VSP
Employer Guide

Customer Service

Vision Service Plan (VSP)
1-800-877-7195
http://www.vsp.com

Premium Payments/Billing Administration

Beneficial Administration, LLC
Mailing Address:
P.O. Box 3100
Newport Beach, CA 92658-9027
Street Address:
2505 McCabe Way
Irvine, CA 92614
Phone: 1-800-854-7417
Fax: 1-949-724-1603
Email: customerservice@beneficialadmin.com
Website: http://www.beneficialadmin.com

Participation and Maintenance Requirements

You have indicated on the employer application that participation would be for:
Option 1 or Option 2 – Only those employees and dependents covered by your in-force group medical or dental policy **or**
Option 3 – 100% of all eligible employees and dependents
or
Option 4 – 100% of all eligible employees and no dependents

Whichever participation requirement you chose, you are required to comply with it throughout the life of the plan.

A minimum employee participation of four employees is required. Should the number of participants in the plan decrease to fewer than the minimum required, the employer will be permitted to continue participating in the plan for a maximum of three additional calendar months following the date in which enrollment dropped below the minimum. In the event the employer wishes to extend coverage beyond the 3-month period by adding to the plan employees who become eligible during the 3-month period, the employer may be required to submit payroll records and other documentation to Beneficial Administration.

Plan Eligibility

An eligible employee is an active, full-time employee who meets the above participation requirements, is working at least 30 hours per week, and is paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made. Partners and proprietors actively engaged in the business on a full-time basis and who meet the above participation requirements also are eligible. If the employer wishes to cover part-time employees who work at least 20 hours per week, he or she may do so, but only as long as the group meets the participation and maintenance requirements outlined in this guide.

An eligible dependent is the employee's lawful spouse or domestic partner and any child of the enrolled applicant or spouse/domestic partner who is under age 26. It is the employee's responsibility to inform the group administrator of any change in status of his/her dependents.

Eligible dependents also must meet the participation requirements as outlined in this guide.

Employee Effective Dates

Employees who are enrolling under Option 1 or Option 2 will have the same effective date as that of their medical or dental plan, based on the first of the month following the waiting period selected by their employer. For employees enrolling under Option 3 or Option 4, the effective date will be the first of the month following the waiting period selected by the employer.

Adding Employees to VSP

Newly eligible employees electing coverage should complete an application for the employer's submission to Beneficial Administration, LLC prior to the effective date of coverage. If an application is not received prior to the effective date, the employee will be added to the plan effective the first of the month following receipt of the employee's application by Beneficial Administration, LLC. In the event the employer selects Participation Option 1or Option 2, a copy of the new employee's medical or dental application or other proof that the employee is covered under the group medical or dental plan must accompany the employee application. When adding a newly eligible employee, the employer should not make any adjustments to the monthly invoice. Premium charges for additional employees will appear on the employer's invoice when the employee's coverage becomes effective.

Employees should receive a copy of the VSP plan brochures from the employer upon enrollment. For additional employee supplies, please contact Beneficial Administration, LLC at the number on the front cover of this Employer Guide.

Adding Dependents to VSP

Employers who have selected Participation Option 1 or Option 2 must add dependents to the plan concurrent with enrollment in the group medical plan or dental plan, depending on which plan you originally elected to match. Employers who have selected Participation Option 3 or Option 4 must add newly eligible dependents of employees covered under the plan within 30 days of the qualifying event.

Reporting Terminated Employees

Employees who terminate employment are contractually entitled to coverage through the last day of the month in which they last worked on a full-time basis. For example, an employee who terminates employment on June 5th is entitled to coverage through June 30th. Premiums are to be paid for the last month of coverage for any such employee. The employer may use the Termination Form (attached at end of document) or can take the following steps to report terminations and delete employees from the policy:

1. Draw a line through the name of the terminated employee on the invoice for the month following the employee's last day of work. In the above example, the employer would make this notation on the July invoice.
2. Note the date the employee last worked beside his or her name on the invoice. Beneficial Administration, LLC will not be able to process the request without an exact termination date.
3. Adjustments will be made on the next month's invoice.

Employers must report terminations no later than one month following the date of the termination. For the employee in the above example, the premium credit must be deducted by the employer from the July invoice. **Beneficial Administration, LLC will not allow a premium credit for more than one month's premium.**

Terminating an active employee is permitted only if the employer continues to maintain the minimum participation and maintenance requirements outlined in the section entitled, "Participation and Maintenance Requirements."

