network health

AGENT GUIDE

TO UNDERSTANDING OUR PRODUCTS

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INDIVIDUAL AND FAMILY PLAN

ASSURE LEVEL-FUNDED PRODUCT 2-100 EMPLOYEES

SMALL GROUPS 2–50 employees

MID-SIZE GROUPS 51–100 employees

LARGE GROUPS 101+ employees

MEDICARE

1533-13-0302

MEET NETWORK HEALTH

We're a locally based health plan, living in the communities we serve. If you haven't heard of us, we've been in Wisconsin for over 35 years, handling customer service, claims, billing, enrollment and more. With each passing year, our reputation for quality and personal service has grown stronger and stronger.

Because we're not a nationwide health plan, we can offer the flexibility to create custom solutions based on each customer. We process over one million claims a year and have over 120,000 members. We have the experience and capabilities to serve you.

At Your Service

The Network Health customer service team is based in Menasha, WI. We understand the landscape for local businesses and we're familiar with the providers and medical facilities in the area, so customers get personalized service from someone who understands them and their community.

CULTURE

MISSION

Our **mission** at Network Health is to create **healthy** and **strong Wisconsin communities**.

VISION

Network Health will transform our industry by **collaborating** with the **highest-quality health care providers** to deliver **innovative health plan solutions** that provide **exceptional value** to our customers and owners.

BRAND POSITION

We understand health insurance can be complex. As your **partner**, we **promise** to be more than a typical health plan, bringing **value** to our **relationship**.

VALUES

INNOVATION
Bringing **ideas** to **life**

SERVICE EXCELLENCE
Providing **exceptional service** at the **right time**, **right place** and with the **right attitude**

INTEGRITY
Demonstrating **honesty** in **every** action

COLLABORATION
Working as **one team** toward a **common goal**

ACCOUNTABILITY
Honoring and **respecting** the **trust** people place in us

NETWORK HEALTH'S HISTORY

1982

NOVEMBER
Network Health Plan (first known as Nicolet Health Plan) is incorporated by the Physicians of Nicolet Clinic as a group Health Maintenance Organization (HMO).

1983

APRIL
Nicolet Health Plan becomes operational. Nicolet Clinic was the plan's first group customer.

1986

MAY
Nicolet Health Plan becomes Network Health Plan.

1991

SEPTEMBER
The new management team for Network Health Plan is established, overseeing the member services, Management Information System (MIS), claims processing, network development, marketing and health services departments.

1994

MARCH
La Salle Clinic's ownership structure changes as St. Elizabeth Hospital, Wheaton Foundation and La Salle Clinic form Network Health System.

1995

OCTOBER
Network Health Plan receives an amended certificate of authority to operate as an indemnity insurer, allowing it to offer indemnity products including point-of-service plans, preferred provider organization and third-party agreement product lines, as well as a variety of ancillary products.

1998

AUGUST
Network Health System merges with Affinity Health System, which then included La Salle Clinic, St. Elizabeth Hospital and Network Health Plan.

2001

DECEMBER
Network Health Plan receives an amended certificate of authority reverting it to an HMO. Network Health Plan also establishes Network Health Insurance Corporation as a wholly owned subsidiary.

2005

FEBRUARY
Medicare Advantage PPO launch.

2012

FEBRUARY
Ministry Health Care, Inc. becomes the sole sponsor of Affinity Health System.

AUGUST
Individual and Family Plan launch.

2013

APRIL
Ministry Holdings, Inc. is established as a parent company of sister companies Network Health Plan and Network Health Insurance Corporation, and Ascension Health becomes the sole corporate member of Ministry Health Care, Inc.

2014

OCTOBER
MSA Medicare product launch statewide.

NOVEMBER
Froedtert Health purchases 50 percent of Network Health.

2015

APRIL
Commercial service area expansion to southeast Wisconsin.

OCTOBER
Health Insurance Exchange product launch.

2016

OCTOBER
Medicare service area expansion into southeast. Wisconsin Assure Level-Funded product launch.

2018

OCTOBER
Medicare HMO in southeast Wisconsin product launch.

2019

OCTOBER
Family Savings Plan™ launch.

SALES TEAM CONTACTS

SALES MANAGEMENT		
Erin Kelly *VP of Sales and Marketing*	Office: 262-825-9779 Cell: 920-410-1898	**ekelly@networkhealth.com**
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ACCOUNT EXECUTIVES		
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Penny Koehler *Account Executive*	Office: 920-720-1571 Cell: 920-896-2255	**pekoehle@networkhealth.com**
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Brian Vranek *Account Executive*	Office: 262-825-9793 Cell: 414-248-0685	**bvranek@networkhealth.com**
CLIENT MANAGERS, SALES SUPPORT AND SERVICE **Sales Support Specialists Hours: Monday–Friday, 8 a.m. to 5 p.m.**		
Christy Herden *Client Manager*	Office: 262-825-9759 Cell: 414-745-3836	**cherden@networkhealth.com**
Sara Pergolski *Client Manager*	Office: 920-720-1248 Cell: 920-570-9910	**spergols@networkhealth.com**
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Dawn Booth *Sales Advisor*	Office: 800-276-8004	**dbooth@networkhealth.com**
Brooke Braemer *Medicare Sales Specialist*	Office: 800-276-8004	**bbraemer@networkhealth.com**
Kathy Krentz *Sales Advisor*	Office: 800-276-8004	**kakrentz@networkhealth.com**
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Heather Guyette *Sales Coordinator*	Office: 800-276-8004	**hguyette@networkhealth.com**
Kim Hoff *Quoting Specialist*	Office: 800-276-8004	**khoff@networkhealth.com**

AGENT MANAGEMENT		
Jenn Resch *Manager, Enterprise Analytics*	Office: 920-720-1481	**jresch@networkhealth.com**
Sarah Mueller *Agent Management Specialist*	Office: 920-720-1226	**samuelle@networkhealth.com**
Gina Van Straten *Agent Management Specialist*	Office: 920-720-1805	**gvanstra@networkhealth.com**

ADDITIONAL SUPPORT	
Pharmacy Hotline	920-720-1287 or 888-665-1246
Quote Requests and Submissions	**smallgroupquotes@networkhealth.com** **largegroupquotes@networkhealth.com**
Licensing and Appointment	**AgentManagementSpecialists@networkhealth.com**
Sales Call Center	800-983-7587
Sales Support Specialists	800-276-8004 (Sales Call Center open 8 a.m.–5 p.m.)
Sales Fax Number	920-720-1256
Health Care Concierge General Number	800-378-5234 (TTY 800-947-3529)
Application Fax Numbers	920-720-1931, 920-720-1932 or 920-720-1933
Commission Questions	Please contact the Agent Management Specialists
For Contracting Changes *(Errors and omissions, contact info, agency change, etc.)*	Please contact the Agent Management Specialists

DEPARTMENT CONTACTS

ENROLLMENT SERVICES	CUSTOMER SERVICE	SALES AND SERVICE
Phone: 920-720-1350 Toll Free: 877-549-8793 Fax: 920-720-1904	Phone: 920-720-1300 Toll Free: 800-826-0940 Fax: 920-720-1909	Phone: 920-720-1250 Toll Free: 800-276-8004 Fax: 920-720-1256
Questions regarding. . . Subscriber eligibility • Out-of-service area • Addition of new members • Effective dates • Reinstatement issues • Term questions Name changes Address changes ID cards New member packets Billing Electronic funds transfer (EFT)	**Questions regarding. . .** Benefits Coordination of benefits PCP changes Claims questions Duplicate ID cards Duplicate member packets Out-of-area coverage Term dates Subscriber address changes **INDIVIDUAL PLAN CUSTOMER SERVICE** Toll Free: 855-275-1400	**Questions regarding. . .** Group and Individual supplies • Enrollment forms • Change forms • Enrollment packets Administrative materials • Summary Plan Description (SPD) • Summary Benefit Coverage (SBC) • Health service policies • Certificate of coverage • Renewals Agent licensing

LOCATIONS

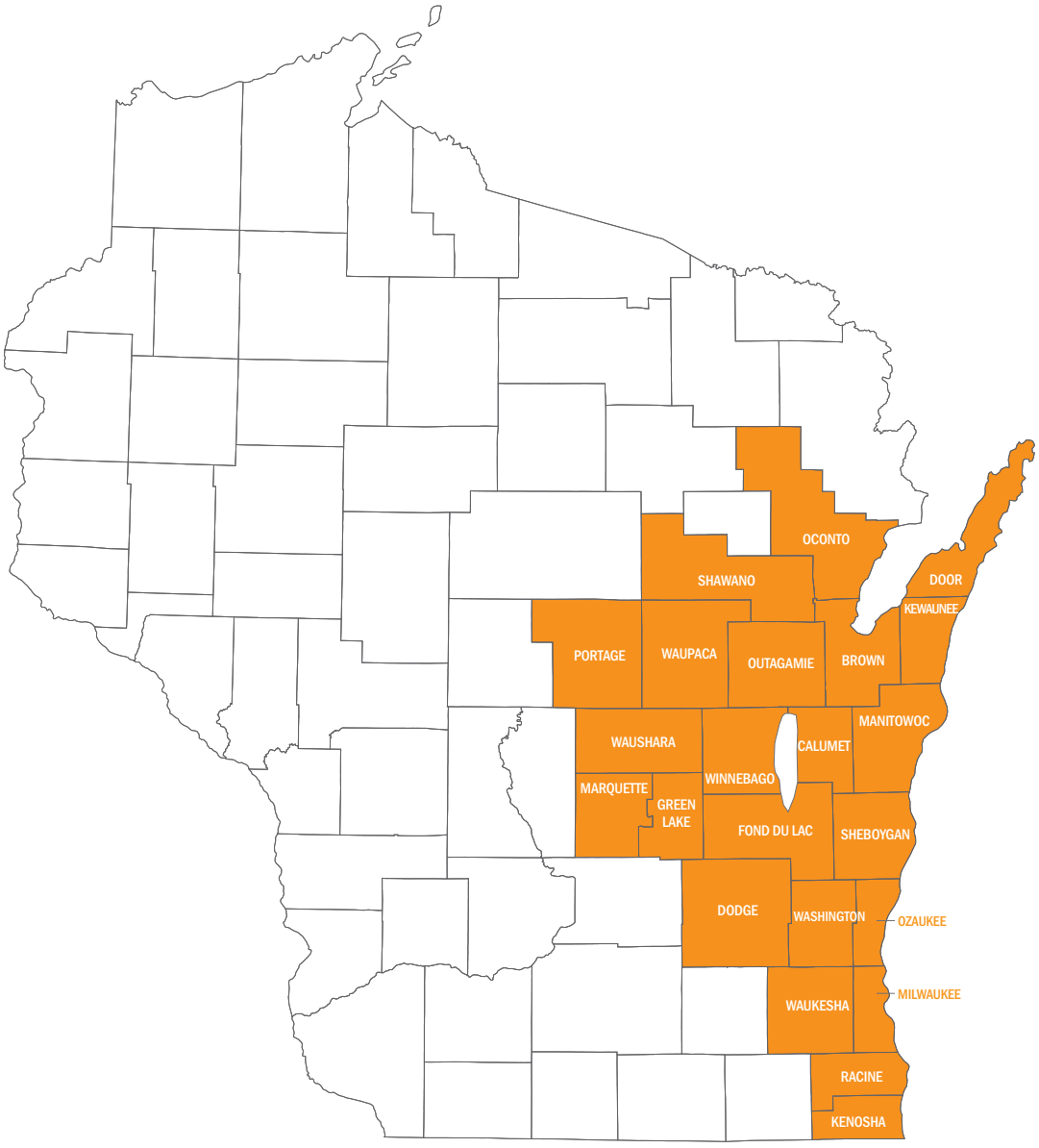
1570 Midway Place, Menasha

16960 W. Greenfield Ave., Suite 5, Brookfield

NETWORK HEALTH'S SERVICE AREA

COUNTIES

- Brown
- Calumet
- Dodge
- Door
- Fond du Lac
- Green Lake
- Kenosha
- Kewaunee
- Manitowoc
- Marquette
- Milwaukee
- Oconto
- Outagamie
- Ozaukee
- Portage
- Racine
- Shawano
- Sheboygan
- Washington
- Waukesha
- Waupaca
- Waushara
- Winnebago



AGENT LICENSING

Network Health strives to establish long-term relationships with our agents. We require new agents to participate in education and training to be appointed by Network Health. We require all agents to participate in training to stay updated on Network Health's current benefits, policies and procedures.

To comply with Wisconsin Administrative Code Ins. 6.57 "Listing of Insurance Agents by Insurers," Network Health will require verification of licensure and OCI listing of all agents. Verification of licensure and OCI listings must be completed before Network Health accepts business from an agent. Network Health requires agents to comply with all state and federal regulations. For appointment with Network Health, an agent must agree to abide by the terms of Network Health's Agent Contract.

Please contact agent management at 800-276-8004 or email **AgentManagementSpecialists@networkhealth.com**.

COMMISSIONS

Commercial New Business and Renewal Commission Schedules

This new business and renewal commission schedule details the terms and conditions under which Network Health will compensate agents for commercial business services (individual and group) as defined under the Group Marketing Agent and Agency Agreement. Unless otherwise specified in this attachment, all terms have the identical meaning as in the Group Marketing Agent and Agency Agreement.

Individual Policies

Commission will be based on the paid premium according to the following schedule.

Policy Year	Commission
1	$18 Per Member Per Month (PMPM)
Renewal Years	$18 Per Member Per Month (PMPM)

- **Frequency of commission payment**
  - Members may pay monthly, quarterly, semi-annually or annually. *(NOTE: monthly payment requires automatic bank withdrawal or credit card.)*
  - Commissions will be paid following receipt of premium payment from the insured. If a member pays quarterly, semi-annually or annually, commissions will be paid monthly as they are earned.

Group Policies

Commission will be paid on a per-subscriber (or employee), per-month basis according to the following schedule.

Employer Plan Type	Number of Subscribers in Month	Monthly Commission Rate
Fully Insured	1–3	$10 PEPM
	Next 4–50	$25 PEPM
	Next 51 +	$28 PEPM
Assure Level-Funded (Beginning May 1, 2019)	2-100 enrolled	$60 PEPM for new groups, $45 PEPM for renewals

1) The commission for any month is calculated by the applicable monthly commission rate for the group, multiplied by the number of subscribers. The calculation is based on subscribers, and summed using a next methodology on enrolled subscribers.
2) All commission payments are based on billed premium for each group. Payments for terminated employees or groups and retroactive enrollments will be deducted from or added to future commission payments.
3) This commission schedule will be superseded by an agreement between an employer group and broker which specifies a different commission payment.

Medicare Commission Schedule Effective January 1, 2020

Medicare Policies

For business sold in 2020, the Renewal Commission rate will be based on a per-member, per-month basis according to the schedule on right. Initial rate is paid when CMS determines the member is brand new to Medicare and notifies Network Health through electronic files.

Type of Agent Commission	Rate
Initial – one time annual payment	$510
Renewal – monthly	$21.25

Renewal commissions will be considered for continuation in accordance with CMS Guidance. In order to be eligible for initial and renewal commissions all agents must attend four agent training meetings annually (September-August), go through yearly certifications, meet ride along requirement and follow all Medicare Marketing Guidelines. Member disenrollment within the first six months of enrollment will result in full chargeback of commissions paid. Per CMS guidelines, all business will be paid at the renewal rate unless it is determined that the contract is for an Initial Election Period or if the plan is notified by CMS reports that this is not a renewal.

WELLNESS PROGRAMS

At Network Health, we prioritize the health of our members. Our workplace wellness programs help employers reward their employees for making healthy choices.

- Small groups with 2 to 50 total employees, may choose to participate in the **Strive** wellness program.
- Larger employers have the opportunity to participate in **Millennium**.

STRIVE

Strive is a wellness program for small group plans with 2 to 50 total employees and for companies with 2 to 100 enrolled employees who are insured through the Assure level-funded plan. Strive rewards members and their spouses for participating in healthy activities and maintaining healthy lifestyles.

- Up to $250 in rewards
- WebMD® Health Assessment
- Fitbit® Inspire tracker (one per member per lifetime)
- High-risk telephonic coaching
- Wellness support through a call center

MILLENNIUM

Millennium is the wellness program available for purchase by large groups that have at least 51 or more total employees. There are two different Millennium options, which are detailed below.

Millennium Eclipse

For companies with 51 or more total employees.

Eclipse is designed for the employer who wants to completely integrate a wellness solution into the company culture. Eclipse offers employers wellness rewards based on program outcomes and offers strategies that help employers reduce employee health risks and motivates employees to make healthier lifestyle choices.

Millennium Essential

For traditional self-insured companies.

Millennium Essential is for employers who are looking for a more flexible approach to building a culture of health and wellness. Employers can choose which reward level to offer, and pay each month only for rewards that are earned. Employers receive advice and guidance about reducing existing employee health risks and about how to motivate employees to make healthier lifestyle choices.

MILLENNIUM	Millennium Eclipse (51 or more total employees)	Millennium Essential (Self-insured)
Services for Enrolled Employees and Spouses • Health screenings at the workplace • Online health assessment • Online lifestyle improvement programs and tools • Millennium member website • Online wellness educational programs • Health coaching via telephone for high-risk participants • Pedometer with data upload capability • Confidential health management services for participants with high-risk chronic conditions	Included	Included
Services for the Employer • Wellness specialist to provide wellness consulting services and program coordination • Program reporting that integrates claims data, predictive modeling and information interpretation • Targeted intervention planning assistance	Included	Included
Integrated rewards program with flexible incentives including gift cards and merchandise, payroll contribution, premium discounts, HSA or HRA contributions	Included	N/A
Annual reward up to $250 value per participant	Included	N/A
Pay as you go rewards	N/A	Included
Health coaching via telephone for low and/or moderate risk participants	Included	Included
Health assessment, screenings and/or rewards for employees who are not covered under the employer's health plan	Included	Included
Onsite health coach for assistance with individual goal setting and interpretation of health assessment results	Included	Included

INDIVIDUAL AND FAMILY PLAN PRODUCTS

ACA-COMPLIANT PLANS

Network Health offers a variety of individual and family plans. Plans are available on the health insurance exchange (known as the Marketplace) and directly through Network Health. Shoppers may be eligible for a subsidy from the government when purchasing a plan on the Marketplace.

Please click here to see the available plans.

ELIGIBILITY

Dependent Eligibility Requirements
Eligible dependents are a spouse, natural child, stepchild, legally adopted child or a child for whom the applicant or spouse has been appointed legal guardian, pursuant to a valid court order.

Spouse – Legally married, residing in the state of Wisconsin and within the service area.

Children – A child not residing with the primary applicant must still reside in Wisconsin and within the service area. A child who is an out-of-state student is eligible for coverage provided their state of residency remains Wisconsin. It should be noted that for all products only emergency benefits are covered outside the Network Health service area.

Dependent children under age 26 may be covered as an eligible dependent. Addition of a newborn grandchild (of covered child under age 18), within 60 days of the birth, is guaranteed issue. The effective date of coverage is the date of birth of the child.

CHILD(REN) - ONLY POLICIES

Under the Affordable Care Act (ACA) children under the age of 19 may enroll for coverage without a parent or guardian.

RESIDENCY REQUIREMENTS

The address of the applicant's primary residence must be in the state of Wisconsin and within the Network Health geographical service area for 12 months of the year. A residence address must be provided on the application. A P.O. Box number will not count as a residence address, although it may be used for the mailing address.

A full-time student, attending a college/university outside the service area, is eligible to apply as a dependent on his or her parent's policy, assuming the residency requirement is met by the parent and the child's state of residency remains Wisconsin and within the service area.

CITIZENSHIP STATUS

Policies with effective dates of January 1, 2014, and beyond
Most people in the following groups are eligible for coverage:

- U.S. Citizens
- Lawfully present immigrants

Find out more about other eligibility requirements by contacting us at 844-635-1322.
Refer to the policy language for policies with effective dates prior to January 1, 2014.

SOCIAL SECURITY NUMBER REQUIREMENT

Social Security numbers are required for all applicants, including dependents, if they have one. It is extremely important that only a valid Social Security number be provided on the application. If the primary applicant or dependent(s) does not have, or has not applied for, a Social Security number, an explanation should be provided upon submission of the application.

TOBACCO USE

An adult applicant who has used tobacco products in any form (cigarettes, cigars, pipes, snuff, chewing tobacco or other) four or more times a week within the past six months will be assigned tobacco-user rates (excludes religious or ceremonial use of tobacco).

APPLICANTS NOT ELIGIBLE TO APPLY

The following indicates situations in which an applicant would not be eligible for coverage, that have not been captured elsewhere.

- Currently receiving Medicare
- Currently incarcerated

HOW TO OBTAIN A QUOTE

Please go to networkhealth.com to obtain a quote during open enrollment or if your client has a qualifying event outside of open enrollment. Network Health's quoting portal allows you to easily obtain a quote in either of these situations. On networkhealth.com, click **Individual and Family Plans**, **Get a Quote** or **Enroll**.

APPLICATION/ENROLLMENT

COMPLETION OF THE APPLICATION

The following information will be needed to complete the application.

