** information that you feel is incorrect. Your request must be in writing and must include the reason for the request. If we deny the request, you may file a written statement of disagreement.
- **Provide** an accounting of disclosures we have made of your PHI. We are not required to, and we will not, account for disclosures made for treatment, payment, or health care operations, or to government agencies or law enforcement personnel, pursuant to your authorization, or to you. Please note the time period for which you want an accounting and the format desired (e.g., paper or electronic).

We will not account for disclosures made more than six years prior to your request, nor for disclosures made before HIPAA privacy compliance was required (April 14, 2003). We will provide one accounting of disclosures free of charge every 12 months. A cost-based fee will be charged for additional accountings that you request.

You may make any of the requests described above in writing by contacting us at the address and phone number provided below. You also have the right to submit a complaint if you think your privacy rights have been violated. To do so, please follow the grievance procedures described in your Summary Plan Description or on the www.employersresource.com website. You will not be retaliated against for submitting a complaint nor will you be asked to waive your rights in order to receive treatment or coverage.

THIS NOTICE IS SUBJECT TO CHANGE

We may change the terms of this Notice and our privacy policies at any time. If we do, the new terms and policies will be effective for all of the information that we already have about you, as well as any information that we may receive or hold in the future. If we make a material revision to this Notice, the revision will be posted through the www.employersresource.com website within 60 days of the revision being made.

Please note that we do not destroy PHI about you when your coverage with us is terminated. It may be necessary to use and disclose this information for the purposes described above even after your coverage terminates. Policies and procedures will remain in place to protect against inappropriate use or disclosure.

This is a summary notice of our privacy practices. For a complete copy of our Notice of Privacy Practices, please refer to the www.employersresource.com website or contact us at the address below.

If you have questions regarding this Notice, please contact our Privacy Official by mail at ERBT/ERM/ERA/IHC, 1301 South Vista Avenue, Suite 250, Boise, Idaho 83705; by phone at 866-214-9506; or by fax at 888-201-6365. Please include your name, phone number, and fax number.



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2) EMPLOYEE WELFARE BENEFIT PLANS (Self-funded and Fully Insured): PLAN NO. 502

NOTICE OF RIGHT TO CONTINUATION COVERAGE UNDER COBRA

Introduction

COBRA eligibility and coverage is available during the period the Client Service Agreement or other written agreement between the Co-Employer and ERM is in effect. Termination of the Client Service Agreement by any means whatsoever terminates COBRA eligibility and coverage.

You are receiving this notice because you have recently become covered, or may become covered, under an applicable group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay *or* are not required to pay] for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct, or
- Your leave ends under the Family Medical Leave Act, and you do not return to work.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.



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You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. If notice is not received within that 60-day period, the dependent or spouse will not be entitled to choose continuation coverage. You must provide this notice to: Employers Resource, 1301 S. Vista Ave, Suite 250, Boise, ID 83705. If you do not choose continuation coverage within the 60-day election period, your group health coverage will end at the end of the month in which the qualifying event occurred.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months as long as the COBRA payments are received timely. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional/District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Employers Resource/Employers Resource Benefit Trust • 1301 S. Vista Ave, Suite 250 • Boise, ID 83705 • 208-426-8006



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3) SPECIAL ENROLLMENT RIGHTS

Under the special enrollment provisions of HIPAA, you may be eligible, in certain situations, to enroll in an Employers Resource Benefit Trust/Employers Resource medical plan during the year, even if you previously declined coverage. This right extends to you and all eligible family members. You will be eligible to enroll yourself (and eligible dependents) in an Employers Resource Benefit Trust/Employers Resource medical plan if, during the year you or your dependents have lost coverage under another plan because:

- Coverage ended due to termination of employment, divorce, death, or a reduction in hours that affected benefits eligibility;
- Employer contributions to the plan stopped;
- The plan was terminated;
- COBRA coverage ended; or
- The lifetime maximum for medical benefits was exceeded under the existing medical coverage option.