COBRA and State Continuation of Benefits Participation

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires employers with 20 or more employees to offer certain employees and dependents Federal continuation of benefits beyond normal coverage termination dates. Employers with 2 to 19 employees may be similarly required to offer employees coverage under their State's law for continuation of benefits coverage.

Generally, covered employees and their covered dependents may become eligible for continuation coverage under COBRA or State guidelines due to such qualifying events as a reduction of work hours, termination of employment, divorce, legal separation, death, loss of dependent status or Medicare eligibility. There are certain actions employers must take in order to comply with continuation of benefits coverage, as applicable.

Reporting Other Changes

Continuation Coverage

The VSP plan certificate states that covered employees, though not working full-time, may under certain circumstances continue to be covered by the plan, provided that premiums are paid in full by the employee. It is the employer's responsibility to notify Beneficial Administration, LLC in writing of any employee who wishes to elect continuation of coverage (disability, leave of absence, exhaustion of continuation of benefits coverage) and the duration of time in which benefits are to be continued. This notification must be received by Beneficial Administration, LLC prior to the beginning of the continuation period. Please use the VSP Termination Form at the end of this document for the notification.

Change of Name or Address

Employers who have a company name change, relocate or have a change of billing address must notify Beneficial Administration, LLC either by noting the change on the invoice or by forwarding the change in letter form.

Change of Dependent Status

Employees wishing to add or delete dependents may do so, provided that the participation requirements outlined in this guide are met. Employees must complete a new Employee Application and submit it to Beneficial Administration, LLC.

Premiums and Fees

Premiums

Premium checks should be made payable to Beneficial Administration, LLC. Be sure to write your employer number on your check, and enclose the remittance copy of your invoice along with your check in the return envelope provided.

Fees

The employer is responsible for the payment of any fees that appear on the monthly invoice.

- **The administration fee** (if applicable) appears each month on your invoice and covers, among other items, the cost of billings, collections, insurance record maintenance, and printing of forms.
- **The delinquency fee** is a charge for late payment of premium.
- **The not-negotiable check fee** is a charge for all returned checks.

Billing and Premium Payment

Premium Due Dates

Premium invoices are sent out on or about the 25th of the month prior to the billed month. Premiums are due on the first of each month. Employees are not eligible for benefits until the premium due is received and processed by Beneficial Administration, LLC. Because of the unpredictability of mail delivery, there may be months in which 1) the bill is received later, or 2) the bill is not received. It is the employer's responsibility to make payment regardless of whether or not you receive a bill.

Delinquent Payment

Premiums are considered delinquent if they are not received by Beneficial Administration, LLC by the 15th of the current month. A Delinquency Fee will be charged for late remittance of premium.

Cancellation of Coverage

If premiums have not been received by Beneficial Administration, LLC by the 15th of the month following the month they are due, coverage for all employees and dependents will be cancelled. For example, if a premium payment is due on February 15th, coverage will automatically be cancelled if the delinquent premium is not received by March 15th. In the above example, the effective date of cancellation would be January 31st.

Not-Negotiable Checks

Checks returned by the bank for insufficient funds, stop-payment, missing signature, or any other reason for which the bank would deem a check not-negotiable will be treated as though no premium payment was received. A handling fee will be charged for all not negotiable checks.

Customer Service

If you need additional information beyond what is outlined in this guide, please contact Beneficial Administration, 7:00 a.m. to 5:00 p.m. Pacific Standard Time, Monday through Friday.
Be sure to have your Employer Number handy when you call.
The Employer Number can be found in the top-left-hand corner of your monthly premium invoice.

Supplemental Vision Benefit Employer Trust (SVBET)
Existing Group Employee Vision Application/Change Form

Company Name: _____ Customer Number: _____

Please send this application to Beneficial Administration Company.
Fax (949) 724-1603 or email customerservice@beneficialadmin.com

1. Enrollment Status (check one)

❑ New Hire Enrollment

□ Family Addition: Date of Marriage _____
□ Family Addition: Date of Birth or Adoption _____
□ Family Addition: Qualifying Event (i.e. loss of other coverage) _____

□ State Continuation Effective date _____/_____/_____ □ Federal COBRA Effective date _____/_____/_____

2. Employee Information

Last Name	First Name	Middle Initial	Gender (M/F)

Social Security Number _____ - _____ - _____	Date of Birth (MM/DD/YY) / _____ / _____
Marital Status: ❑ Single ❑ Married	Number of Eligible Children *: _____

Home Street Address (P.O. Box not acceptable unless Rural P.O. Box)	Apt. Number

City	State	Zip Code	Home Phone (_____) _____ - _____

Job Title	Date of Hire (MM/DD/YY) _____ / _____ /_____	Business Phone (_____) _____ -_____	Hours Worked per Week

3. Dependent Information: An employee may only enroll his/her dependent(s) if the following criteria is met:

*An eligible dependent is an employee's spouse/domestic partner and/or any child of the enrolled applicant or spouse/domestic partner who is under age 26.
Enrollment on this plan is determined by the employer's participation selection.