- Date of birth for all persons applying for coverage
- Social Security numbers for all persons applying for coverage who have them, including dependents
- Complete primary resident address (P.O. Box is not acceptable), including dependent children living elsewhere (parents must reside in Wisconsin and in the service area). See Residency Requirements.
- Email addresses for each applicant, if available
- Tobacco usage (tobacco use includes chewing tobacco, cigarettes, cigars, e-cigarettes, vaping, snuff, etc.)

ENROLLMENT

An application is valid for 60 days from the original signature date of the application.

For coverage during open enrollment November 1–December 15.

- The effective date of coverage will be January 1 if you select coverage between November 1–December 15.

Special Enrollment Periods

An individual may enroll themselves or a dependent during a 60-day special enrollment period if they have a qualifying event.

Qualifying events include the following.

- Birth, adoption, placement for adoption or placement in foster care
- Marriage or loss of minimum essential coverage
- The individual gains status as a citizen, national or as a person who is lawfully present
- An individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent or erroneous and is the result of the error, misrepresentation or inaction of an officer, employee or agent of the Health Insurance Marketplace or HHS as determined by the Health Insurance Marketplace. In such cases, the Health Insurance Marketplace may take action necessary to correct or eliminate the effects of such error, misrepresentation or inaction.
- An individual demonstrates to the Health Insurance Marketplace that the qualified health plan in which he/she was enrolled substantially violated a material provision in its contract
- The individual becomes newly eligible or ineligible for the advance payment tax credits through the Health Insurance Marketplace or has a change in eligibility for cost-sharing reductions. This is subject to certain requirements and limitations.
- The individual or his/her dependent, gains access to new health insurance coverage as a result of a permanent move
- The individual or his/her dependent, demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by the Department of Health and Human Services, that the individual or his/her dependent, meets other exceptional circumstances as the Health Insurance Marketplace may provide.

Their effective date of coverage will be:

Life Event	SEP Window	Effective Date (subject to change)
Birth or Adoption	60 days from event	Date of Birth or Adoption
Marriage	60 days from event	1st of the following month from application submission
Loss of employer sponsored health insurance, as a result of • Termination of employment • Employer reduces work hours to the point where no longer covered by the health plan • Employer's plan decides it will no longer offer coverage to a certain group of individuals (for example, those who work part time) • Termination of employer contributions	60 days from event	1st of the following month from application submission
Loss of coverage for a dependent child who has reached the dependent limiting age	60 days from event	1st of the following month from application submission
Exhaustion of COBRA	60 days from event	1st of the following month from application submission
Loss of eligibility for Medicaid or CHIP	60 days from event	1st of the following month from application submission
Divorcée/Legal Separation	60 days from event	1st of the following month from application submission
Loss of retiree coverage due to former employer filing for bankruptcy protection	60 days from event	1st of the following month from application submission
Death of the policyholder	60 days from event	1st of the following month from application submission
Incur a claim that meets or exceeds a lifetime limit on all benefits under existing coverage	60 days from event	1st of the following month from application submission
Gaining status as a citizen, national or lawfully present individual	60 days from event	1st of the following month from application submission
No longer incarcerated	60 days from event	1st of the following month from application submission
Loss of coverage due to a permanent move outside of the plan's service area	60 days from event	- If application is submitted between the 1st and the 15th of the month effective date=1st of the following month - If application is submitted between the 16th and the end of the month effective date=1st of the subsequent month
Plan is due for renewal outside of open enrollment	30 days from event	1st of the following month from application submission

OTHER MEDICAL INSURANCE

If the applicant has existing medical coverage at the time of his or her application with Network Health, he or she will be asked to provide the name of the other carrier, the names of the individuals covered under the policy, and the coverage dates if coverage is with Network Health. The applicant will also be asked if he or she plans to keep the current coverage if accepted for the Network Health plan (this does not include limited plans such as Hospital Cash, Daily Benefit, Critical Illness, Cancer Insurance, Specified Disease, etc.). This information will be used to coordinate benefits between medical insurance carriers.

REPLACEMENT OF EXISTING INSURANCE

The applicant should be advised not to cancel his or her current coverage until notified of enrollment by Network Health.

RIGHT TO RETURN POLICY / NOT-TAKEN POLICIES

If the member is not satisfied with the policy for any reason within 10 days following the receipt of the policy, the member may return the policy to Network Health. Network Health will refund to the member all premiums paid for the first month of coverage, less any claims paid. Coverage will be terminated as of the effective date and claims will not be eligible for payment.

PAYMENT OF PREMIUMS

Premiums for the Network Health policy are the full responsibility of the applicant/member. An employer may not contribute any portion of the premium for individual coverage; therefore, a business check for payment of premium is not acceptable. The only exception to this is a small business owner purchasing coverage for self/family. In this situation, payment from the applicant's business account is acceptable; subject to completion of the Declaration of Employer Status form.

An initial premium is required. The applicant can select to pay via automatic bank withdrawal, credit card or check. The applicant's check will be deposited or bank account/credit card will be debited the appropriate premium once the applicant(s) has been approved. To help ensure a smoother premium payment, please include Subscriber number on the check so we are able to match the check correctly.

For subsequent payments, the applicant must select automatic bank withdrawal, credit/debit card payment or direct mail billing. Monthly, quarterly, semi-annual and annual payments are available through automatic bank withdrawal and credit/debit card options. Automatic bank withdrawals and credit/debit payments will be processed on the first, fifteenth or twenty-fifth of the month, to coincide with the original policy effective date. Quarterly, semi-annual and annual payment options are available with the direct mail billing (monthly payment option is not available for direct mail billing).

- Premium payment information for the first premium payment (not deducted until the application is approved), as well as ongoing premium payments. Credit card information and/or bank account information including the name, address and phone number of the bank, as well as the bank account number and ABA routing number located on check and deposit slips. See Payment of Premiums.
- The check option is only available for initial payment and on-going payments quarterly, semi-annual or annual payments
  - Automatic bank withdrawal – bank account information (including the name, address and phone number of the bank) and bank routing number located on check and deposit slips
  - Credit card – name on the credit card, type of card (Visa or MasterCard), credit card number and expiration date.
  - Premium payment information for the first premium payment (not deducted until the application is approved), as well as ongoing premium payments. Credit card information and/or bank account information including the name, address and phone number of the bank, as well as the bank account number and ABA routing number located on check and deposit slips. See Payment of Premiums.

PAYMENT/BILLING SCHEDULE INFORMATION

ACH

- Initiated on the twentieth of each month, allow two to three business days to see the payment pull from the bank account. If the twentieth falls on a weekend or holiday, the premium drafts the next business day

Statements
- Mailed between the tenth and twelfth of each month and due the last day of the month

Recurring credit card payments
- Taken out on the twenty-fifth of each month for the upcoming month (For example, a payment is taken out on January 25 to cover the February premium)

Recurring payments (ACH and credit card) automatically pull the entire balance due on the account
- If the previous month's premium payment is declined, the next month two months of premium are pulled

MEMBER MATERIALS

Each Network Health member will receive a mailing including the two items listed below.

- **Network Health ID cards**
- **How to Use Your Health Plan Guide**

Additional information is available through the member portal at **login.networkhealth.com**. This is detailed in the How to Use Your Health Plan Guide.

RENEWALS

INDIVIDUAL RENEWALS

Individuals will receive a renewal notice via mail from Network Health at least 60 days before the renewal date. Agents have the ability to view the renewal online through the Network Health agent portal and view alternate plans.

RENEWING CURRENT OR ALTERNATE PLAN(S)

Renewal acceptance and enrollment changes can be made on the Agent portal. When renewal acceptance and enrollment changes are received by the 6th of the month prior to the renewal, Network Health is able to process the renewal timely.

If Network Health is not notified of any changes at renewal, the renewal plan with the adjusted rates will automatically renew as of the renewal date.

BUY DOWN IN BENEFITS OFF RENEWAL

Individuals are allowed to buy down their benefit plans upon renewal.

CHANGES TO AN EXISTING CONTRACT

The following chart outlines the requirements for making a change to the contract after issue.

Change	Action
Addition of an adopted child or a court-ordered legal guardianship	Addition of an adopted child, within 60 days of placement, is allowed as a guaranteed issue. The effective date of coverage is the date the child is legally placed for adoption. Written notification and a copy of the adoption agreement and/or proof of legal placement is required. Addition within 60 days of the issuance of a court order assigning permanent legal guardianship is guaranteed issue. The effective date of coverage is the date the child is legally placed with the guardian. Proof of legal court ordered Guardianship Papers are required.

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Change	Action
Addition of a newborn	Addition of a newborn, within 60 days of the birth, is guaranteed issue. The effective date of coverage is the date of birth of the child. Addition of a newborn within the first six months of the policy effective date will be fully investigated. Written notification is required. Also, guaranteed issue is the adding of a newborn child within one year after birth, subject to payment of all required past-due premiums plus interest on such premium payments at the rate of 5.5 percent per year. The effective date for such family coverage will be the date of that child's birth. Addition of a newborn grandchild (of covered child under age 18), within 60 days of the birth, is guaranteed issue. The effective date of coverage is the date of birth of the child.
Addition of a dependent child(ren)	A dependent child, under age 19, other than a newborn, newly adopted child or court ordered legal guardianship within 60 days of birth/placement, may apply as an add-on during open enrollment on an ACA-compliant metal plan, or with underwriting approval on a pre-ACA plan.
Addition of a spouse	Addition of a spouse requires a fully completed application and may only be done during open enrollment on an ACA-compliant metal plan, or with underwriting approval on a pre-ACA plan
Address change	A policyholder change of address may be submitted any time after policy issue by contacting customer service or by submitting a written request. The new address must be in Wisconsin in the service area. If the address change is within the same county, the rates will not be affected. However, if the address is in a different county, the applicable rates will apply. Coverage of a policyholder who no longer resides in Wisconsin or in the service area will be terminated.
Plan deductible changes, addition of benefits and other plan changes	Pre-ACA policies are able to change to another plan within the same product (HMO, POS or HDHP). New plans cannot be added to Pre-ACA policies. ACA policies are able to change plans upon renewal.
Removal of tobacco rating	A request may be made if the policyholder has discontinued all tobacco products, including medication for smoking cessation, for a minimum of six consecutive months. A signed statement from the policyholder, to this effect, accompanied with proof of a current negative urine cotinine test (at the policyholder's expense), submitted to Network Health, is required.
Transfer of coverage	If a currently insured dependent child becomes ineligible for coverage under a parent's plan due to age, or, if a currently insured dependent spouse becomes ineligible as a result of the primary insured's death or divorce, coverage may be transferred to their own policy, provided Network Health is notified within 60 days. The same plan benefits as the prior coverage, or a downgrade of benefits, if desired, will apply.

ASSURE LEVEL-FUNDED

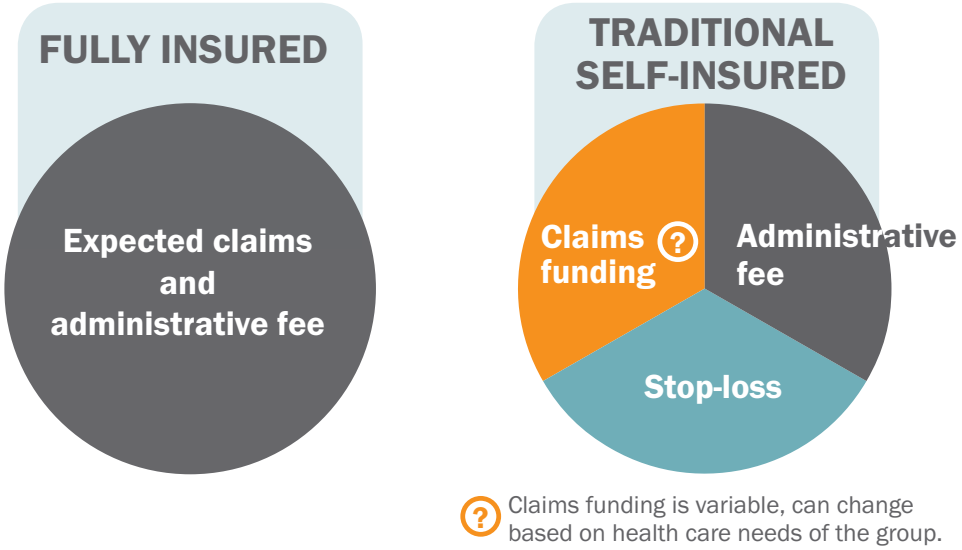
2–100 Total Enrolled Employees

PRODUCT DESCRIPTION

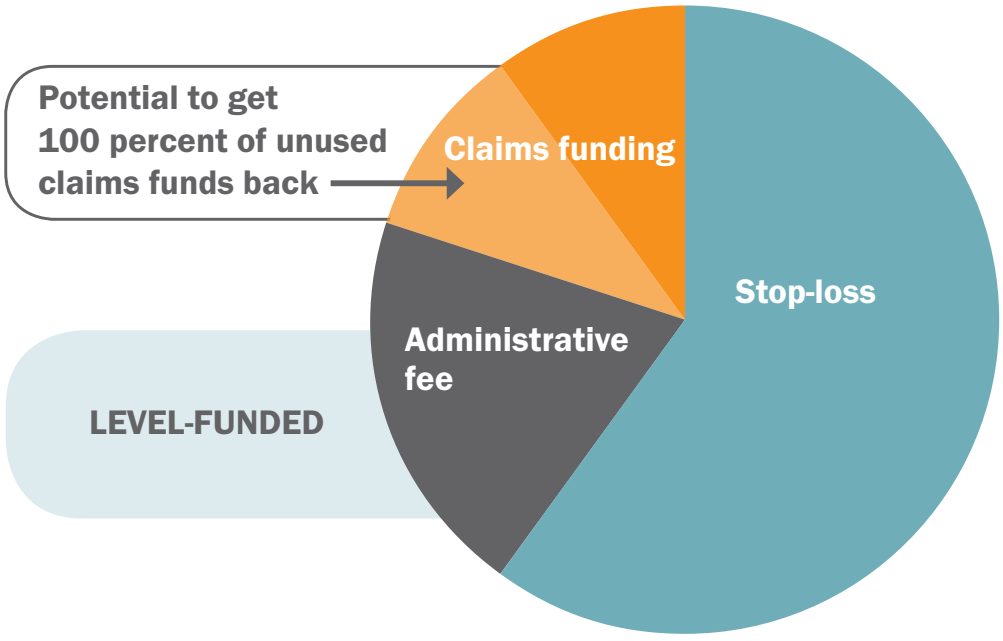
Our Assure level-funded plan is a hybrid of a traditional self-insured plan and a fully insured plan. The group funds the health plan and Network Health Administrative Services (NHAS) administers the plan. Employer groups can enjoy all the benefits of a fully insured product (health management, wellness program, network discounts and online tools) but limited financial risk with stop-loss coverage.

ADVANTAGE OF LEVEL FUNDING

The maximum liability is the same, but with a level-funded plan, there is an opportunity for a potential 100 percent refund to the employer group at the end of the contract year.



? Claims funding is variable, can change based on health care needs of the group.



PRESCRIPTION DRUG COVERAGE

Prescription drug coverage is provided through Express Scripts, Inc. Network Health's base pharmacy plans are five-tier copayment programs providing up to a 30-day supply of covered prescriptions. Network Health uses a preferred drug list, and copayments are determined by the drug tier on this list. Prescriptions are classified as preferred generic, preferred brand, non-preferred brand, preferred specialty and non-preferred specialty. Participants have the added benefit of a mail order program for maintenance medications. The mail order program provides up to a 90-day supply of medications at a reduced copayment for preferred drugs.

View Network Health's Preferred Drug List at
https://networkhealth.com/look-up-medications

PRIOR CARRIER DEDUCTIBLE CREDIT FOR PREVIOUSLY ENROLLED EMPLOYEES ONLY

Groups have a calendar year deductible. Groups start fulfilling their deductible on their effective date. Information on prior carrier deductible credit for previously enrolled employees must be submitted to Network Health within 90 days of the group's effective date in order to receive credit.

- Either a deductible report from the previous insurer; or
- Individual Explanation of Benefits (EOB)

OUT-OF-AREA COVERAGE

It can be challenging to find health coverage for all of a group's employees if there are employees who reside outside our service area. Network Health offers Network Extend for these situations, which requires underwriting review for participation.

A group can choose Network Health's local plans to cover those employees residing in the Network Health service area, and then select Network Extend to allow out-of-area employees to use health care providers in their area at an in-network benefit level. This allows the group to use health care dollars effectively, while not sacrificing service.

To qualify for Network Extend, the business must have the following.

- Employer is applying for the Assure product
- A minimum of 80 percent of enrolled employees must reside in Network Health's service area
- A minimum of 90 percent of enrolled employees must reside in Wisconsin
- A maximum of 5 percent of enrolled employees may reside in a single state other than Wisconsin
- Network Extend is available for POS and EPO (Exclusive Provider Organization) plans

If you would like additional information on either of these options, please contact the Network Health Sales Department at 800-276-8004.

ELIGIBILITY

GROUP ELIGIBILITY

Network Health benefit plans are available to employer groups that meet the following requirements.

- Located within our service area
- May have no more than 20 percent of the enrolled employees living outside the Network Health service area
- Group operates as a legal entity, including as a proprietorship, partnership or corporation
- Group has a visible and legal employer/employee relationship with its employees
- Groups with 1099 contracted employees are generally ineligible
- Group may be ERISA (private employers, non-profit agencies, or schools) or Non-ERISA groups (municipalities and church plans)

24-HOUR COVERAGE

The only participants who can have 24-hour coverage are participants who can legally opt out of workers' compensation, such as owners.

PARTICIPANT ELIGIBILITY

Eligible employees include all permanent, non-seasonal employees working an average of 30 or more hours per week. Groups may extend an offer for health plan coverage to permanent, non-seasonal employees working not less than 20 hours per week with approval of Network Health.

DEPENDENT ELIGIBILITY

Eligible dependents include the employee's lawful spouse and children up to age 26. Children are defined as the employee's biological child, stepchild, lawfully adopted child or a child for whom the employee is a legal guardian.

EARLY RETIREE ELIGIBILITY

Early retiree coverage is available for Assure groups that have between 50-100 enrolled employees. This is based on employer class selection and retired employees may remain on the plan up to age 65.

WAITING PERIODS FOR NEW HIRES

Employers may choose a probationary or waiting period for their newly hired employees, which may not exceed a period longer than 90 days. Effective dates for timely enrollees will be administered as indicated on the Employer Group Application. Changes to waiting periods can be made at the time of a group's renewal and are to be applicable to all employees within the group.

LATE ENROLLMENT

A late enrollee is defined as an eligible employee and/or dependent who wishes to enroll more than 31 days after their eligibility period and is not eligible under a special enrollment period. This would include those who waive coverage initially and wish to enroll in the plan at a later date.

Eligible employees who didn't previously enroll in the plan will be able to enroll themselves and their eligible dependents for coverage during the annual open enrollment period.

SPECIAL ENROLLMENT

This plan provides special enrollment rights to eligible employees and dependents in the following situations.

- Loss of coverage (except under Medicaid or a State Children's Health Insurance Program)
- Change in family status
- Loss of eligibility under Medicaid or state children's health insurance program
- Eligibility for state premium assistance

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If an employee properly applies for coverage during this special enrollment period as described above, the coverage will become effective as follows.

- In the case of marriage, no later than the first of the month following the marriage date or actual marriage date
- In the case of a dependent's birth, on the date of such birth
- In the case of a dependent's adoption, the date of adoption or placement for adoption
- In the case of eligibility for premium assistance under a State's Medicaid plan or State's Children's Health Insurance Program, on the date the approved request for coverage is received
- In the case of loss of coverage, on the date following loss of coverage

FIDUCIARY LIABILITY LANGUAGE

As an agent it is important you understand the background of Fiduciary Liability and how to effectively communicate the importance of it to potential customers. Below is information that explains Fiduciary Liability and provides background to help you answer potential questions.

- Under the Employee Retirement Income Security Act of 1974 (ERISA), fiduciaries can be held personally liable for losses to a benefit plan incurred as a result of their alleged errors, omissions or breach of their fiduciary duties.
- Governmental entities and church plans are not subject to ERISA. These Non-ERISA groups receive SPDs that are compliant to their unique requirements ERISA is a federal law that sets minimum standards for employee benefit plans. ERISA regulates not just retirement plans, but virtually all employer plans that provide employee benefits, including health, life, profit sharing, disability and employee leave. ERISA includes standards of conduct for those who manage an employee benefit plan and its assets. They are called "fiduciaries."
- Under ERISA, a fiduciary is a person who exercises any discretionary authority or control over management of the plan or management or disposition of plan assets. A plan must have at least one fiduciary (a person or entity) named in the written plan, or through a process described in the plan, as having control over the plan's operation and assets.

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- Under ERISA Section 409, both employers (the plan sponsors) and outside providers hired in a fiduciary capacity (such as Network Health, as the third-party administrator) are potentially exposed to significant liabilities. If a plan is not managed properly and/or benefits are lost because employees were not given adequate information or instruction, fiduciaries can be held "personally liable" to "make good" on any losses for which they are responsible.
- Fiduciary liability insurance is the proper insurance that can protect against this liability. There are several ways to get fiduciary liability coverage. A company can purchase a policy directly. Similar coverage may also be established using directors and officers (D&O) liability, commercial general liability (CGL), or trust E&O/professional liability policies as long as those policies have attached an endorsement specifically tailored to cover fiduciary liabilities.