In addition, if you gain a new dependent during the year as a result of marriage, birth, adoption or placement for adoption, you may enroll that dependent, as well as yourself and any other eligible dependents, in the plan — again, even if you previously declined medical coverage.

Please note that special enrollment rights:

- Will be extended to you only if you notify Human Resources within 31 days of the event; and,
- Allow you to either:
- Enroll in your current medical coverage; or
- Enroll in any medical plan benefit option for which you and your dependents are eligible.

Medicaid or CHIP Special Enrollment Right

Effective April 1, 2009, you will be eligible to enroll yourself and eligible dependents if either of two events occur:

- You or your dependent loses Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible.
- You or your dependent qualifies for state assistance in paying your employer group medical plan premiums.

Regardless of other enrollment deadlines, you will have 60 days from the date of the Medicaid/CHIP event to request enrollment in the Employers Resource Benefit Trust medical plan.

Please note that special enrollment rights for Medicaid/CHIP allow you to either:

- Enroll in your current medical coverage; or
- Enroll in any medical plan benefit option for which you and your dependents are eligible.

4) PRE-EXISTING CONDITIONS EXCLUSION NOTICE

The plan in most instances imposes a pre-existing condition exclusion (there are sometimes exceptions such as HMO plans, but please refer to your plan or your administrator to confirm how this exclusion applies). This means that if you have a medical condition before your plan coverage begins, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 31 days after birth, adoption, or placement for adoption.

The exclusion may last up to 12 months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the exclusion period by your creditable coverage, you should give Human Resources a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, Human Resources will help you obtain one from your prior plan or issuer. There also are other ways that you can show you have creditable coverage. Please contact Human Resources if you need help demonstrating creditable coverage.

All questions about preexisting condition exclusions and creditable coverage should be directed to your plan administrator or to the Employers Resource Benefits Department at: 1 (866) 214-9506.



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5) WOMEN'S HEALTH AND CANCER RIGHTS

A Beneficiary who is receiving medical and surgical benefits under this Plan in connection with a covered mastectomy and who elects breast reconstruction in connection with such mastectomy and in a manner determined in consultation with the attending physician shall be entitled to receive benefits for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Coverage provided shall be consistent with the benefits of this Plan and may be subject to the applicable Deductible and/or Coinsurance provisions of this Plan.

6) NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

The Plan may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods.

7) SUMMARY ANNUAL REPORT

Summary Annual Report
for
EMPLOYERS RESOURCE BENEFIT TRUST

This is a summary of the annual report for the EMPLOYERS RESOURCE BENEFIT TRUST, (Employer Identification No. 54-1340867, Plan No. 503) for the period July 1, 2007 to June 30, 2008. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

BASIC FINANCIAL STATEMENT

The value of plan assets, after subtracting liabilities of the plan, was \$235489 as of June 30, 2008 compared to \$111078 as of July 1, 2007. During the plan year the plan experienced an increase in its net assets of \$124411. This increase includes unrealized appreciation or depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year, or the cost of assets acquired during the year. During the plan year, the plan had total income of \$3029925. This income included employer contributions of \$2705498, employee contributions of \$12083 and earnings from investments of \$12344. Plan expenses were \$2905514. These expenses included \$530016 in administrative expenses and \$2375498 in benefits paid to participants and beneficiaries.

YOUR RIGHTS TO ADDITIONAL INFORMATION

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. An accountant's report;
2. Assets held for investment; and
3. Insurance information including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write or call the office of

American Guaranty, Title and Trust, Inc.
1301 S. Vista Avenue, Suite 200
Boise, ID 83705
47-0927569 (Employer Identification Number)
208-376-3000



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You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. These portions of the report are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan:

American Guaranty, Title and Trust, Inc.
1301 S. Vista Avenue, Suite 200
Boise, ID 83705

and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: U.S. Department of Labor, Employee Benefits Security Administration, Public Disclosure Room, 200 Constitution Avenue, NW, Suite N-1513, Washington, D.C. 20210.