Last Name	First Name	Birthdate (MM/DD/YY)
❑ Husband ❑ Wife ❑ Domestic Partner		_____ / _____ / _____
❑ Son ❑ Daughter		_____ / _____ / _____
❑ Son ❑ Daughter		_____ / _____ / _____
❑ Son ❑ Daughter		_____ / _____ / _____
❑ Son ❑ Daughter		_____ / _____ / _____

4. Authorization: (The following authorization section must be signed by the employee applying for coverage.)

I understand that my employer is applying for membership in the Supplemental Vision Benefit Employer Trust ("Trust") and I am simultaneously applying for insurance for which I am now or may be eligible for under the provisions of the Vision Benefit Plan issued to that Trust by Vision Service Plan. I understand that my insurance will not be in force until the application is approved by Vision Service Plan ("VSP") or their authorized Administrator in accordance with the underwriting guidelines in effect. I understand that acceptance of the check submitted with the application does not constitute approval or guarantee of coverage.

I understand that some of the contracts Warner Pacific Insurance Services, Inc. ("Warner Pacific") holds with insurance carriers allow incentives, bonuses and excess surplus compensation ("compensation"). In the sole and exclusive discretion of Warner Pacific, such compensation may be retained by Warner Pacific or paid to other parties. Such compensation will not be returned to you or your dependents. Any vision benefits claims submitted under your policy/certificate will be paid without regard to such compensation.

I agree that all information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. I further authorize my employer to deduct from my earnings the contribution (if any) required to apply toward the cost of this plan.

I understand that my employer's application will determine coverage and that there is no coverage unless and until this application and an application made by my employer have been accepted and approved by Beneficial Administration Company and/or Vision Service Plan.

Even if this application is approved, any misstatements or omissions may result in future claims being denied and the policy being rescinded.
I, the applicant, acknowledge that I have read and understand this application in its entirety.

Signature of Employee: _____ Date: _____

Supplemental Vision Benefit Employer Trust (SVBET)
Underwritten by Vision Service Plan (VSP)

Vision Plan Termination Form

Use this form for notification of terminations of employees/dependents and request for COBRA Election Form (groups of 20 or more) or State Continuation Election Form (groups with 2 to 19 full-time and part-time employees).

Employer Certification

Company Name		**Customer #**	
Name of person completing form	**Signature**	**Date**	**Phone Number** ( ) -
Is your company subject to state continuation or federal continuation of benefits by law? □ State □ Federal			

Employee's Information

Last Name		**First Name**	**Middle Initial**
Social Security Number ___ ___		**Daytime Phone Number** ( )	
Mailing Address	**Apt #**	**City**	**State** **Zip Code**

- **BAC requires the contact information to send State Continuation paperwork, if applicable. The personal information will not be shared in accordance with HIPAA law.**

Terminate coverage for:

Last Name	**First Name**	**Middle Initial**	**Relationship to Employee**
			□ Self □ Spouse/Domestic Partner □ Child
			□ Self □ Spouse/Domestic Partner □ Child
			□ Self □ Spouse/Domestic Partner □ Child

Qualifying Event – check one:
□ Resignation □ Reduction Of Hours □ Child No Longer Eligible □ Death Of Employee □ Medicare Entitlement
□ Divorce/Legal Separation from Employee □ Voluntary Termination
□ Involuntary Termination - Is COBRA an eligible AEI*: □ Yes □ No □ Waived
* AEI – Assistance Eligible Individual who qualifies for COBRA subsidy

Date of Qualifying Event: _____/_____/_____

Mailing Address for terminated member if different from employee's address stated above.

Address	**Apt #**	**City**	**State**	**Zip Code**

To submit this request:
Email to: customerservice@beneficialadmin.com
Fax to: Attn: Administration (949) 724-1603
Mail to: Beneficial Administration, LLC
PO Box 3100
Newport Beach, CA 92658-9027
Phone: (866) 706-2225

PLEASE NOTE: Do not make adjustments on your bill for terminated employees or dependents. When termination of coverage is processed, the adjustment will appear on your bill.

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