THE PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE

The Patient-Centered Outcomes Research Institute (PCORI) is an independent, non-profit, nongovernmental organization authorized by Congress to provide responsible information for patients, their families and clinicians for health treatment and health care options.

To help fund PCORI, fees are paid annually by plan sponsors (employers). As a self-insured employer group and the plan sponsor, the group is responsible for filing these fees annually. If a group has any questions about what they need to do to pay these fees, we recommend them following up with their tax advisor.

Governmental entities and church plans are not subject to ERISA. However, these non-ERISA groups maintain fiduciary responsibilities as the plan sponsor.

HOW TO OBTAIN A QUOTE

Submit the information listed below to largegroupquotes@networkhealth.com, using a secure email.
You can also mail the forms to: **Network Health**
Attn: Underwriting
1570 Midway Place
Menasha, WI 54952

Questions? Contact the sales and service team at 800-276-8004.

GUIDELINES FOR ASSURE QUICK QUOTE SUBMISSION

With the following information, Network Health will provide an Assure quick quote for groups with 2–100 enrolled employees.

- Group name, county and zip code
- Requested effective date
- Requested benefit plans (optional)
- Agent and agency
- Census – make sure to include the employee's date of birth or age, gender and type of coverage such as E, E/S, E/C, FAM (a quick quote census template is available in the agent portal on our website)

GUIDELINES FOR ASSURE PROPOSAL SUBMISSION

With the following information, Network Health will provide an Assure Proposal for groups with 2–100 enrolled employees.

- Group name, county and zip code
- Requested effective date
- Requested benefit plans
- Agent and agency
- Assure enrollment forms for all full-time employees, including waivers
- Current quarterly Wage and Tax report with employee status marked
- Prior carrier most recent monthly bill
- Census – make sure to include the employee's date of birth or age, gender and type of coverage such as E, E/S, E/C, FAM (a proposal census template is available in the agent portal on our website)
- Completed eligibility certification form listing any eligible applicants or waivers who do not appear on the most recent wage and tax report

*NOTE: If an employer is a newly established company, and **has not yet filed** a UCT State Quarterly Unemployment Compensation Report, Network Health will require the following.*

- All eligible employees must be listed on the eligibility certification form
- The employer must provide Articles of Incorporation

NOTE: Any material misstatement pertaining to health history may result in rates being re-evaluated and adjusted.

FINAL PROPOSALS FOR MIDSIZE ASSURE GROUPS WITH RAPID UNDERWRITING

Network Health can offer final proposals to midsize Assure groups with 51-100 people enrolled using risk score in place of applications. To determine the risk score, we need this information.

- Full member census – including legal first and last name, zip code, date of birth, gender and type of coverage (whether the individual is an employee or dependent)
- Employer name, address and requested effective date
- Copy of prior carrier bill
- Copy of renewal
- SIC Code

Network Health reserves the right to request applications if we determine they are required for a certain situation. Once the group is sold, we need wage and tax form, enrollment applications, employer application, waivers and premium payment. If final enrollment changes by +/- 10 percent, Network Health reserves the right to rerate the group.

PARTICIPATION REQUIREMENTS

Groups must have at least 70 percent of eligible employees covered for health coverage, excluding those who waive for other coverage. If the group fails to meet this requirement, they will not be offered this product. Groups that fall below the minimum group size or do not meet participation requirements are not longer eligible for coverage. TPA, at its sole option, may provide notice allowing for 30 days for the group to cure the deficiency by either 1) meeting the minimum group size or 2) meeting participation requirements. Not meeting minimum group size or participation requirements may result in termination of coverage at the end of the 30-day notice.

APPLICATION/ENROLLMENT

ITEMS NEEDED TO ISSUE A GROUP

Incomplete submissions may delay processing of a group's application and the participant ID cards. To ensure timely delivery of participant materials, Network Health requests receipt of final acceptance by the 20th of the month before the requested effective date.

- Completed Assure Group Application (available under Assure Forms and Resources)
- Signed rate sheet page
- Signed terms and conditions page
- Plan elections, if multiple plans
- First month's premium or Assure ACH Form (available under Assure Forms and Resources)
- Financial forms to include the following
  - W-9
  - Articles of Incorporation

NOTE: Group is limited to four plan options at the time of issue.

Additional documents that will require signature

- Stop Loss Application
- Stop Loss Rate Exhibit
- Stop Loss Policy
- Administrative Services Agreement (ASA)

PAYMENT

Payment is required at time of application, in the form of check or EFT form and voided check. If group elects not to participate in EFT they will be charged a $25 monthly administrative fee. Subsequent payments are due on the 1st of every month. If the group pays by EFT, payments will be withdrawn on the 1st day of each month from the designated checking account. Should the 1st fall on a weekend or Federal Reserve Bank holiday, the payment will be withdrawn on the following business day.

NOTE: If payment is not received timely, all medical and pharmacy claims will be pended until payment is received. The preferred method of payment is EFT.

PAYMENT WHEN ADDING OR TERMING COVERAGE MID MONTH

Aside from the initial effective date, Network Health does not apply daily prorating on calculating individual premiums. We use the "15/16 rule." According to this basic formula, any new enrollment during the first 15 days of the month is billed for the full month. If a new enrollment occurs on or after the 16th of the month, then the premium for that month is wa ived. Likewise, if an employee is terminated within the first 15 days of the month, the premium for that month is waived. If the termination date falls on or after the 16th of the month, the full month of payment is owed.

NETWORK HEALTH TERMINATION OF A GROUP PLAN

Network Health can terminate a group if they do not fund the plan. A group will receive notification if their payment is delinquent or they are below participation requirements. If a group is terminated because they did not fund the plan or failed to meet participation requirements, but they want to continue being enrolled in the Assure plan through Network Health, contact your client manager to discuss options for re-instatement.

PARTICIPANT MATERIALS

Each enrolled employee will be mailed the following materials to their home address.

- Network Health ID cards with medical coverage information and Express Scripts, Inc. pharmacy information
- How to Use Your Health Plan guide which includes information about the member portal where the member can find important health plan documents, like their Member Handbook, including the following.
  - Summary Plan Description (SPD)
  - Summary of Participant Responsibility
  - Prescription Benefit Summary
  - Summary of Benefits and Coverage (SBC)

RENEWALS

GROUP RENEWALS

Agents will receive a renewal notice from Network Health at least 60 days before the renewal date.

RENEWING CURRENT OR ALTERNATE PLAN(S)

Renewal acceptance and enrollment changes can be made by contacting your client manager. When renewal acceptance and enrollment changes are received by the 10th of the month prior to the renewal, Network Health is able to process the renewal timely.

ELIGIBILITY REQUIREMENT CHANGES

Groups are allowed to change eligibility requirements and plans upon renewal. If multiple plans are offered, employees are allowed to change between plan offerings at renewal time without a qualifying event.

ITEMS NEEDED TO RENEW A GROUP

The following documents require a signature to process a group's renewal. If all necessary documents are not completed within 30 days of the date of renewal the offer for administrative services under the Assure plan will be withdrawn.

- Signed renewal rate sheet page
- Signed renewal terms and conditions page
- Stop Loss Application, to include Rate Exhibit
- Administrative Services Agreement (ASA)

BUY DOWN IN BENEFITS OFF RENEWAL

There are some special circumstances that we allow renewals to change mid-year. Please call your client manager for help with these circumstances.

LOCAL CLIENT MANAGEMENT TEAM

We assign our local service team to provide support with a group's client management and administration. Our team works to assist with everything including plan selection and open enrollment preparation. Each group is provided a client manager with first-hand experience in plan implementation, who is available for regular onsite meetings. Think of the client manager as a resource for everything including data analysis, monthly reports, enrollment or any other questions

CHANGES TO AN EXISTING CONTRACT

PLAN AND ELIGIBILITY REQUIREMENT CHANGES

Groups interested in changing their plan offerings or eligibility requirements can do so by contacting their client manager during the renewal period.

EMPLOYEE AND DEPENDENT CHANGES

Administration of the group plan (such as employee additions, terminations or changes) can take place by submitting a

completed “Participant Application and Change Form.”

CONTINUING COVERAGE – COBRA

Network Health has partnered with Employee Benefits Corporation (EBC), a Wisconsin-based company, to administer tax-advantaged benefits and COBRA.

COBRA administration is included as a value-added service for Assure level-funded groups with greater than 20 total employees.

All other groups can purchase EBC COBRA administrative services at competitive rates.
Visit the United States Department of Labor website at **www.dol.gov/ebsa/cobra.html** for details on COBRA.
Visit Wisconsin Department of Health Services website at **www.dhs.wisconsin.gov** for details on state continuation rights.

FORMS AND RESOURCES

Assure Enrollment Application

Eligibility Certification Form

Change Healthcare

Assure Group Application

Assure ACH Form

Express Scripts, Inc., Mobile Application Download

Preferred Drug List

MDLive®

SMALL GROUPS

2-50 Total Employees on Quarterly Wage and Tax Residing in Oconto County

PRODUCTS

MEDICAL PLANS

- Network Health offers one ACA-compliant HMO plan to small groups residing in Oconto County
- Network Health will only sell small group ACA-compliant plans in Oconto County starting January 1, 2019
- The group renewal date is the only time that a group can elect any ACA-compliant plan that Network Health has available

Please click on the link to view the available plans: HMO

PRESCRIPTION DRUG COVERAGE

Prescription drug coverage is provided through Express Scripts, Inc. Network Health's base pharmacy plans are five tier copay programs providing up to a 30-day supply of covered prescriptions. Network Health uses a preferred drug list and copays are determined by drug tier on this listing. Prescriptions are classified as preferred generic, preferred brand, non-preferred brand, preferred specialty and non-preferred specialty. There may be an ancillary charge of up to $200 per prescription per month. This charge is the cost difference between the brand name product and the generic product. Members have the added benefit of a mail-order program for maintenance medications. The mail-order program provides up to a 90-day supply of medication at reduced copay for preferred drugs.

View Network Health's Preferred Drug List.

PRIOR CARRIER DEDUCTIBLE CREDIT

New groups to Network Health will be placed onto plans with calendar year deductibles. Calendar year deductible plans will restart their deductible on January 1. If a group is moving from another carrier's plan where they had a calendar year deductible, we will apply the deductible that members met through the previous insurer to their new Network Health plan. Prior carrier deductible credit will be given if Network Health receives one of the following documents no later than 90 days from the effective date of coverage.

- A deductible report from the previous insurer; or
- Individual Explanation of Benefits (EOB)

ELIGIBILITY

GROUP ELIGIBILITY

Network Health benefit plans are available to employer groups that meet the following requirements:

- Located in Oconto County
- Business group of two or more enrolled employees (one-life groups or individuals are not eligible for coverage)
- May have no more than 20 percent of the enrolled employees living outside the Network Health service area
- Group operates as a legal entity, including as a proprietorship, partnership or corporation, in Oconto County
- Group has a visible and legal employer/employee relationship with its employees
- Employers must contribute a minimum of 50 percent of the single premium of the lowest cost plan offered
- Groups with 1099 contracted employees are generally ineligible
- Employers may purchase coverage at any point during the year. However, if a small employer is unable to comply with Network Health's employer contribution or group participation rules they may be declined, but are eligible to enroll during an annual enrollment period that begins November 15 and extends through December 15 of each year

24-HOUR COVERAGE

The only members who can have 24-hour coverage are members who can legally opt out of workers' compensation, such as owners.

MEMBER ELIGIBILITY

Employee Eligibility

Eligible employees include all permanent, non-seasonal employees working an average of 30 or more hours per week. Groups may extend an offer for health insurance coverage to permanent, non-seasonal employees working not less than 20 hours per week with approval from Network Health.

DEPENDENT ELIGIBILITY

Eligible dependents include the employee's lawful spouse and children up to age 26. Children are defined as a subscriber's biological child, stepchild, lawfully adopted child or a child for whom the subscriber or spouse is a legal guardian.

A dependent may also include a child of an eligible dependent who is less than 18 years of age. Coverage of the grandchild terminates on the date the grandchild's parent reaches age 18. Addition of a newborn grandchild (of covered child under age 18), within 60 days of the birth, is guaranteed issue. The effective date of coverage is the date of birth of the child.

WAITING PERIODS FOR NEW HIRES

Employers may choose a probationary or waiting period for their newly hired employees, which may not exceed a period longer than 90 days. Effective dates for timely enrollees will be administered as indicated on the Employer Group Application. Changes to waiting periods can be made at the time of a group's renewal and are to be applicable to all employees within the group.

OPEN ENROLLMENT

Small employer groups (50 or fewer total employees) with an ACA-compliant (metal) plan have an open enrollment period at renewal time. Small employer groups having a pre-ACA plan do not have an open enrollment period.

LATE ENROLLMENT

A late enrollee is defined as an eligible employee and/or dependent who wishes to enroll more than 31 days after their eligibility period and is not eligible under a special enrollment period. This would include those who waive coverage initially and wish to enroll in the plan at a later date.

For small employer groups (50 or fewer total employees) the effective date of the late entrant will either be the group's open enrollment period (if applicable) or the end of the 90-day waiting period.

SPECIAL ENROLLMENT

A special enrollment period is defined as a period during which eligible, but non-enrolled employees and/or dependents may enroll. To be eligible under a special enrollment period:

- The employee and/or dependent must have been covered under another health insurance plan at the time they originally declined coverage
- The employee and/or dependents must apply within 31 days of the special enrollment date
- Special enrollment events include:
  - Marriage
  - Birth
  - Adoption
  - Divorce
  - Involuntary loss of other coverage

Employees who are eligible to join the plan due to a loss of other coverage may need to provide proof that coverage was lost. Employees have 31 days from the loss of coverage to apply. The employee will be enrolled on the plan effective the day after the other coverage was terminated to ensure there is no gap in coverage.

HOW TO OBTAIN A QUOTE

QUICK QUOTE PROCESS

With the following information, Network Health will be able to provide you an ACA quote for groups with 2-50 total employees.

- Group name and zip code
- Requested effective date
- Census – make sure to include the employee's date of birth or age, and type of coverage (single, employee/spouse, employee/child or family)
- Requested benefit plans
- Agent and agency
- Spouse's date of birth or age
- Number of children, enter each age

Agents and agency staff can generate ACA quotes at your convenience through Network Health's broker portal at networkhealth.com. If you do not have access to the broker portal, please contact your client manager at 800-276-8004. You may also send your ACA quote request to smallgroupquotes@networkhealth.com.

RATING STRUCTURE DETERMINATION

Network Health will provide member-specific rates to small groups.

APPLICATION/ENROLLMENT

To obtain a rate offer, submit the forms listed below to either smallgroupquotes@networkhealth.com or

Network Health
Attn: Quoting Specialist
1570 Midway Place
Menasha, WI 54952

Incomplete submissions may delay processing of a group's application, and members' receipt of health insurance cards. Complete group submissions up to the 15th of a month may be effective the 1st of the following month. Complete group submissions after the 15th will be effective the first of the next following month (i.e., submission on 3/16 would be effective 5/1).

If an employer is a newly established company and has not yet filed a UCT State Quarterly Unemployment Compensation Report, Network Health will require the following.

- All eligible employees must be listed on the eligibility certification form
- The employer must provide Articles of Incorporation
- The employer must provide two weeks of payroll records as soon as those are available

If the group is written, the following information is also required.

- First month's premium check or EFT form and voided check

REQUIRED FORMS NEEDED

- Employer Group Application
- Nine-page Wisconsin Small Employee Uniform App-OCI26-501 (rev6-2010)
- Applications must be completed and signed within 90 days of requested effective date
- Waiver forms for each eligible employee waiving coverage for themselves and/or their dependents including reason for waiving
- Copy of prior carrier's most recent monthly bill if other coverage is being replaced
- Most recent filing of UCT State Quarterly Unemployment Compensation Report
- Completed eligibility certification form listing if there are any eligible applicants or waivers who do not appear on the most recent wage and tax report

PARTICIPATION REQUIREMENTS

Eligible Employees	Number That Must Enroll
2 - 4	2
5 - 6	3
7	4
8-9	5
10	6
11 - 50	70 percent

Groups that fall below required participation levels, as shown, will be notified prior to the group's renewal. They will have the 90 days preceding the renewal to meet the participation requirements. Not meeting minimum participation requirements will result in termination of coverage at the group's next renewal date. If the group elects not to participate in EFT they will be charged a $25 monthly administration fee.

PAYMENT OF PREMIUMS

Premium is required at time of application, in the form of check or EFT form and voided check.
Subsequent payments are due on the 1st of every month. If the group pays by EFT, premiums will be drawn on the 7th day of each month from the designated checking account. Should the 7th fall on a weekend or Federal Reserve Bank holiday, the payment will be drawn on the following business day.

PREMIUM WHEN ADDING OR TERMING COVERAGE MID-MONTH

Network Health does not apply daily prorating on calculating individual premiums. The basic formula we follow is that any new enrollment during the first 15 days of the month is billed for the full month. If a new enrollment occurs on or after the 16th of the month, then the premium for that month is waived. Likewise, if an employee is terminated within the first 15 days of the month, the premium for that month is waived. If the termination date falls on or after the 16th of the month, the full month of premium is owed.

NETWORK HEALTH TERMINATION OF A GROUP PLAN

Network Health can terminate a group's coverage due to nonpayment of premium. A group will receive notification if their policy is delinquent or they are below participation requirements.

MEMBER MATERIALS

Each Network Health member will be sent a mailing containing these materials.

- Network Health ID cards
- How to Use Your Health Plan Guide

Additional information is available through the member portal at **login.networkhealth.com**. This is detailed in the How to Use Your Health Care Guide.

RENEWALS

SMALL GROUP RENEWALS

Effective January 1, 2019, only groups located in Oconto County will receive a renewal notice via mail from Network Health at least 60 days before the renewal date. Agents have the ability to view the renewal online through the Network Health agent portal and view alternate plans.

RENEWING CURRENT OR ALTERNATE PLAN(S)

Renewal acceptance and plan changes can be made on the Agent portal or by contacting your client manager.
When renewal acceptance and plan changes are received by the 10th of the month prior to the renewal, Network Health is able to process the renewal timely.

If Network Health is not notified of any changes at renewal, the renewal plan with the adjusted rates will automatically renew as of the renewal date.

Pre-ACA policies can change to another plan within the same product (HMO, POS or HDHP). New products cannot be added to pre-ACA policies.

ELIGIBILITY REQUIREMENT CHANGES

Groups are allowed to change eligibility requirements and plans upon renewal.

LOCAL CLIENT MANAGEMENT TEAM

We assign our local service team to provide support with a group's client management and administration. Our team works to assist with everything including plan creation and open enrollment preparation. Each account is provided a client manager with first-hand experience in plan implementation. Think of the client manager as your resource for everything from data analysis, monthly reports, enrollment or any other questions.

CHANGES TO AN EXISTING CONTRACT

PLAN AND ELIGIBILITY REQUIREMENT CHANGES

Groups interested in changing their plan offerings or eligibility requirements can do so upon renewal by contacting their client manager in writing.

EMPLOYEE AND DEPENDENT CHANGES

Administration of the group policy (such as employee additions, terminations or changes) can take place by submitting a completed **Membership Application and Change Form** or by any of the following.

- Secure email to **nhcommercialenrollment@networkhealth.com**
- Using our **online employer portal**
- Fax forms to 920-720-1904
- Mail to: **Network Health**
  Enrollment Services
  1570 Midway Place
  Menasha, WI 54952

Agents have the ability to make changes on behalf of the employer in the employer portal. Agents may register for the employer portal by contacting your client manager at 920-720-1250.

COBRA

Under federal law, employers offering fully insured products and having 20 or more employees are required to offer employees and covered dependents who experience specific qualifying events the opportunity to continue their group health coverage for a specific amount of time through COBRA.

The qualifying COBRA events include:

1. Employee's death (36 months)
2. Termination of employment or retirement (18 months)
3. Reduction of hours causing loss of coverage (18 months)
4. Entitlement of Medicare by employee (dependents only, 36 months)
5. Divorce (36 months)
6. Loss of dependent status (36 months)
7. Disabled under Medicare guidelines (29 months)

STATE CONTINUATION COVERAGE

Wisconsin State Continuation is available to fully insured groups with less than 20 total employees. Eligible employees must have been on the group plan for at least three months and experience a specific qualifying event. State Continuation benefits are available for 18 months.

The qualifying events are:

1. Divorce or annulment
2. Termination of employment
3. Employee's death

* Network Health does not administer COBRA or State Continuation services.

UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT (USERRA)

Network Health, to comply with the Uniform Services Employment and Re-Employment Rights Act of 1994, requires all employer groups to provide health care coverage during an active military leave to current Network Health members and their dependents as required by law.

FORMS

Eligibility Certification Form

Member Application and Change Form

EFT Enrollment and Change Form

Employer Group Application

HMO Group Plan Summaries

Express Scripts, Inc., Mobile Application Download

Preferred Drug List

MID-SIZE GROUPS

51-100 Total Employees on Quarterly Wage and Tax

PRODUCTS

- Network Health offers ACA-compliant benefits to mid-size groups.
- The group renewal date is the time that an existing group can elect any plan Network Health has available.
- The group's renewal or a qualifying event are the times an employee can move between plans if the employer offers more than one plan.

Please click on the link to view available plans: Mid-size Plans

PRESCRIPTION DRUG COVERAGE

Prescription drug coverage is provided through Express Scripts, Inc. Network Health's base pharmacy plans are five tier copay programs providing up to a 30-day supply of covered prescriptions. Network Health uses a preferred drug list and copays are determined by the drug tier on this listing. Prescriptions are classified as preferred generic, preferred brand, non-preferred brand, preferred specialty and non-preferred specialty. Members have the added benefit of a mail-order program for maintenance medications. The mail-order program provides up to a 90-day supply of medication at reduced copay for preferred drugs.

View Network Health's Preferred Drug List.

PRIOR CARRIER DEDUCTIBLE CREDIT

Groups have the option to have a plan year or calendar year deductible. Groups that choose to have a plan year deductible will start fulfilling their deductible on their effective date. Groups that choose a calendar year deductible will start their deductible on January 1. If a group is moving from another carrier's plan where they had a calendar year deductible, we will apply the deductible that members met through the previous insurer to their new Network Health. Prior carrier deductible credit will be given if Network Health receives one of the following documents no later than 90 days from the effective date of coverage.

- A deductible report from the previous insurer; or
- Individual Explanation of Benefits (EOB)

OUT-OF-AREA COVERAGE SOLUTIONS

It can be challenging to find health insurance coverage for all employees if there are employees who reside outside our service area. Network Health offers two programs that can help, Network Options. This program requires underwriting approval for participation.

A group can choose Network Health's local plans to cover those employees residing in the Network Health service area, and then select Network Options to allow the out-of-area employees to use health care providers in their area at an in-network benefit level. This allows the group to use the company's health care dollars effectively, while not sacrificing service.

To qualify for Network Options, the business must have the following.

- Employer has 51+ total employees and 35 or more enrolled employees
- A minimum of 80 percent of enrolled employees must reside in Network Health service area
- Network Options is available for POS and EPO (Exclusive Provider Organization) plans

If you would like additional information on either of these options, please contact the Network Health Sales Department at 920-720-1250.

ELIGIBILITY

GROUP ELIGIBILITY

Network Health benefit plans are available to employer groups that meet the following requirements.

- Located within our service area
- May have no more than 20 percent of the enrolled employees living outside the Network Health service area
- Group operates as a legal entity, including as a proprietorship, partnership or corporation, within our service area
- Group has a visible and legal employer/employee relationship with its employees.
- Employers must contribute a minimum of 50 percent of the single premium of the lowest cost plan offered
- Groups with 1099 contracted employees are generally ineligible

24-HOUR COVERAGE

The only members who can have 24-hour coverage are members who can legally opt out of workers' compensation, such as owners.

EMPLOYEE ELIGIBILITY

Eligible employees include all permanent, non-seasonal employees working an average of 30 or more hours per week. Groups may extend an offer for health insurance coverage to permanent, non-seasonal employees working at least 20 hours per week with approval of Network Health.

DEPENDENT ELIGIBILITY

Eligible dependents include the employee's lawful spouse and children up to age 26. Children are defined as a subscriber's biological child, stepchild, lawfully adopted child or a child for whom the subscriber or spouse is a legal guardian.

A dependent may also include a child of an eligible dependent who is less than 18 years of age. Coverage of the grandchild terminates on the date the grandchild's parent reaches age 18.

EARLY RETIREE ELIGIBILITY

Early retiree coverage is available for mid-sized groups based on employer class selection. Retired employees may remain on the plan up to age 65.

WAITING PERIODS FOR NEW HIRES

Employers may choose a probationary or waiting period for their newly hired employees, which may not exceed a period longer than 90 days. Effective dates for timely enrollees will be administered as indicated on the Employer Group Application. Changes to waiting periods can be made at the time of a group's renewal and are to be applicable to all employees within the group.

OPEN ENROLLMENT

Mid-sized employer groups with 51 or more total employees have the option of including an annual open enrollment period. This option allows eligible employees who have not previously enrolled with Network Health to do so without being underwritten.

LATE ENROLLMENT

A late enrollee is defined as an eligible employee and/or dependent who wishes to enroll more than 31 days after their eligibility period and is not eligible under a special enrollment period. This would include those who waive coverage initially and wish to enroll in the plan at a later date.

For mid-sized employer groups with 51 or more total employees a 90-day waiting period for late entrants will apply. In those situations, the effective date of the late entrant will be the earlier of the next enrollment period (if applicable), the end of the 90-day waiting period or on the date of a qualifying event.

SPECIAL ENROLLMENT

A special enrollment period is defined as a period during which eligible, but non enrolled employees and/or dependents may enroll. Eligibility under a special enrollment period includes the following.

- The employee and/or dependent must have been covered under another health insurance plan at the time they originally declined coverage.
- The employee and/or dependents must apply within 31 days of the special enrollment date.
- Special enrollment events includes the following.
  - Marriage
  - Birth
  - Adoption
  - Divorce
  - Involuntary loss of other coverage

Employees that are eligible to come onto the plan due to a loss of other coverage may need to provide proof that coverage was lost. Employees have 31 days from the loss of coverage to apply. The employee will be enrolled on the plan effective the day after the other coverage was terminated to ensure there is no gap in coverage.

HOW TO OBTAIN A QUOTE

FINAL PROPOSALS WITH RAPID UNDERWRITING

Network Health can offer final proposals on midsize groups using risk score in place of applications. To determine the risk score, we will need this information.

- Full member census – including legal first and last name, zip code, date of birth, gender and type of coverage (whether the individual is an employee or dependent)
- Employer name, address and requested effective date
- Copy of prior carrier bill
- Copy of renewal
- SIC Code

Network Health reserves the right to request applications if we determine they are required for a certain situation. Once the group is sold, we need wage and tax form, enrollment applications, employer application, waivers and premium payment. If final enrollment changes by +/- 10 percent, Network Health reserves the right to rerate the group.

If you prefer, you may still provide a base quote for a group.

GUIDELINES FOR BASE RATE QUOTE SUBMISSION

With the following information, Network Health will provide a base-rate quote for groups with 51-100 total employees.

- Group name
- Zip code
- Requested effective date
- Census – make sure to include the employee's date of birth or age, gender and type of coverage
- Requested benefit plans
- Agent and agency
- SIC code

For a base rate quote, please contact the sales and service team at 920-720-1250, toll-free at 800-276-8004, or email your quote request to largegroupquotes@networkhealth.com.

FULLY UNDERWRITTEN MID-SIZED GROUP RATE REQUEST PROCESS

To obtain a fully underwritten rate offer, submit the forms listed below to either largegroupquotes@networkhealth.com or

Network Health
Attn: Quoting Specialist
1570 Midway Place
Menasha, WI 54952

Incomplete submissions may delay processing of a group's application, and members' receipt of health insurance cards. To ensure timely delivery of member materials, Network Health requests receipt of final acceptance by the 20th of the month before the requested effective date. We will, however, accept information to complete the new group process up to the 15th of the month after the requested effective date. However, all groups must have a base-rate quote prepared prior to the requested effective date to be eligible for retroactive effective dates.
NOTE: Any material misstatement pertaining to health history may result in rates being re-evaluated and adjusted.

REQUIRED FORMS NEEDED FOR FULLY UNDERWRITTEN RATES

- Employer Group Application
- Completed nine page Wisconsin Small Employee Uniform App-OCI26-501 (rev6-2010) or the Network Health three-page application
- Applications must be completed and signed within 90 days of requested effective date
- Waiver forms for each eligible employee waiving coverage for themselves and/or their dependents including reason for waiving
- Copy of prior carrier's most recent monthly bill if other coverage is being replaced
- Most recent filing of UCT State Quarterly Unemployment Compensation Report
- Completed eligibility certification form listing if there are any eligible applicants or waivers who do not appear on the most recent wage and tax report

NOTE: If an employer is a newly established company, and has not yet filed a UCT State Quarterly Unemployment Compensation Report, Network Health will require the following.

- All eligible employees must be listed on the eligibility certification form.
- The employer must provide Articles of Incorporation

PARTICIPATION REQUIREMENTS

Groups must have at least 70 percent of eligible employees covered for health insurance **excluding** those who waive for other coverage.

APPLICATION/ENROLLMENT

CASE SUBMISSION

In order to ensure members will receive member materials and ID cards by the requested effective date we require the following information to be completed and received by Network Health by the 15th of the month prior to the requested effective date.

- Completed employer group application
- Enrollment forms for each employee
- First month's premium

Incomplete submissions may delay members receiving member materials.

PAYMENT OF PREMIUMS

Premium is required at time of application, in the form of check or EFT form and voided check. If groups elect not to participate in EFT they will be charged a $25 monthly administrative fee.

Subsequent payments are due on the 1st of every month. If the group pays by EFT, premiums will be withdrawn on the 7th day of each month from the designated checking account. Should the 7th fall on a weekend or Federal Reserve Bank holiday, the payment will be withdrawn on the following business day.

PREMIUM WHEN ADDING OR TERMING COVERAGE MID MONTH

Network Health does not apply daily prorating on calculating individual premiums. The basic formula we follow is that any new enrollment during the first 15 days of the month is billed for the full month. If a new enrollment occurs on or after the 16th of the month, then the premium for that month is waived. Likewise, if an employee is terminated within the first 15 days of the month, the premium for that month is waived. If the termination date falls on or after the 16th of the month, the full month of premium is owed.

NETWORK HEALTH TERMINATION OF A GROUP PLAN

Network Health can terminate a group's coverage due to nonpayment of premium. A group will receive notification if their policy is delinquent or they are below participation requirements. If a group is terminated due to nonpayment of premium or failure to meet participation requirement, and wants to continue being insured by Network Health, they should contact their client manager to discuss options for reinstatement.

MEMBER MATERIALS

Each Network Health member will receive the following at their home address.

- Network Health ID cards
- How to Use Your Health Plan guide with information about how to log in to the member portal and gain access to these important plan documents.
  - Summary of Member Responsibility Table
  - Certificate of Coverage
  - Summary of Benefits Coverage (SBC)
  - Any applicable riders

RENEWALS

MID-SIZE GROUP RENEWALS

Agents will receive a renewal notice from Network Health at least 60 days before the renewal date.

RENEWING CURRENT OR ALTERNATE PLAN(S)
Renewal acceptance (signed rate sheet) and enrollment changes should be sent in writing to your client manager. When renewal acceptance and enrollment changes are received by the 10th of the month prior to the renewal, Network Health is able to process the renewal timely.

ELIGIBILITY REQUIREMENT CHANGES
Groups are allowed to change eligibility requirements and plans upon renewal. If multiple plans are offered, employees are allowed to change between plan offerings at renewal time without a qualifying event.

BUY DOWN IN BENEFITS OFF RENEWAL
There are some special circumstances that we allow renewals to buy down benefits mid-year. Please call your client manager to help you with these circumstances.

CHANGING RENEWAL DATE
Groups may request a change to their renewal date by requesting new 12 month rates. Contact your client manager 90 days before the requested new renewal date to see if this is an option or not.

LOCAL CLIENT MANAGEMENT TEAM
We assign our local service team to provide support with a group's client management and administration. Our team works to assist with everything, including plan creation and open enrollment preparation. Each account is provided a client manager with first-hand experience in plan implementation, who is available for regular onsite meetings. Think of the client manager as a resource for everything from data analysis, monthly reports, enrollment or any other questions.

CHANGES TO AN EXISTING CONTRACT
PLAN AND ELIGIBILITY REQUIREMENT CHANGES
Groups interested in changing their plan offerings or eligibility requirements can do so by contacting their client manager in writing upon renewal.

EMPLOYEE AND DEPENDENT CHANGES
Administration of the group policy (such as employee additions, terminations or changes) can take place by submitting a completed **Membership Application and Change Form** or by any of the following.

- Secure email to **nhcommercialenrollment@networkhealth.com**
- Using our **online employer portal**
- Fax forms to 920-720-1904
- Mail to:
  Network Health
  Enrollment Services
  1570 Midway Place
  Menasha, WI 54952

Agents can make changes on behalf of the employer in the employer portal. Agents may register for the employer portal by contacting your client manager at 920-720-1250.

COBRA
Under federal law, employers offering fully-insured products and having 20-100 total employees are required to offer employees and covered dependents the opportunity to continue their group health coverage for a specific amount of time through COBRA, in the event of specific qualifying events. The qualifying events include the following.

1. Employee's death (36 months)
2. Termination of employment or retirement (18 months)
3. Reduction of hours causing loss of coverage (18 months)
4. Entitlement of Medicare by employee (dependents only, 36 months)

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5. Divorce (36 months)
6. Loss of dependent status (36 months)
7. Disabled under Medicare guidelines (29 months)

COBRA administration services are available through Employee Benefits Corporation at no additional cost to mid-size employer groups.

Visit the United States Department of Labor website at **www.dol.gov/ebsa/cobra.html** for details on COBRA.
Visit Wisconsin Department of Health Services website at **www.dhs.wisconsin.gov** for details on state continuation rights.

UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT (USERRA)

Network Health, to comply with the Uniform Services Employment and Re-Employment Rights Act of 1994, requires all employer groups to provide health care coverage during an active military leave to current Network Health members and their dependents as required by law.

FORMS

Application for Employees 51-100

Eligibility Certification Form

Member Application and Change Form

EFT Enrollment and Change Form

Employer Group Application

Express Scripts, Inc., Mobile Application Download

Preferred Drug List

MDLIVE®

LARGE GROUPS

101+ Total Employees on Quarterly Wage and Tax

PRODUCTS

All large groups insured with Network Health may offer our core plans as well as customized plans to meet the group's needs.

Large Group Plan information is available on the Agent Resources page.

FULLY INSURED

- Predictable monthly premiums
- Easy to budget
- No financial risk

Large groups can offer Network Health's coverage alongside another carrier's coverage.

PRESCRIPTION DRUG COVERAGE

Prescription drug coverage is provided through Express Scripts, Inc. Network Health's base pharmacy plans are five tier copay programs providing up to a 30-day supply of covered prescriptions. Network Health uses a preferred drug list and copays are determined by drug tier on this listing. Prescriptions are classified as preferred generic, preferred brand, non-preferred brand, preferred specialty and non-preferred specialty. There may be an ancillary charge of up to $200 per prescription per month. This charge is the cost difference between the brand name product and the generic product. Members have the added benefit of a mail-order program for maintenance medications. The mail-order program provides up to a 90-day supply of medication at reduced copay for preferred drugs.

View Network Health's Preferred Drug List.

PRIOR CARRIER DEDUCTIBLE CREDIT

Groups have the option to have a plan year or calendar year deductible. Groups that choose to have a plan year deductible will start fulfilling their deductible on the effective date of their plan. Groups that choose a calendar year deductible will start their deductible on January 1. If a group is moving from another carrier's plan where they had a calendar year deductible, we will apply the deductible that members met through the previous insurer to their new Network Health plan. Prior carrier deductible credit will be given if Network Health receives one of the following documents no later than 90 days from the effective date of coverage.

- Either a deductible report from the previous insurer; or
- Individual Explanation of Benefits (EOB)

OUT OF AREA COVERAGE SOLUTIONS

It can be challenging to find health insurance coverage for all of a group's employees if there are employees who reside outside our service area. Network Health offers a program that can help, Network Options. This program requires underwriting approval for participation.

A group can choose Network Health's local plans to cover those employees residing in the Network Health service area, and then select Network Options to allow the out-of-area employees to use health care providers in their area at an in-network benefit level. This allows the group to use the company's health care dollars effectively, while not sacrificing service.

To qualify for Network Options, the business must be a large group and have the following.

- A minimum of 80 percent of enrolled employees must reside in Network Health Plan service area
- Network Options is available for POS and EPO (Exclusive Provider Organization) plans

If you would like additional information on either of these options, please contact the Network Health Sales Department at 920-720-1250.

ELIGIBILITY

GROUP ELIGIBILITY

Network Health benefit plans are available to employer groups that meet the following requirements.

- Located within our service area
- May have no more than 20 percent of the enrolled employees living outside the Network Health service area
- Group operates as a legal entity, including a proprietorship, partnership or corporation, within our service area
- Group has a visible and legal employer/employee relationship with its employees
- Business must operate year round
- Employers must contribute a minimum of 50 percent of the single premium of the lowest cost plan offered

EMPLOYEE ELIGIBILITY

Eligible employees include all permanent, non-seasonal employees working an average of 30 or more hours per week. Groups may extend an offer for health insurance coverage to permanent, non-seasonal employees working at least 20 hours per week with approval of Network Health.

DEPENDENT ELIGIBILITY

Eligible dependents include the employee's lawful spouse and children up to age 26. Children are defined as a subscriber's biological child, stepchild, lawfully adopted child or a child for whom the subscriber or spouse is a legal guardian.

A dependent may also include a child of an eligible dependent who is less than 18 years of age. Coverage of the grandchild terminates on the date the grandchild's parent reaches age 18.

EARLY RETIREE ELIGIBILITY

Early retiree coverage is available for large groups based on employer class selection. Retired employees may remain on the plan up to age 65. Medicare retiree rates are also available.

WAITING PERIODS FOR NEW HIRES

Employers may choose a probationary or waiting period for their newly hired employees, which may not exceed a period longer than 90 days. Effective dates for timely enrollees will be administered as indicated on the Employer Group Application. Changes to waiting periods can be made at the time of a group's renewal and are to be applicable to all employees within the group.

OPEN ENROLLMENT

Large employer groups (51 or more total employees) have the option of including an annual open enrollment period. This option allows eligible employees who have not previously enrolled with Network Health to do so without being underwritten.

LATE ENROLLMENT

A late enrollee is defined as an eligible employee and/or dependent who wishes to enroll more than 31 days after their eligibility period and is not eligible under a special enrollment period. This would include those who waive coverage initially and wish to enroll in the plan at a later date.

For large employers groups (51 or more total employees) a 90-day waiting period for late entrants will apply. In those situations, the effective date of the late entrant will be the earlier of the next enrollment period (if applicable), the end of the 90-day waiting period or on the date of a qualifying event.

SPECIAL ENROLLMENT

A special enrollment period is defined as a period during which eligible, but non-enrolled employees and/or dependents may enroll. Eligibility under a special enrollment period includes the following.

- The employee and/or dependent must have been covered under another health insurance plan at the time they originally declined coverage
- The employee and/or dependents must apply within 31 days of the special enrollment date.
- Special enrollment events include the following.
  - Marriage
  - Birth
  - Adoption
  - Divorce
  - Involuntary loss of other coverage

Employees that are eligible to join the plan due to a loss of other coverage may need to provide proof that coverage was lost. Employees have 31 days from the loss of coverage to apply. The employee will be enrolled on the plan effective the day after the other coverage was terminated to ensure there is no gap in coverage.

HOW TO OBTAIN A QUOTE

QUOTE REQUEST FOR GROUPS WITH 101+ EMPLOYEES

With the following information, Network Health will provide a base-rate quote for groups with 101+ total employees.

- Group name, physical address, group contact information, renewal date and agent name
- Current census – include age (date of birth), gender, coverage type (employee only, employee/spouse, employee/child, or family) and zip code
- Total number of eligible employees
- Most recent two years claims experience
- Large claim report for all claims over $10,000
- List all lasers and amount of laser
- Union information if appropriate
- Employer contribution level
- Current and prior benefit plan designs and rates, including provider network, matching the two years recent claims experience
- Copy of the renewal if available or projected renewal increase
- If above requirements are not available, refer to midsize group quote requirements

NOTE: If an employer is a newly established company, and has not yet filed a UCT State Quarterly Unemployment Compensation Report, Network Health will require the following.

- All eligible employees must be listed on the eligibility certification form
- The employer must provide Articles of Incorporation

To obtain a preliminary quote for large employer groups, please contact Network Health's Sales Department at 920-720-1250 or 800-276-8004 or email **largegroupquotes@networkhealth.com**.

APPLICATION/ENROLLMENT

CASE SUBMISSION

In order to assure members will receive member materials and ID cards by the requested effective date, we require the following information to be completed and received by Network Health by the 15th of the month prior to the requested effective date.

- Completed employer group application
- Enrollment forms for each employee enrolling
- First month's premium or ACH form

Incomplete submissions may delay members receiving member materials.

CARRIER PLAN OFFERINGS

EMPLOYEES' OPTIONS

- As the exclusive carrier, Network Health allows groups to choose more than one benefit plan option. A minimum 70 percent participation of eligible employees, excluding those who waive for other coverage, is required.
- We will offer our HMO or POS products with another carrier's comparable products. A minimum of 20 percent of eligible employees must enroll with Network Health.

CONTRIBUTION REQUIREMENTS FOR NETWORK HEALTH OFFERING COVERAGE WITH ANOTHER CARRIER(S)

The monthly employee contribution for the Network Health benefit option must be within the following of the low-cost benefit option: $10 for single, $20 for limited family (employee +1, employee + spouse, or employee + children) and $30 for family.

12-MONTH RATE GUARANTEE

Initial rates issued upon approval are guaranteed for 12 months. Renewal rates are influenced by experience, changes in the cost of health care and a group's census. All groups are renewed on the anniversary date of the initial effective date, unless otherwise specified in the health service policy.

PAYMENT OF PREMIUMS

Premium is required at time of application, in the form of check or EFT form and voided check. If groups elect not to participate in EFT they will be charged a $25 monthly administrative fee.

Subsequent payments are due on the 1st of every month. If the group pays by EFT, premiums will be withdrawn on the 7th day of each month from the designated checking account. Should the 7th fall on a weekend or Federal Reserve Bank holiday, the payment will be withdrawn on the following business day.

PREMIUM WHEN ADDING OR TERMING COVERAGE MID-MONTH

Network Health does not apply daily prorating on calculating individual premiums. The basic formula we follow is that any new enrollment during the first 15 days of the month is billed for the full month. If a new enrollment occurs on or after the 16th of the month, then the premium for that month is waived. Likewise, if an employee is terminated within the first 15 days of the month, the premium for that month is waived. If the termination date falls on or after the 16th of the month, the full month of premium is owed.

NETWORK HEALTH TERMINATION OF A GROUP PLAN

Network Health can terminate a group's coverage due to nonpayment of premium. A group will receive notification if their policy is delinquent or they are below participation requirements. If a group is terminated due to nonpayment of premium or failure to meet participation requirement and wants to continue being insured by Network Health. Contact your client manager to discuss options for reinstatement.

MEMBER MATERIALS

Each Network Health member or participant will receive a mailing containing the following materials.

- Network Health ID cards
- How to Use Your Health Plan Guide

Additional information is available through the member portal at **login.networkhealth.com**. This is detailed in the How to Use Your Health Care Guide.

RENEWALS

LARGE GROUP RENEWALS

Agents will receive a renewal notice from Network Health at least 60 days before the renewal date.

RENEWING CURRENT OR ALTERNATE PLAN(S)

Renewal acceptance (signed rate sheet) and enrollment changes should be sent in writing to your client manager. When renewal acceptance and enrollment changes are received by the 10th of the month prior to the renewal, Network Health is able to process the renewal timely.

If Network Health is not notified of any changes at renewal; the renewal plan with the adjusted rates will automatically renew as of the renewal date.

ELIGIBILITY REQUIREMENT CHANGES

Groups are allowed to change eligibility requirements and plans upon renewal. If multiple plans are offered, employees are allowed to change between plan offerings at renewal time without a qualifying event.

BUY DOWN IN BENEFITS OFF RENEWAL

There are some special circumstances that we allow renewals to buy down benefits mid-year. Please call your client manager to help you with these circumstances.

CHANGING RENEWAL DATE

Groups may request a change to their renewal date by requesting new 12 month rates. Contact your client manager 90 days before the requested new renewal date to see if this is an option.

LOCAL CLIENT MANAGEMENT TEAM

We assign our local service team to provide support with a group's client management and administration. Our team works to assist with everything including plan creation and open enrollment preparation. Each account is provided a client manager with first-hand experience in plan implementation, who is available for regular onsite meetings. Think of the client manager as a resource for data analysis, monthly reports, enrollment or any other questions.

CHANGES TO AN EXISTING CONTRACT

Administration of the group policy (such as employee additions, terminations or changes) can take place by submitting a completed **Membership Application and Change Form** or by any of the following.

- Secure email to **nhcommercialenrollment@networkhealth.com**
- Using our **online employer portal**
- Fax forms to 920-720-1904
- Mail to:

  Network Health
  Enrollment Services
  1570 Midway Place
  Menasha, WI 54952

Agents may make changes on behalf of the employer in the employer portal. Agents may register for the employer portal by contacting your client manager at 920-720-1250.

COBRA

Under federal law, employers offering fully-insured products and having 20 or more employees are required to offer employees and covered dependents the opportunity to continue their group health coverage for a specific amount of time through COBRA in the event of specific qualifying events. The qualifying events include the following.

1. Employee's death (36 months)
2. Termination of employment or retirement (18 months)
3. Reduction of hours causing loss of coverage (18 months)
4. Entitlement of Medicare by employee (dependents only, 36 months)
5. Divorce (36 months)
6. Loss of dependent status (36 months)
7. Disabled under Medicare guidelines (29 months)

Network Health does not administer COBRA. Network Health works with Employee Benefits Corporation to administer COBRA benefits. Through this partnership, large employer groups can receive discounted rates on COBRA administration. Discounted rates are also available with Employee Benefits Corporation for the administration of tax-advantaged benefits such HRA, FSA and HSA.

UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT (USERRA)

Network Health, to comply with the Uniform Services Employment and Re-Employment Rights Act of 1994, requires all employer groups to provide health care coverage during an active military leave to current Network Health members and their dependents as required by law.

FORMS

Eligibility Certification Form

Member Application and Change Form

EFT Enrollment and Change Form

Employer Group Application

Express Scripts, Inc. Mobile Application Download

Preferred Drug List

MDLIVE®

MEDICARE

MEDICARE BASICS – WHAT IS MEDICARE, AND HOW DO PEOPLE QUALIFY?

WHAT IS ORIGINAL MEDICARE?

Medicare is health insurance for three groups of people.

- 65 and older
- Under 65 with certain disabilities
- Any age with end-stage renal disease (ESRD)

Original Medicare is administered by the Centers for Medicare & Medicaid Services (CMS). Enrollment is handled by the Social Security Administration for most people, but the Railroad Retirement Board is also an option.

HOW DOES ORIGINAL MEDICARE WORK WITH A NETWORK HEALTH MEDICARE ADVANTAGE PLAN?

Original Medicare is managed by the federal government. Original Medicare covers some medical benefits, but not prescription drug coverage. In a Medicare Advantage Plan, the federal government pays private insurance companies like Network Health to take care of an individual's Medicare coverage. As long as an individual continues to pay the Medicare Part B premium, they are eligible for our plan.

HOW DO I KNOW IF AN INDIVIDUAL CAN JOIN A NETWORK HEALTH MEDICARE ADVANTAGE PLAN?

- They must live in our service area.
- They must have Medicare Part A and Part B Medicare coverage.
- They must continue to pay their Medicare Part B premium.
- They must not be diagnosed with end-stage renal disease at the time of enrollment.

WHAT ARE THE DETAILS OF MEDICARE ENROLLMENT AND ELIGIBILITY?

HOW DOES SOMEONE ENROLL IN MEDICARE?

Some people are automatically enrolled if they are already receiving Social Security or Railroad Retirement benefits. They will receive an Initial Enrollment Package (IEP) in the mail that will include their Medicare card. It will also include instructions to follow if they don't want Part B. For somebody who is automatically enrolled, they will receive their Medicare card in the mail approximately three months prior to turning 65.

Some people are not automatically enrolled and need to sign up. If they are not getting Social Security or Railroad benefits they must enroll through Social Security Administration (SSA) or the Railroad Retirement Board for railroad retirees. They can apply three months before age 65. They don't need to be retired.

ELIGIBILITY FOR MEDICARE PART A (HOSPITAL)

For most people, Medicare Part A is free as long as the beneficiary or their spouse paid Medicare taxes while working at least 40 quarters (10 years). If they are not eligible for free Part A, they may be able to buy it at a cost of up to $422 each month. This amount can change yearly. If beneficiaries aren't eligible for premium-free Part A and they don't buy it when they're first eligible, their monthly premiums may go up 10 percent. They will have to pay the higher premium for twice the number of years they could have had Part A but didn't sign up. If they were eligible for Part A for two years but didn't sign up, they'll have to pay the higher premium for four years. Usually, they don't have to pay a penalty if they meet certain conditions that allow them to sign up for Part A during a special enrollment period.

ENROLLING IN MEDICARE PART B (MEDICAL)

It's important to understand when beneficiaries can enroll in Medicare Part B, because there are only specific times of the year when they can join.

INITIAL ENROLLMENT PERIOD (IEP)

This is a seven-month window around the beneficiary's 65th birthday when he or she can enroll in a Medicare Part B. The IEP includes the following.

- Three months before the 65th birthday
- The month of the 65th birthday
- Three months after the 65th birthday

GENERAL ENROLLMENT PERIOD (GEP)

If a beneficiary didn't sign up for Part B when first eligible and they don't have a Special Enrollment (see next page), they can apply to sign up for Part B between January 1 through March 31 of each year. The coverage will be effective on July 1. They may have to pay a higher premium for late enrollment in Part A and/or a higher premium for late enrollment in Part B.

ANNUAL ENROLLMENT PERIOD (AEP)

Every year from October 15 to December 7, a beneficiary can make changes to their Medicare coverage. Any changes made during AEP will be effective January 1 of the following year.

OPEN ENROLLMENT PERIOD* (OEP)

From January 1 to March 31, beneficiaries may change from one Medicare Advantage plan to another; they can also change back to Original Medicare. This option can be used only once during the open enrollment period and does not apply to NetworkPrime MSA.

SPECIAL CIRCUMSTANCES (SPECIAL ENROLLMENT PERIODS)

Once the Initial Enrollment Period ends, beneficiaries may sign up for Medicare during a Special Enrollment Period. If the beneficiary is covered under a group health plan based on current employment, he or she has a Special Enrollment Period to sign up for Part A and/or Part B any time as long as the beneficiary or their spouse is working, and they're covered by a group health plan through the employer or union-based on that work.

Usually, beneficiaries don't pay a late enrollment penalty if they sign up during a Special Enrollment Period.

Important Note: COBRA and retiree health plans aren't considered coverage based on current employment. Beneficiaries are not eligible for a Special Enrollment Period when that coverage ends.

PART B LATE ENROLLMENT PENALTY

In most cases, if beneficiaries don't sign up for Part B when first eligible, they'll have to pay a late enrollment penalty for as long as they have Part B. The monthly premium for Part B may go up 10 percent for each full 12-month period that they could have had Part B, but didn't sign up for it. Also, they may have to wait until the General Enrollment Period (from January 1 to March 31) to enroll in Part B, and coverage will start July 1 of that year.

Usually, beneficiaries don't pay a late enrollment penalty if they meet certain conditions that allow them to sign up for Part B during a Special Enrollment Period. The Social Security Administration can answer any questions regarding late enrollment penalties.

HOW MUCH DOES PART B COST?

The cost of Part B is based on the beneficiary's yearly income from two years previous.			
Beneficiaries who file individual tax returns with income	**Beneficiaries who file joint tax returns with income**	**Beneficiaries who file married and separate tax returns with income**	**Monthly premium amount**
$87,000 or less	$174,000 or less	$87,000 or less	$144.60
above $87,000 up to $109,000	above $174,000 up to $218,000	Not applicable	$202.40
above $109,000 up to $136,000	above $218,000 up to $272,000	Not applicable	$289.20
above $136,000 up to $163,000	above $272,000 up to $326,000	Not applicable	$376.00
above $163,000 up to $500,000	above $326,000 up to $750,000	above $87,000 up to $413,000	$462.70
above $500,000	above $750,000	above $413,000	$491.60

WHAT MEDICARE OPTIONS ARE THERE?

MEDICARE'S FOUR PARTS

What else do I need to know about Medicare Advantage Plans?
Medicare Advantage Plans contract with the federal government to administer Medicare benefits to members. Medicare pays a set amount of money per member, per month to the plan for the plan to take care of that member. Contracts are renewed annually between the health plan and Medicare.

	PART A HOSPITAL	PART B MEDICAL	PART C MEDICARE ADVANTAGE	PART D DRUG COVERAGE
COVERAGE	Covers hospital stays, home health hospice and skilled nursing care	Covers doctor visits and outpatient services	Covers what both Parts A and B cover. Part C is also referred to as a Medicare Advantage Plan and sometimes includes Part D	Covers prescription drugs only
COST	Typically, there is no cost to members	The cost is set by the government and varies from year to year. It may also vary based on income	The cost varies depending on which private health plan is selected and what services are covered	The cost varies, and Part D can be purchased as a Stand Alone Prescription Drug Plan (PDP) or as part of a Medicare Advantage Plan (Part C)
HOW TO ENROLL	Beneficiaries are automatically enrolled at age 65, if he or she is collecting Social Security. If the beneficiary is 65 and not collecting Social Security, he or she must enroll online at www.ssa.gov or at a local Social Security office	The beneficiary can enroll during the seven-month period around his or her 65th birthday. If the beneficiary did not enroll at that time, he or she will have to wait until January 1–March 31 and may have to pay a penalty	The beneficiary enrolls through a private insurance company, like Network Health. Typically, he or she enrolls during the seven-month period around their 65th birthday or during the annual enrollment period, October 15–December 7	The beneficiary enrolls through a private insurance company, like Network Health. Typically, he or she enrolls during the seven-month period around their 65th birthday or during the annual enrollment period, October 15–December 7

Original Medicare, HMO, PPO, MSA, PFFs, MS and SNP are all types of Medicare plans.

Original Medicare
Original Medicare is made up of Parts A and B and is managed by the federal government.

Medicare Advantage
This type of plan covers Medicare Parts A and B and some Medicare Advantage Plans cover Part D Prescription drug coverage. Medicare Advantage may also be called Part C.

MEDICARE ADVANTAGE PLAN

Health Maintenance Organization (HMO)
This type of Medicare Advantage plan requires the member to use doctors who are contracted by his or her plan. That means the member will have to use certain doctors and hospitals for their health care to be covered.

Preferred Provider Organization (PPO)
This Medicare Advantage Plan also has contracts with doctors, but it allows the member to choose between going to a contracted doctor (in-network) or seeing a non-contracted doctor (out-of-network). It's the member's choice to go to any doctor or hospital he or she chooses which accepts Medicare beneficiaries, but the member can save money by going to a contracted doctor.

Special Needs Plan (PPO SNP)
This Medicare Advantage Plan is specifically designed for people with both Medicare and Medicaid, those who are institutionalized or those who have a chronic condition. It can be either a PPO or HMO plan depending on which company is offering the insurance plan.

Medical Savings Account (MSA)
This is a plan that combines a high-deductible health insurance plan with a medical savings account. The beneficiary can use the medical savings account to pay for health care services, while the high-deductible plan limits the out-of-pocket costs.

Private Fee for Service (PFFS)
This Medicare Advantage Plan determines how much it will pay doctors, health care providers and hospitals and how much beneficiaries must pay when they get care.

Medicare Supplement
Also called Medigap insurance, this type of plan helps pay for the gap between Original Medicare and what the beneficiary would pay out-of-pocket. It covers some additional medical care that Original Medicare doesn't cover, but it does not include drug coverage. It is sold by private insurance companies.
Beneficiaries cannot be enrolled in a Medicare Supplement AND a Medicare Advantage (MA) plan at the same time.

Stand Alone Prescription Drug Plan
This plan helps cover the cost of prescription drugs only. The beneficiary must have Medicare Part A or Part B coverage to enroll in this type of plan, and it can be combined with Original Medicare or a Medicare Supplement plan. It cannot be combined with a HMO or PPO Medicare Advantage Plan.

WHAT ARE A BENEFICIARY'S GUARANTEED RIGHTS?

Medicare has established guaranteed rights for Medicare beneficiaries. They include the following.

- Have their questions about Medicare answered
- Get information in a way that they understand from Medicare, health care providers, and, under certain circumstances, contractors
- Get emergency care when and where they need it
- Get a decision about health care payment or service, or prescription drug coverage
- Have personal and health information kept private
- Be treated with dignity and respect
- Be protected from discrimination
- Have access to doctors, specialist and hospitals in any situation
- Learn about all of their treatment choices and participate in treatment decisions
- Get a review of certain decisions about health care payment, coverage of services or prescription drug coverage

WHAT GRIEVANCES AND APPEAL RIGHTS DOES A BENEFICIARY HAVE?

- A member can file an appeal if the plan does not pay for, allow or end a service that should be covered
- The appeal process is provided by the plan to the beneficiary in writing
- Grievance and appeal information can be found in all the Evidence of Coverage booklets and in all pre-enrollment kits

WHAT ARE MEDICARE STAR RATINGS?

The Medicare Star Ratings program is how Medicare gives beneficiaries a snapshot of the quality of care a plan will provide. Medicare rates plan performance in different categories.

- **Staying healthy** - includes whether members received various screening tests, vaccines and other check-ups that help them stay healthy
- **Managing chronic (long-term) conditions** - includes how often members with different conditions got certain tests and treatments that help them manage their condition
- **Member experience with the health plan -** includes ratings of member satisfaction with the plan
- **Member complaints and changes in the health plan's performance** - includes how often Medicare found problems with the plan, how often members had problems with the plan and how much the plan's performance has improved (if at all) over time
- **Health plan customer service** - includes how well the plan handles member appeals

For plans covering drug services, the overall score for quality of those services covers many different topics that fall into four categories listed below.

- **Drug plan customer service** - includes how well the plan handles member appeals
- **Member complaints and changes in the drug plan's performance** - includes how often Medicare found problems with the plan, how often members had problems with the plan and how much the plan's performance has improved (if at all) over time
- **Member experience with plan's drug services** - includes ratings of member satisfaction with the plan
- **Drug safety and accuracy of drug pricing** - includes how accurate the plan's pricing information is and how often members with certain medical conditions are prescribed drugs in a way that is safer and clinically recommended for their condition

Network Health must provide information about our plan ratings to current and prospective enrollees by referring them to **www.medicare.gov**, including it in our enrollment kits and making it available on our website at **networkhealth.com**.

MEDICARE ELECTION PERIODS

#	POPULATION	CODING
	NEW TO MEDICARE	
1	Newly Eligible (IEP/ICEP)	ICEP: MA Election IEP: MAPD Election
2	Enrolling Into Part B After Delayed Enrollment	ICEP
3	Beneficiary Turning 65	MRD
4	Enrolled Into Part B During the Part B General Enrollment	IEP
	ANNUAL ELECTION PERIOD (AEP)	
5	All Beneficiaries	AEP
6	All Beneficiaries	OEP
	BENEFICIARIES WHO MOVE	
7	Change in Primary Residence	MOV
8	Change in Residence Returning to the U.S.	RUS
	INSTITUTIONALIZED BENEFICIARIES	
9	Institutionalized Beneficiaries	LTC
	LOW INCOME BENEFICIARIES	
10	LIS (Non-Medicaid)	HLP
11	LIS (Loss of Status)	NLS
12	Dual Eligible	MDE
13	Dual Eligible (Loss of Status)	SNP
14	Loss of Employer Group Coverage	LEC
15	Involuntary Loss of Creditable Coverage	LCC
	TERMINATION OF PLAN CONTRACT	
16	Termination of Plan Contract with Medicare with Mutual Consent	EOC
17	Termination of Plan Contract with Medicare without Mutual Consent	EOC
	STATE PHARMACEUTICAL ASSISTANCE PROGRAMS	
18	State Pharmaceutical Assistance Program (SPAP) like Wisconsin Senior Care	PAP
	5-STAR PLAN	
19	Enroll Into 5-Star Plan	5ST
	DISENROLLMENT ELECTIONS	
20	Gain or Maintain Other Creditable Coverage	OCC
21	Trial Period	12G
22	Beneficiary Turning 65	12J
	CANCELLING APPLICATIONS	
23	First time MSA enrollees (during AEP)	
24	New applications to Network Health	

#	POPULATION	QUALIFICATION	REFERENCE	TIME FRAME	EFFECTIVE DATE	CODING
NEW TO MEDICARE						
1	Newly Eligible (IEP/ICEP)	Has both Medicare Parts A and B for the first time. Either you are turning 65 or you are in month 24 of receiving Social Security or Rail Road Retirement Disability Benefits.	Copy of Medicare Card Medicare Entitlement Letter SSA Award Letter	Seven Month Election Frame **Begins** three months before month of entitlement. Includes birthday or month 24 of disability. **Ends** last day of the third month after the A/B start date.	Enrollment request made prior to month of eligibility, effective date is first day of the month of eligibility. Enrollment request made during or after first month of eligibility, effective date is first day of the month following the month of election. Generally, a beneficiary with a birth date of the first of the month will have an effective date that will be the first day of the previous month.	ICEP: MA Election IEP: MAPD Election MSA Eligible
2	Enrolling into Part B after delayed enrollment	Entitled to Medicare Part A. Newly enrolled to Part B.	Copy of Medicare Card Medicare Entitlement Letter SSA Award Letter	**Begins** three months before Part B effective date. **Ends** last day of the month prior to effective date of Part B.	Equivalent to Part B effective date. Example: Part A has an effective date of 6-1-2015 Part B has an effective date of 8-1-2016. The plan effective date would be 8-1-2016.	ICEP MSA Eligible
3	Beneficiaries turning 65	Have Part A and B due to disability and are turning 65.	Individual's 65th Birthday	**Begins** month before month of birthday. Includes birthday month. **Ends** last day of the third month after the A/B start date.	Enrollment request made prior to month of birthday, effective date is first day of the month of birthday. Enrollment request made during or after birth month, effective date is first day of the month following the month of election.	MRD MSA Not Eligible
4	Enrolled into Part B during the Part B General Enrollment	Entitled to Medicare Part A. Enrolling into Part B for the first time during General Enrollment Period.	Copy of Medicare Card Medicare Entitlement Letter SSA Award Letter	General Enrollment Period **Begins** April 1 **Ends** June 30	July 1	ICEP MSA Eligible
ANNUAL ELECTION PERIOD (AEP)						
5	All Beneficiaries	Annual Election Period (AEP)		**Begins** October 15 **Ends** December 7	January 1	AEP MSA Eligible

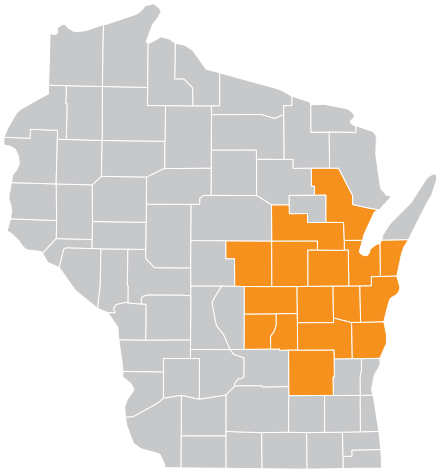
#	POPULATION	QUALIFICATION	REFERENCE	TIME FRAME	EFFECTIVE DATE	CODING
6	All Beneficiaries	Open Enrollment Period (OEP)		Begins January 1; Ends March 31 Also available during the initial election period (IEP) for new beneficiaries.	First day of the month following the enrollment request. Starts the month Part A and B are effective. Last day is the third day of the month of entitlement.	OEP MSA Not Eligible
BENEFICIARIES WHO MOVE						
7	Change in Primary Residence	Permanently moved inside plan's service area with new plan options available. Permanently moved outside plan's service area.	Beneficiary's Attestation	**Before Move Begins** the month before month of permanent move. **Ends** two months after the move. **After the Move Begins** month beneficiary notified plan of the move. **Ends** two months after notification of the move.	First day of the month following the notification of the move, but not earlier then the move.	MOV MSA Not Eligible
8	Change in Residence	Returning to the U.S. after permanently living outside the U.S.	Beneficiary's Attestation	**Before Move Begins** the month before month of permanent move. **Ends** two months after the move. **After Move Begins** month beneficiary notified plan of the move. **Ends** two months after notification of the move.	First day of the month following the notification of the move, but not earlier then the move.	RUS MSA Not Eligible
INSTITUTIONALIZED BENEFICIARIES						
9	Institutionalized Beneficiaries	Resides in skilled nursing facility, intermediate care facility, psychiatric, rehab, long-term care, or swing-bed hospital.	Beneficiary's Attestation Members address located in the facility	**Begins** first day Institutionalized. **Ends** two months after discharge. This election is continuous for those that reside in these facilities.	First of the month following receipt of the enrollment request.	LTC MSA Not Eligible
LOW INCOME BENEFICIARIES						
10	LIS (Non-Medicaid)	Have Part D subsidy.	Beneficiary's Attestation SSA	Once per quarter as long as beneficiary has a subsidy.	First of the month following receipt of the enrollment request.	HLP MSA Not Eligible

#	POPULATION	QUALIFICATION	REFERENCE	TIME FRAME	EFFECTIVE DATE	CODING
11	LIS (Loss of Status)	Have lost the Part D subsidy.	Beneficiary's Attestation SSA	**Begins** month of lost eligibility. **Ends** two months after loss of eligibility.	First of the month following receipt of the enrollment request.	NLS MSA Not Eligible
12	Dual Eligible	Have Medicaid.	Medicaid validated using the ForwardHealth Portal	Once per quarter as long as they have Medicaid.	First of the month following receipt of the enrollment request.	MDE MSA Not Eligible
13	Dual Eligible (Loss of Status) *Consider Member Most Likely Has LIS	Have lost Medicaid benefits.	Medicaid validated using the ForwardHealth Portal	**Begins** month of lost eligibility. **Ends** two months after loss of eligibility.	First of the month following receipt of the enrollment request.	SNP MSA Not Eligible
14	Loss of Employer Group Coverage	Voluntary or involuntary termination of group coverage.	Beneficiary's Attestation	**Begins** month group allows or disenrollment or date COBRA ends. **Ends** two months after group coverage ends.	Can choose an effective date up to three months in advance after receipt of election but not earlier than the first of the month following month in which the request is made.	LEC MSA Not Eligible
15	Involuntary Loss of Creditable Prescription Drug Coverage	Involuntary loss of coverage. Coverage is no longer creditable. This does not include loss of coverage due to nonpayment of premium. *Enrollment into MAPD.	Beneficiaries' Attestation Letter stating loss of creditable coverage	**Begins** either month of notice or month the loss or reduction of coverage occurs, whichever is later. **Ends** two months later.	First of the month following receipt of the enrollment request.	LCC MSA Not Eligible
TERMINATION OF PLAN CONTRACT						
16	Termination of plan contract with Medicare with mutual consent	Contract with Medicare is ending with mutual consent.	Beneficiaries' Attestation Termination Letter	**Begins** two months before termination. **Ends** one months after effective termination.	First day of the month after notice received or up to two months after the effective date of termination but not earlier than receipt of election.	EOC MSA Not Eligible
17	Termination of plan contract with Medicare without mutual consent	Contract with Medicare is ending without mutual consent.	Member Attestation Termination Letter	**Begins** one month before termination. **Ends** two months after effective termination.	First day of the month after notice received up to three months after month of termination but not earlier than receipt of election.	EOC MSA Not Eligible

#	POPULATION	QUALIFICATION	REFERENCE	TIME FRAME	EFFECTIVE DATE	CODING
STATE PHARMACEUTICAL ASSISTANCE PROGRAMS						
18	Some beneficiaries belonging to a State Pharmaceutical Assistance Program (SPAP) like Wisconsin Senior Care	Wisconsin Senior Care at any level. Senior Care ending. (Loss of Senior Care due to failure to pay premium is not considered involuntary.)	Wisconsin Senior Care award letter State of Wisconsin ForwardHealth Portal Member Attestation	**Begins** Immediately. **Ends** date of disenrollment. This election can only be used once per year.	First of the month following receipt of the enrollment request. This SEP is only to enroll into an MAPD or to switch from MA to MAPD.	PAP MSA Not Eligible
5-STAR PLAN						
19	Enroll into 5- Star Plan	Beneficiary may enroll into a plan with a 5-Star Rating during the year the plan has an overall 5-Star.	Plan Performance Star Rating	Continuous when the plan holds the 5-Star Rating.	First of the month following receipt of the enrollment request.	5ST MSA Not Eligible
DISENROLLMENT ELECTIONS						
20	Gain or maintain other creditable coverage	Gain or enroll in coverage such as Tri-Care, Wisconsin Senior Care or Veterans Affairs (VA).	Validation of Wisconsin Senior Care Letter indicating gain of creditable coverage	**Begins** immediately. **Ends** date elect disenrollment.	First of the month following receipt of the **written disenrollment request.** This is election is for disenrollment from a MAPD plan It can also be used to change from MAPD to MA.	OCC MSA Not Eligible
21	Trial Period	Individuals who are within their first 12 months of trying a Medicare Advantage Plan and wish to go back to go to a supplement with a guaranteed issue.	Plan must receive written request to disenroll to go back to Original Medicare or Supplement sighting they are in their first 12 months of an MA plan. *With MSA members who were previously enrolled in a supplement and who are enrolling for the first time into a Medicare Advantage plan and have a valid SEP to disenroll during their first 12 months of being on the MSA. They may go back to original Medicare and have a guaranteed issue of a Medicare Supplement. *With members of an MSA who have used their Initial Election Period (IEP) to enroll in the plan and do not have a valid disenrollment period. They may not use the SEP trial to disenroll from the plan.	**Begins** first time they are enrolled in MA. **Ends** 12 months after effective date.	First of the month following receipt of the **written disenrollment request.** This is election is for disenrollment from a MAPD plan It can also be used to change from MAPD to MA.	12G

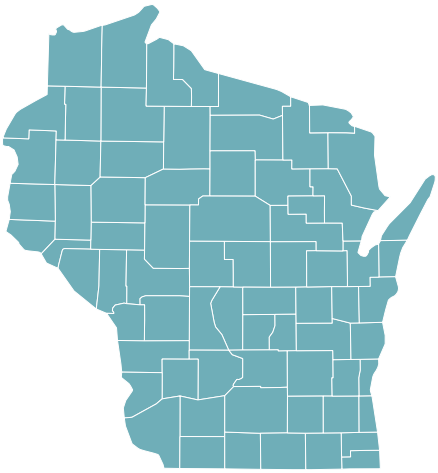
#	POPULATION	QUALIFICATION	REFERENCE	TIME FRAME	EFFECTIVE DATE	CODING
22	Beneficiaries turning 65	Have Parts A and B due to disability and are turning 65.	Individual's 65th Birthday	**Begins** three months before month of birthday. Includes birthday month. **Ends** last day of the third month after the 65th birthday.	**Written disenrollment request** made prior to month of birthday, termination date is first day of the month of birthday. **Written disenrollment request** made during or after birth month, termination date is first day of the month following the month of written notice.	12J
CANCELLING APPLICATIONS						
23	First time MSA enrollees (during AEP)	First time MSA application.	Return to original Medicare	After December 7 and up to December 15.	Verbal or written request.	
24	New applications to Network Health	Prior to plan effective date.	Return to prior plan or original Medicare	Prior to application date.	Verbal or written request.	

NETWORK HEALTH MEDICARE ADVANTAGE SERVICE AREA

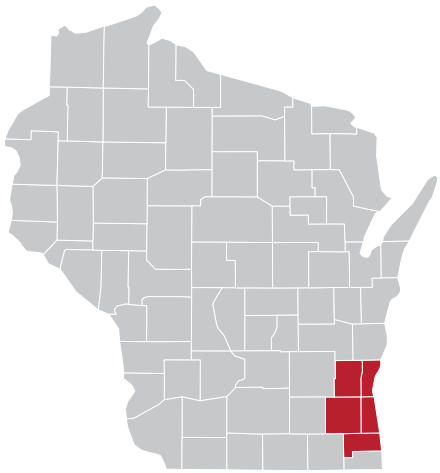


NORTHEAST PPO SERVICE AREA

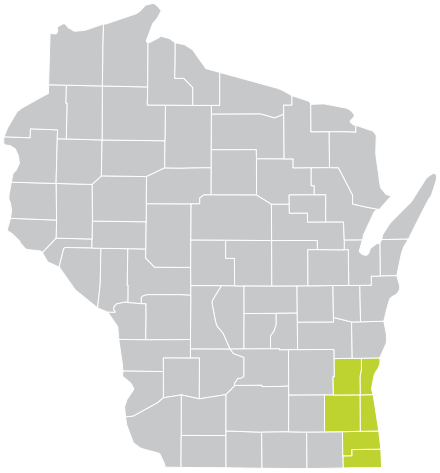
Network Platinum*Select* (PPO)
Network Platinum*Choice* (PPO)
Network Platinum*Plus* (PPO)
Network Platinum*Plus* Pharmacy (PPO)
Network Platinum*Premier* (PPO)
Network Platinum*Premier* Pharmacy (PPO)
Network*Cares* (PPO SNP)



NORTHEAST and SOUTHEAST MSA SERVICE AREA
Network*Prime* (MSA)



SOUTHEAST PPO SERVICE AREA
Network Health Medicare Go (PPO)
Network Health Medicare Anywhere (PPO)



SOUTHEAST HMO SERVICE AREA
Medicare Explore (HMO)

network health

Network*Prime* is a Medicare Medical Savings Account (MSA) plan. Here's how it works.

2020

Network*Prime* (MSA)

High-Deductible Health Plan

Medicare MSA Plans Have Two Parts

Medical Savings Account

This is a Medicare Advantage plan which covers your hospital and medical care (known as Medicare Parts A and B). Once you've paid a certain amount for health care (called the deductible), the plan begins paying.

Network*Prime* has a $5,100 deductible and a $0 monthly premium.

This is a special savings account used for health care costs. Once a year, Medicare deposits money into your account, and you can use this money to pay for health care before you meet the deductible.

Medicare deposits $1,500 into this account once a year.

BENEFIT	Network*Prime*
Premium	$0
Deductible	$5,100 See the chart on the back. Based on your plan effective date, your deductible will be prorated.
Annual deposit from Medicare	Medicare will deposit $1,500 into your account prorated based on when you enroll. See the chart on the back based on your plan effective date. *If you disenroll for any reason during 2020, you'll be asked to pay back a prorated amount based on the date you disenroll.*
Services like hospital stays, doctor visits and emergency room visits	All Medicare covered services are billed at the Medicare-approved amount until you reach the deductible. You pay nothing after you reach your deductible.

WHAT'S THAT?

MEDICARE MSA PLAN

This is a special type of Medicare Advantage plan that combines a high-deductible health insurance plan with a medical savings account. MSA plans are offered by private companies like Network Health and work with Medicare to provide your coverage. You can use the medical savings account to pay for health care services, while the high-deductible plan limits your out-of-pocket costs.

Account deposits pro-rated based on when a member joins

The deposits are prorated by Medicare based on the month the member joins the plan. See the chart below to learn what will be deposited each month.

Plan Effective Date	Deposit Dollar Amount	Plan Deductible
January 1, 2020	$1,500	$5,100
February 1, 2020	$1,375	$4,675
March 1, 2020	$1,250	$4,250
April 1, 2020	$1,125	$3,825
May 1, 2020	$1,000	$3,400
June 1, 2020	$875	$2,975
July 1, 2020	$750	$2,550
August 1, 2020	$625	$2,125
September 1, 2020	$500	$1,700
October 1, 2020	$375	$1,275
November 1, 2020	$250	$850
December 1, 2020	$125	$425

EXTRAS

Benefits that Travel with You

Are you always on the go? Then, Network*Prime* may be the plan for you. No matter where you are in the United States, you have access to quality doctors, hospitals and facilities.

With Network*Prime*, there is no such thing as a network. Any doctor or hospital that accepts Medicare beneficiaries should also accept your Network*Prime* coverage.

Wellness Rewards

By completing three activities that are essential to your health and wellness, you can earn up to $180 in gift cards. It's simply that easy to stay healthy.

1. Receive $100 in gift cards for your Annual Wellness Visit.
2. Receive $50 in gift cards for your routine labs.
3. Receive $30 in gift cards for your flu shot.

network health

800-983-7587 (TTY 800-947-3529)

Monday–Friday 8 a.m. to 5 p.m.
From October 1–December 31, we are available
Monday–Friday from 8 a.m. to 6 p.m.
and Saturday, from 8 a.m. to noon.

networkhealth.com

Network*Prime* is a Medical Savings Account (MSA) plan with a Medicare contract. Enrollment in Network Health Medicare Advantage plans depends on contract renewal. Network Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. If you, or someone you're helping, has questions about Network Health, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 800-378-5234 (TTY 800-947-3529). Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Network Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800-378-5234 (TTY 800-947-3529). Hmong: Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Network Health, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 800-378-5234 (TTY 800-947-3529). H1181_2011-02-0819_M Accepted 08232019

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Common Questions about MSA Enrollment for 2020

Who can join a Medicare Medical Savings Account (MSA) plan?

People enrolled in both Medicare Parts A and B, who live in the plan's service area can generally join a Medicare MSA Plan.

Who can't join a Medicare MSA plan?

- A member or prospect who has health coverage that would cover the Medicare MSA plan deductible, including benefits under an employer or union group health plan.
- A member or prospect who gets benefits from the Department of Defense (TRICARE) or the Department of Veterans Affairs.
- A member or prospect who is a retired federal government employee and part of the Federal Employee Health Benefits Program.
- A member or prospect who is eligible for Medicaid.
- A prospect who has end-stage renal disease (ESRD).

Exceptions for Elibigility Rule

1. If the member was a former enrollee of a Medicare Advantage Plan who left Medicare and hasn't joined another Medicare Advantage plan, the member can join a Medicare MSA plan even if he or she has ESRD.
2. If the member is a current member of our commercial group plan, or on one of our other MAPD plans, he or she could go on the MSA.
   - The member has had a successful kidney transplant.
   - A member or prospect who is currently getting hospice care.
   - A member or prospect who lives outside the United States more than 183 (total) days a year.

When can a person join a Medical Savings Account (MSA) Plan?

A prospect can join a Medicare MSA plan during the following times.

- When prospects first become eligible for Medicare during the seven-month period that begins three months before they turn 65, includes the month they turn 65 and ends three months after the month they turn 65. If they have Medicare because they are disabled, they can join three months before and after their 25th month of getting cash disability benefits.
- When prospects delay Part B, they could apply the month prior to their Part B effective date.
- During the annual election period (AEP), members can select a Medicare MSA Plan between October 15–December 7 of each year. Enrollment will be effective on January 1.
- There are no special election periods (SEPs) to join a MSA.
- A **current Network Health member** can join the MSA during the AEP to be effective January 1. **The member must complete a new application**, rather than a short enrollment form. The MSA is under a separate contract from our other plans.

***Note**—The yearly deposit is prorated based on when enrollment begins (see chart on back). Enrollment will be effective no earlier than the first day of the month following the request to enroll.*

When and how can a member leave a Medicare MSA Plan?

- Enrollment is generally for a calendar year. A member can choose to leave during the AEP. Disenrollment will be effective January 1.
- A member can disenroll if the member is entering a nursing home.
- A member can disenroll if the member moves out of the plan's service area.
- Other special elections could apply.

The Medicare Advantage Disenrollment Period between January 1 and March 31 doesn't apply to the MSA.

- If a member or prospect chooses a Medicare MSA Plan for the first time during AEP, and then they change their mind, they can cancel their enrollment up to December 15 of the same year. They still only have until December 7, to join another health or drug plan.
- After December 7 and up to December 15, a member can only return to Original Medicare.

The SEP trial applies in some situations.

- MSA members who were previously enrolled in a supplement and who are enrolling for the first time into a Medicare Advantage Plan have a valid SEP to disenroll during their first 12 months of being on the MSA. They may go back to Original Medicare and have a guaranteed issue of a Medicare Supplement.
- Members of an MSA who used their Initial Election Period (IEP) to enroll in the plan do not have a valid disenrollment period. They may not use the SEP trial to disenroll from the plan.
- MSA enrollees may not use the MA OEP to disenroll from the MSA.

Network Health will terminate an enrollment if—

- The member goes on Medicaid.
- The member enrolls in a Federal Employee Health Benefits Program plan.
- The member receives health care benefits from the Department of Defense (TRICARE) or the Department of Veterans Affairs.
- The member gets benefits (like an employer or union group health plan) that cover all or part of the yearly MSA deductible permanently.
- The member moves outside of the service area of the plan, or is temporarily out of the service area for longer than six months.

Health and Wellness Rewards

Earn gift cards
Up to $180
Wellness exam **$100**
Screening labs **$50**
Flu shot **$30**

Will account deposits be pro-rated based on when a member joins?

Yes. The deposits are prorated by Medicare based on the month the member joins the plan. See the chart to learn what will be deposited each month.

Plan Effective Date	Deposit Dollar Amount	Plan Deductible
January 1, 2020	$1,500	$5,100
February 1, 2020	$1,375	$4,675
March 1, 2020	$1,250	$4,250
April 1, 2020	$1,125	$3,825
May 1, 2020	$1,000	$3,400
June 1, 2020	$875	$2,975
July 1, 2020	$750	$2,550
August 1, 2020	$625	$2,125
September 1, 2020	$500	$1,700
October 1, 2020	$375	$1,275
November 1, 2020	$250	$850
December 1, 2020	$125	$425

What happens to the money in the account if a member leaves the plan or the application is canceled before the end of the year?

No more money will be added to their account and the member will need to pay part of the most recent yearly deposit (based on the number of months left in the current calendar year) back to Medicare.

Plan Termination Date	Recoupment Amount*
February 1, 2020	$1,375
March 1, 2020	$1,250
April 1, 2020	$1,125
May 1, 2020	$1,000
June 1, 2020	$875
July 1, 2020	$750
August 1, 2020	$625
September 1, 2020	$500
October 1, 2020	$375
November 1, 2020	$250
December 1, 2020	$125

*The recoupment amount is pro-rated by CMS

Service	Can I use the money in my account for this?	Will it count toward my deductible?	Is this expense taxed? (50% tax)
Medicare-Covered Hospital and Medical Care (Part A and B services) • Doctor visits • Hospital stays	Yes	Yes	No
Other Qualified Medical Expenses • Dental care • Vision care • Pat D prescription drugs	Yes	No	No
Non-Medical Items • TV • Groceries	Yes	No	Yes

MSA Agent Pricing

network health

This is only an estimate based on average claims for these services. This is not a guarantee of costs. Actual costs may vary and are dependent on the coding by the provider.

AGENT USE ONLY				
Service	**Low Average Estimated Cost**	**Medium Average Estimated Cost**	**High Average Estimated Cost**	**Comments**
Annual Wellness Visit Only	**$112**	**$163**	**$197**	If sole visit is Medicare wellness visit. Includes complete blood count
Annual Wellness Visit with Other Services	**$182**	**$281**	**$675**	Estimates include wellness visit plus lipid panel, glucose testing, fecal occult blood test and depression screening. High estimate includes cost for screening colonoscopy.
Annual Routine Physical (Non-Medicare Covered)	**$309**	**$408**	**$443**	Since this is a non-Medicare covered service, these estimates are average billed charges as discounts don't apply. If sole visit is routine physical; high cost includes complete blood count.
Flu Vaccine	**$30**	**$48**	**$65**	Estimates include cost for vaccine and administration
Pneumonia Vaccine	**$99**	**$135**	**$178**	Estimates include cost for vaccine and administration
Pap/Pelvic Exam	**$116**	**$134**	**$152**	Estimates include pap smear and interpretation plus pelvic exam/ cervical or vaginal cancer screening
Mammography	**$190**	**$223**	**$256**	Estimates include professional mammography screening and computer aided
Prostate Cancer Screening	**N/A**	**$128**	**$246**	Estimates include digital rectal exam, prostate specific antigen test and an estimate for the office visit cost
Glaucoma Screening	**N/A**	**$49**	**$53**	Estimated cost for glaucoma screenings
Doctor or Specialist Office Visits	**N/A**	**$85**	**$184**	Estimates can vary based on duration of visit, new vs. established patient; estimates do not include additional services during office visit such as additional screenings, labs or other tests
Physical, Speech, Occupational Therapy	**N/A**	**$90**	**$134**	Estimated cost for each therapy visit
Podiatry	**N/A**	**$61**	**$86**	Estimated cost for podiatry visits
Pet Scan	**$946**	**$1,262**	**$1,577**	Estimates include average cost for PET scan +/- 25%
CT Scan	**$243**	**$324**	**$404**	Estimates include average cost for CT scan +/- 25%
MRI	**$362**	**$483**	**$603**	Estimates include average cost for MRI +/- 25%
AGENT USE ONLY				

Network*Prime* is an MSA plan with a Medicare contract. Enrollment in Network Health Medicare Advantage Plans depends on contract renewal. H1181_2132-01-1118_C

Top EIGHT Things to Know About a BenefitWallet Account

BenefitWallet®

1. Debit Card - If the member reports a lost or stolen debit card

- Soft transfer the call to BenefitWallet.
- BenefitWallet will cancel the current card and reissue a new one.
- The account number remains unaffected.
- BenefitWallet will assess a $5 fee for the new debit card. The fee will be deducted from the member's account balance.

2. Checkbook - If the member reports a lost or stolen checkbook

- Soft transfer the call to BenefitWallet.
- BenefitWallet will place a stop payment on the lost/stolen checks.
- BenefitWallet will issue a new checkbook and range of checks.
- BenefitWallet will assess a $5 fee for the checkbook order. The fee will be deducted from the member's account balance.

3. Bank Account Balance Inquiry - Member would like to know current balance in his or her account

- If a BenefitWallet representative is not required, connect members to the automated voice response system which will read back their current balance and recent transactions.
- If the member needs to speak with a representative, soft transfer the call to BenefitWallet.

4. Address Update - Member would like to update his or her banking address

- Soft transfer the call to BenefitWallet.

5. Fraudulent Activities - If member suspects fraudulent activities on his or her bank account

- Soft transfer the call to BenefitWallet.
- Member reports transactions within 60 days of the date that BenefitWallet issues the statement.
- Member will be provided a fraud affidavit to complete and return to BenefitWallet.
- Member would get provisional credit for unauthorized transactions, pending BenefitWallet investigation.
- This applies to both debit card transactions and checks.
- Network Health Enrollment and BenefitWallet will work together to do the following.
  - Go through account opening process
  - Collect new master signature card
  - Create new bank account number
  - Issue new checkbook and new debit card for the new account number
  - Provide bank fraudulent activities affidavit

6. Member Account - If a member leaves the plan and enrolls again at a later time, the member must speak directly to BenefitWallet and provide written authorization via the account reopen form to reopen the account.

7. BenefitWallet's MSA Contact Center phone number is 888-769-4788.

8. U.S. Patriot Act - If members recieve letters from BenefitWallet requesting documentation to verify their identities

- Soft transfer the call to BenefitWallet.
- Members should mail the requested documentation to BenefitWallet.
- Members should speak with a BenefitWallet representative for additional information.

BenefitWallet®

Master Signature Card — Medical Savings Account
The Bank of New York Mellon

Name (1): _____ Account Number: _____

SSN: _____ Date: _____

Name (2): _____ (Please print name of any additional "Authorized Signature" signed below.)

REQUEST FOR TAX CERTIFICATION

Under penalties for perjury, I certify that the SSN number shown on this form is my correct taxpayer identification number and I am a citizen or resident of the United States.

The IRS does not require you to consent to any provision of this document.

By signing this card and opening a Medical Savings Account with The Bank of New York Mellon (the "Bank"), I agree: (a) To be bound by the Deposit Agreement & Disclosure Statement applicable to the Medical Savings Account established by this card, as that agreement may be amended from time to time; (b) To be bound by the Bank's agreements and disclosures applicable to any additional accounts that I establish with the Bank in the future as an individual, custodian, or single trustee.

This Master Signature Card Agreement will remain in effect as long as I continuously maintain at least one covered account with the Bank.

Authorized Signature(s): Please sign your authorized signature(s) in the boxes below.

1. _____ 2. _____

If this signature card was delivered to a P.O. Box, please indicate your residential address below:

Street Address: _____

City: _____ State: _____ Zip: _____

Beneficiary Designation Form

I hereby certify that, if I die before distribution has been completed, the value of my account shall be distributed to the person(s) named below. If all Primary Beneficiaries die before me, the Contingent Beneficiary(ies) named below will receive the value of my account.

Primary Beneficiary(ies)			
Name		Name	
Address		Address	
City, State, and Zip		City, State, and Zip	
Relationship	SSN	Relationship	SSN
Date of Birth	Percent (%)	Date of Birth	Percent (%)
Contingent Beneficiary(ies)			
Name		Name	
Address		Address	
City, State, and Zip		City, State, and Zip	
Relationship	SSN	Relationship	SSN
Date of Birth	Percent (%)	Date of Birth	Percent (%)

Important - Return the completed form with your Medicare Advantage high-deductible plan enrollment form to your agent or by mail by using the prepaid envelope provided, or by mailing your documents to Network Health Insurance Corporation, ATTN Medicare Products, PO Box 120, Menasha WI 54952. 2615-01-0819

Scope of Appointment Form

Personal/individual marketing appointments typically take place in the beneficiary's home, but these appointments can occur in other venues such as a library or coffee shop. All one-on-one appointments with beneficiaries are considered sales/marketing events. However, one-on-one appointments are not entered into the marketing events module.

Before the appointment

- A scope of appointment form must be completed by the beneficiary and returned to the agent prior to the appointment.
- If the agent is unable to receive the signed scope of appointment form prior to the appointment, the agent should have the beneficiary sign the form at the beginning of the marketing appointment.
- CMS expects agents/brokers to maintain documentation on why it was not feasible to obtain the scope of appointment prior to the appointment.

At the appointment

- Representatives can only discuss topics that were agreed upon within the scope of appointment.
- Representative may not market non-health care related products (such as annuities or life insurance).
- If other products need to be discussed at the request of the beneficiary, a second scope of appointment needs to be filled out. Then the appointment can be continued. Ideally this will be completed 48 hours ahead of time when practical.
- A beneficiary may sign a scope of appointment form at a marketing presentation for a follow-up appointment. In these instances, the 48-hour waiting period does not apply. For example, if a beneficiary attends a marketing presentation, and after the presentation, requests an individual appointment, the sales person can arrange for that appointment to occur immediately following the sales presentation provided the beneficiary has completed the scope of appointment form.

Please Note

CMS does not allow agents/brokers to solicit or accept an enrollment request (application) for a January 1 effective date prior to the start of the Annual Enrollment Period (AEP) unless the beneficiary is entitled to another enrollment period.

Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss. Please refer to the other side for product type description.

☐ **Stand-alone Medicare Prescription Drug Plans (Part D)**
☐ **Dental**
☐ **Medicare Advantage Plans (Part C) and Cost Plans**

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan. Signing this form does NOT obligate you to enroll in a plan, affect your current or future enrollment, or automatically enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:	
Signature:	Signature:
Signature Date:	Signature Date:
If you are the Authorized Representative, please sign above and print below:	
Representative Name:	Your Relationship to the Beneficiary:
To be completed by Agent:	
Agent Name:	Agent Phone:
Beneficiary Name(s):	Beneficiary Phone (Optional):
Beneficiary Address (Optional):	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)	
Agent's Signature:	
Plan(s) the agent represented during this meeting:	
Date Appointment Completed:	
[Plan Use Only:]	

Scope of Appointment documentation is subject to CMS record retention requirements

☐ Stand-alone Medicare Prescription Drug Plans (Part D)

Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service Plans, and Medicare Medical Savings Account Plans.

☐ Dental

☐ Medicare Advantage Plans (Part C) and Cost Plans

Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.

Medicare Private Fee-For-Service (PFFS) Plan — A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.

Medicare Special Needs Plan (SNP) — A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.

Medicare Medical Savings Account (MSA) Plan — MSA Plans combine a high deductible health plan with a bank account. Medicare deposits money into the account. You can use it to pay your medical expenses until your deductible is met.

Medicare Cost Plan — In a Medicare Cost Plan, you can go to providers both in- and out-of-network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.

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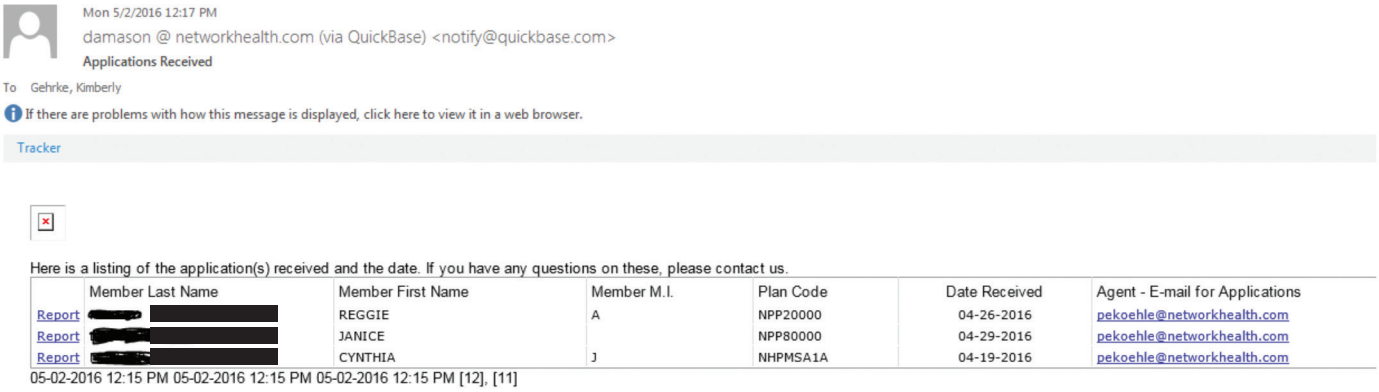
Application Verification Email

When writing new business or submitting short enrollment forms for existing business, agents will receive a verification email within 24-48 business hours. If agents do not receive that email, please call the client managers or your account executive to validate if the application was received.

Sample Verification email



Mon 5/2/2016 12:17 PM
damason @ networkhealth.com (via QuickBase) <notify@quickbase.com>
Applications Received

To Gehrke, Kimberly

If there are problems with how this message is displayed, click here to view it in a web browser.

Tracker

Here is a listing of the application(s) received and the date. If you have any questions on these, please contact us.

	Member Last Name	Member First Name	Member M.I.	Plan Code	Date Received	Agent - E-mail for Applications
Report	[redacted]	REGGIE	A	NPP20000	04-26-2016	pekoehle@networkhealth.com
Report	[redacted]	JANICE		NPP80000	04-29-2016	pekoehle@networkhealth.com
Report	[redacted]	CYNTHIA	J	NHPMSA1A	04-19-2016	pekoehle@networkhealth.com

05-02-2016 12:15 PM 05-02-2016 12:15 PM 05-02-2016 12:15 PM [12], [11]

FORMS

AEP Short Enrollment Request Form (available October 15–December 31)

Post AEP Short Enrollment Form (starts January 1)

Prescription Drug Claim Form Part D

Personal Health Information Consent Form

Services Requiring Authorization

MARKETING COMPLIANCE

Each year, the Centers for Medicare and Medicaid Services (CMS) issues Medicare Marketing Guidelines. These guidelines are designed to implement the CMS marketing requirements and related provisions of the Medicare Advantage (MA, MA-PD), Medicare Prescription Drug Plan (PDP) and 1876 cost plans. Visit cms.gov for a full overview of the marketing guidelines.

Marketing Materials

- All marketing materials need to include disclaimers per CMS guidelines.
- All marketing materials that mention Network Health must be approved by Network Health. Materials which are not approved cannot be used.

Sales Events

- All sales events representing Network Health must be filed with Network Health at least seven days prior to the event.
- If nominal gifts or prizes are offerred, they must be less than $15 per person. Cash gifts are prohibited. For detailed CMS instructions on gifts and prizes, see the Medicare marketing guidelines.
- If a representative is conducting a sales event at a pharmacy or in a health care setting it must be done in a common area (cafeterias, community rooms, etc.).
- Light refreshments (coffee, cookies, juice, etc.) may be served at sales events.
- Representatives cannot require beneficiaries to provide name/addresses.
- Representatives can distribute applications.

Appointments/Leads

- If you are given a lead you must call in advance to schedule an appointment. You cannot show up at the person's house.
- Prior to any appointment, the agent must have a scope of appointment signed which will identify the specific types of plans that will be discussed.
- Representatives can only discuss products agreed upon within the scope of appointment form.
- Agents must always give clear, thorough and accurate information.
- Agents are responsible to ensure all information on the enrollment form is complete, accurate and legible.

Prohibited Forms of Agent Contact

- Cold calling
- Unsolicited texts
- Unsolicited emails
- Door-to-door sales
- Calling/emailing referrals – potential clients must call you

Prohibited Activities

- Offering or giving cash promotions to induce the referrals
- Offering gifts that are greater than nominal value ($15)
- Health screenings of members (other than asking if they have end stage renal disease)
- Back dating enrollment forms (effective date is always the first of the month following completion of the enrollment form)
- Selling in a provider's office
- Selling a Medicare Advantage Plan as a Medicare Supplement or Medicare Supplement Replacement Plan
- Selling a Medicare Supplement in addition to a Medicare Advantage Plan
- Selling against a competitor by unfairly presenting the plan information
- Using disparaging remarks about competing companies or agents
- Presenting misleading information regarding any insurance plan or policy
- Encouraging Medicare beneficiaries to enroll or not enroll based on current health status
- Using high pressure sales tactics
- Requiring a face-to-face meeting if somebody requests information on a product
- Saying a Medicare Advantage Plan is the same as original Medicare
- Making claims about Medicare, CMS or any government agency to include but not limited to the following.
    - Claims that agents work for or represent any of the above
    - Claims that agents endorse our plans
    - Claims that agents recommend beneficiaries enroll in a Medicare Advantage Plan
- Charging marketing, administrative, enrollment or similar fees
- Requesting phone numbers or email addresses when asking for referrals

AGENT DISCIPLINARY PROCEDURES

It is Network Health Plan (NHP) and Network Health Insurance Corporation's (NHIC) intent to uphold integrity through ethical and legal conduct in the operation of our business, the provision of insurance coverage for health care services and the participation in government health care programs. We continually strive to earn and maintain a reputation for lawful and ethical behavior in the treatment of our current members and prospective members.

Concerns about illegal conduct or potential fraud committed by plan representatives or anyone outside NHP/NHIC should always be reported, and will always be taken seriously and fully investigated. Appropriate corrective action will be taken. NHP/NHIC expects all plan representatives to conform to the highest ethical and legal standards. If you have concerns about defining proper legal conduct for you, promptly contact your account executive.

If determined that a plan representative is not following marketing guidelines or behaving unethically, NHP will take disciplinary action up to and including termination of appointment. If appointment is terminated, commissions cannot be paid.

The following procedures will be followed.

A. Interview the person reporting the behavior
B. Interview any other people who were involved, including the plan representative the complaint is about
C. Gather all evidence and information needed to make a fair decision
D. Take appropriate action

The following marketing issues would be grounds for immediate termination.

A. Forgery
B. Marketing in prohibited settings
C. Fraudulent misrepresentation
D. Targeting marketing misrepresentations to vulnerable beneficiaries
E. Marketing without Network Health Insurance Corporation's approval. CMS must approve all marketing materials
F. Churning business
G. Door-to-door solicitation
H. Engaging in sales activities at health fairs, educational events, conference, expos, state or community-sponsored events
I. Representing or misleading prospects by implying you work for Medicare, CMS or any government agency
J. Stating Medicare or CMS endorse our plans
K. Charging Medicare beneficiaries marketing administrative, enrollment or similar fees
L. Failure to use the scope of appointment form
M. Offering gifts of payments to induce enrollment
N. Applicant did not intend to enroll
O. High-pressure sales and tactics

The following marketing issues will be addressed with counseling sessions, up to termination if necessary.

A. Requiring a face-to-face call when prospects request information
B. Requesting phone numbers when asking for referrals
C. Applicant states agent misrepresented plan
D. Giving false, misleading, half true or exaggerated statements
E. Selling against a competitor by unfairly presenting the premiums, benefits, company information and/or coinsurance
F. Using disparaging remarks about competing companies or agents
G. Application changed and not initialed by applicant
H. No Part B of Medicare
I. Out-of-area enrollment
J. Application not signed
K. Application unreadable – must be complete, accurate and legible
L. Holding applications past the signature date

Individual Enrollment Request Agent Agreement

I have reviewed How to Complete an Individual Enrollment Request Form with my account executive and agree to complete the application in its entirety.

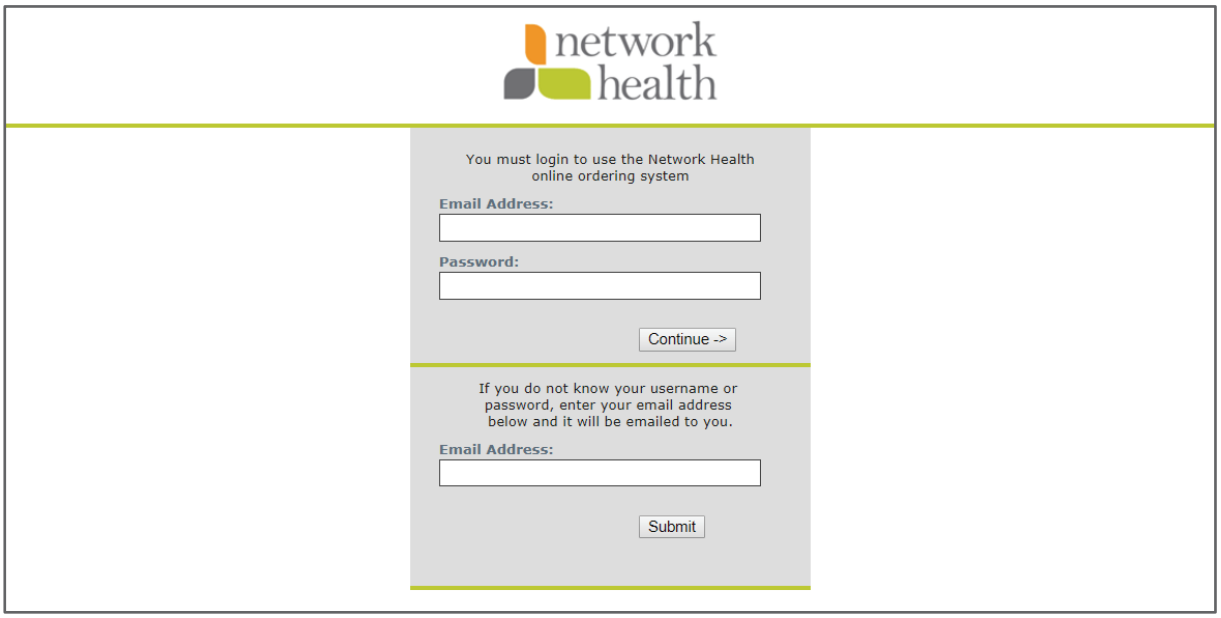
I understand I must check my verification emails to ensure all business I have written is received by Network Health. I will also validate that the plan type is correct. These will be received 24-48 hours after submitting the business.

I understand it is vital that I fax, upload to the NHP Request Tracker, or drop off all applications to Network Health the same day I take possession of the application. If I receive an application via mail and the prospect has already signed and dated the application, I will note on the last page of the application why the signature date is not the same as when I am submitting the business.

Delays in receipt of applications will be tracked, reviewed and investigated by your account executive. Disciplinary action will be taken if applications are not received timely.

MEDICARE AGENT ORDERING SITE

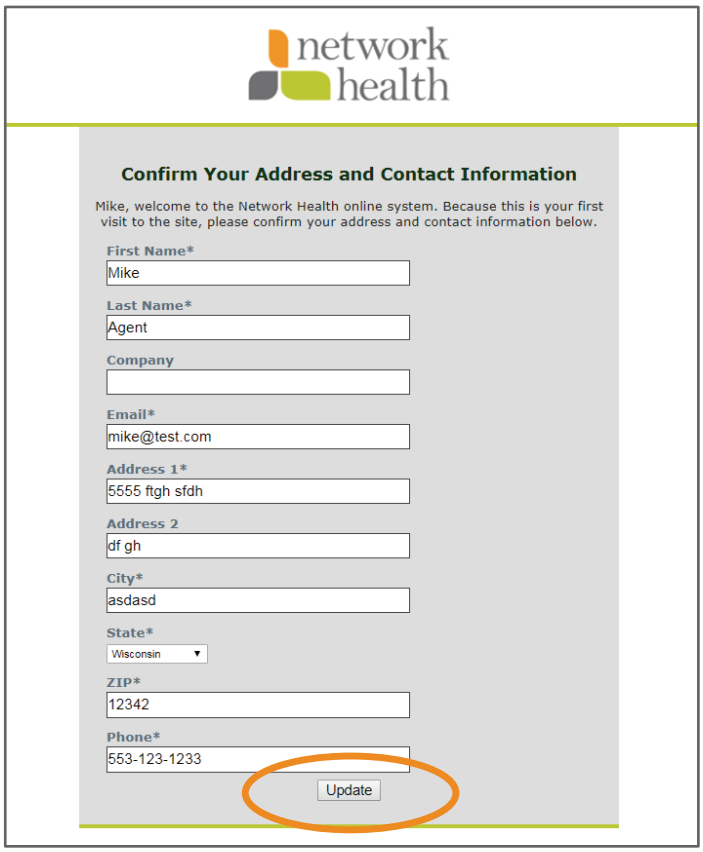
Website address: **networkhealth.envision-ink.com**



At the welcome screen, enter your email address (this is the email address Network Health has on file and uses to communicate with you). Your password will be your 6-digit agent ID. If yours begins with a 0 you will need to enter those leading 0's so you have 6 digits in the password box. Then click **Continue**.

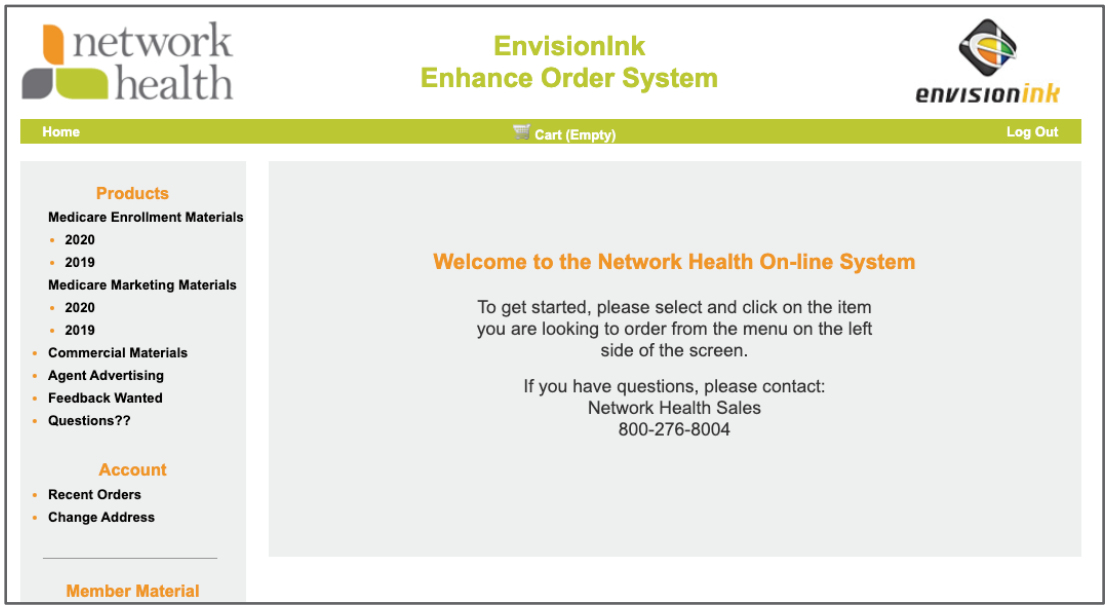
The first time you log in, you will be asked to confirm your address and contact information. The information listed is what Network Health has on file for you. If everything looks correct, select the box to confirm and then click **Continue**.

If the information is incorrect, click on the link **I need to edit my contact information**.



Changes you make to your contact information will be submitted to Network Health agent management for review and you may be contacted to verify the changes.

Now you will be at the home screen. Next time you log in, you will be taken directly to this screen.

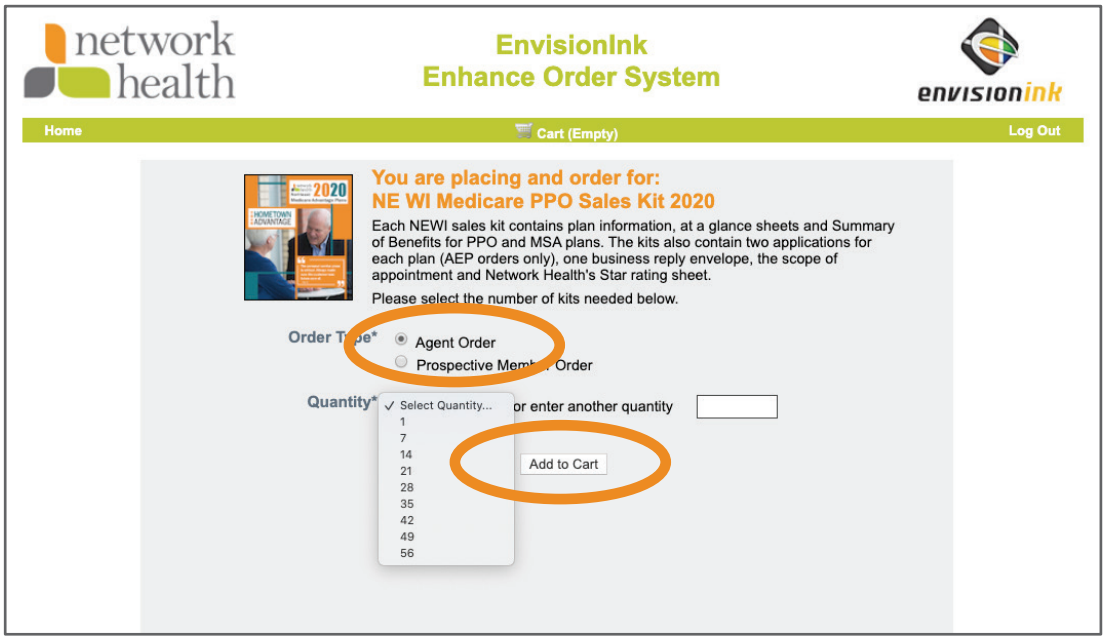


To begin an order for enrollment materials, click the **2020** link on the left of the screen under **Products/Medicare Enrollment Materials**. On the enrollment materials screen you will see all the Network Health sales kits available to order, as well as extra enrollment forms. (*Scroll down the page to display.*)

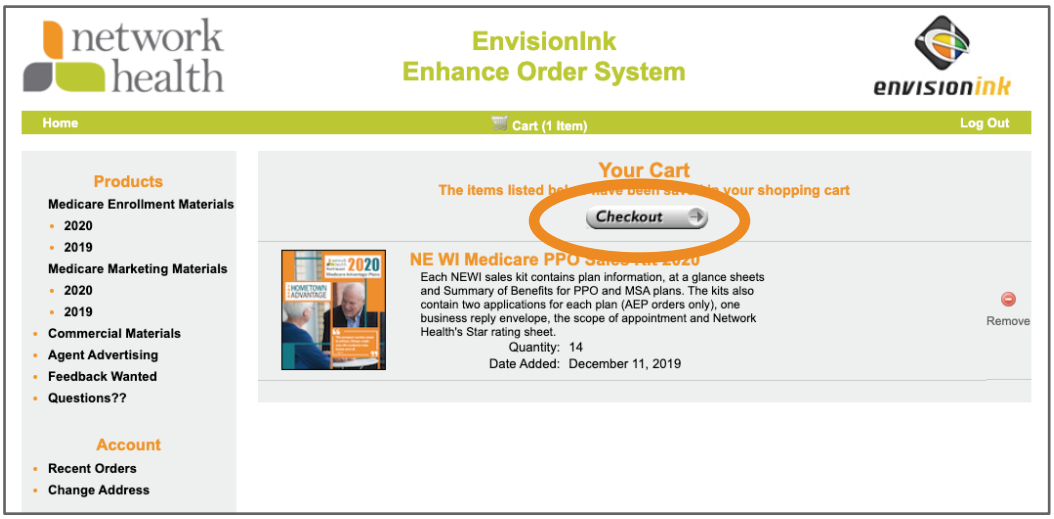
Agents must meet product-specific qualifications to order certain sales kits. If you have not taken the product test, the sales kit will be greyed out with the **Qualifications Not Met** message displayed over it.

Click **Order** for the product you would like to request.

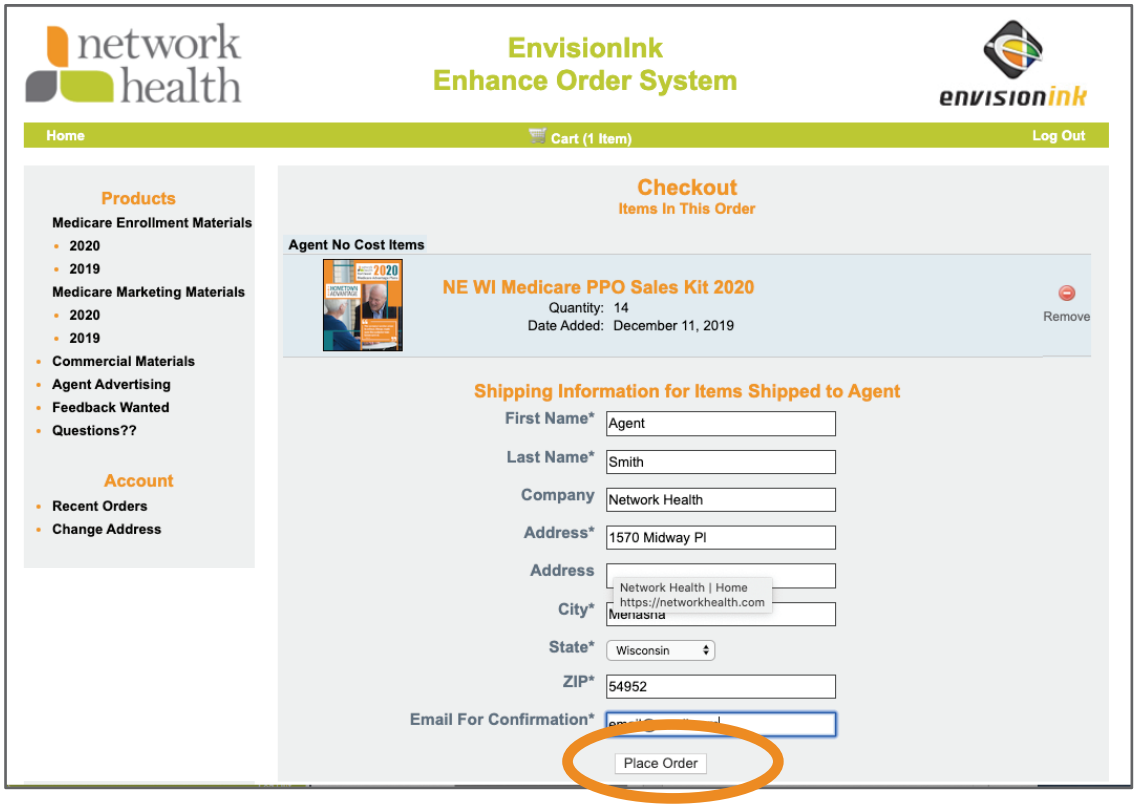
When you reach the product page, you will see two options. The first is to order materials that will be sent directly to you. Select the quantity and then click **Add to Cart**.



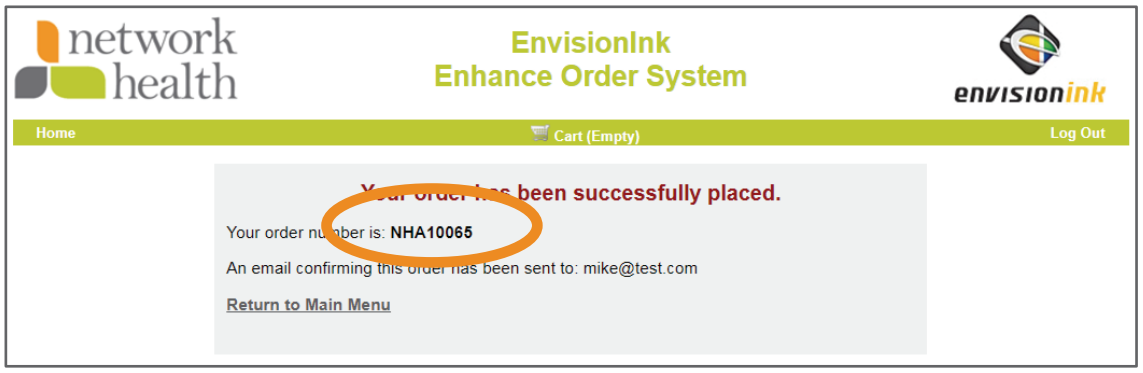
Then you will be taken to your cart where you can see your order. To order more materials, click on **2020** under the **Medicare Enrollment Materials** in the left panel again. If your order is complete, click **Checkout**.



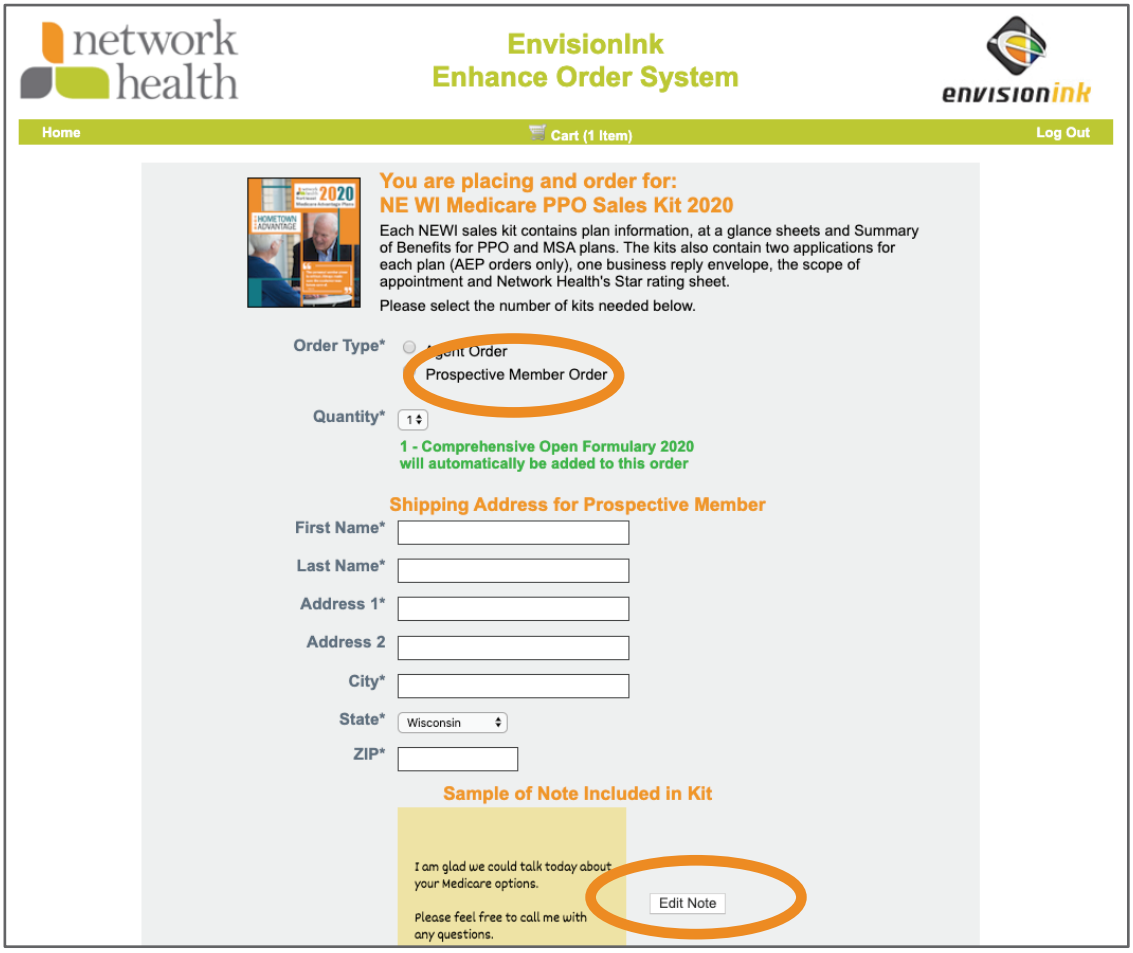
The checkout screen will confirm your address again. If your address is incorrect or you need to ship to a different location, such as your home rather than the office, you have the ability to override the address for that order only. Make any necessary changes, then click **Place Order**.



When your order is placed, a confirmation number will display. You will also receive a confirmation email.

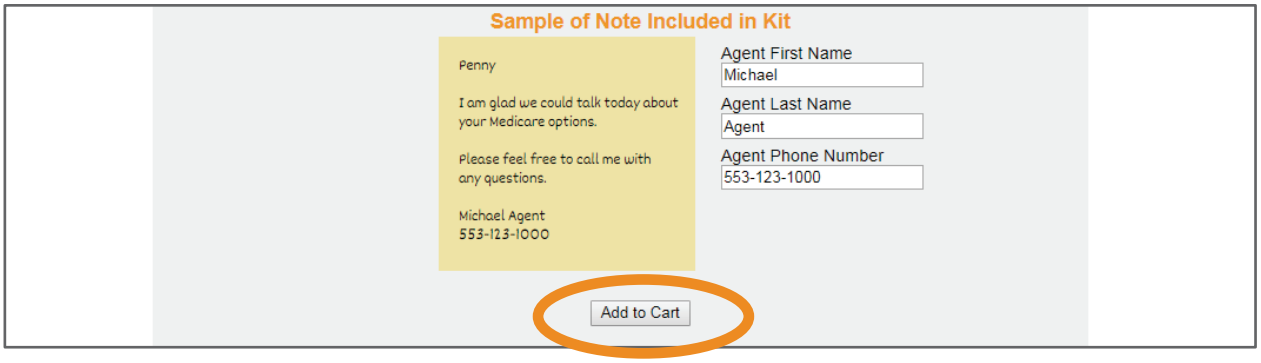


In addition to being able to order materials in bulk, you can also have a sales kit sent directly to your prospect. This will be sent on your behalf and includes a personalized note with your contact information. Simply enter your prospect's name and address information.

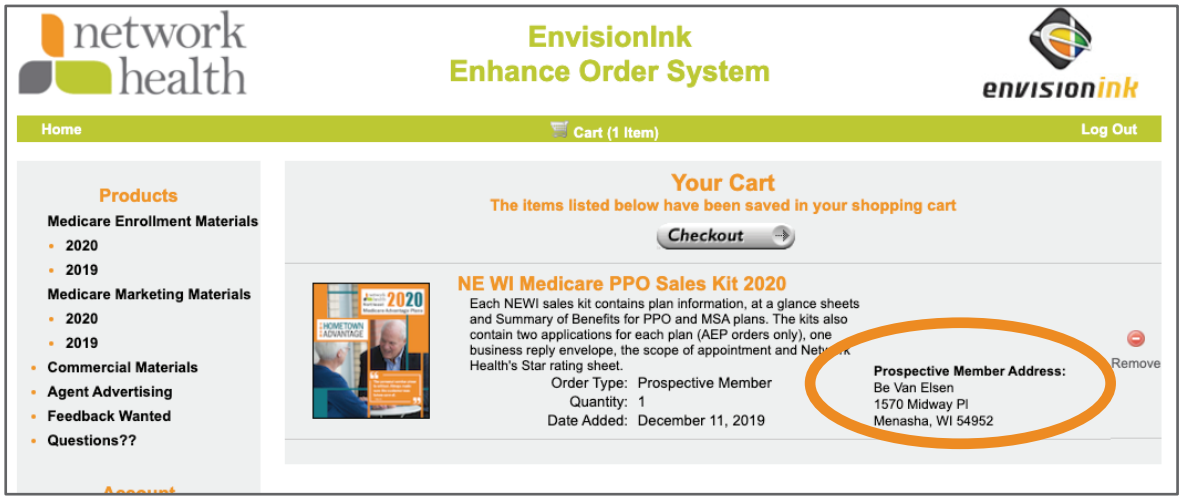


When you enter the prospect's information, you will see the note below populate the prospect's name and your contact information.

If you would like your name or phone number to appear differently, simply click **Edit Note**. The note will update with your changes. Only the agent name and phone number is editable. This note will be affixed to the top of the sales kit. When you are finished with your entry, click **Add to Cart**.



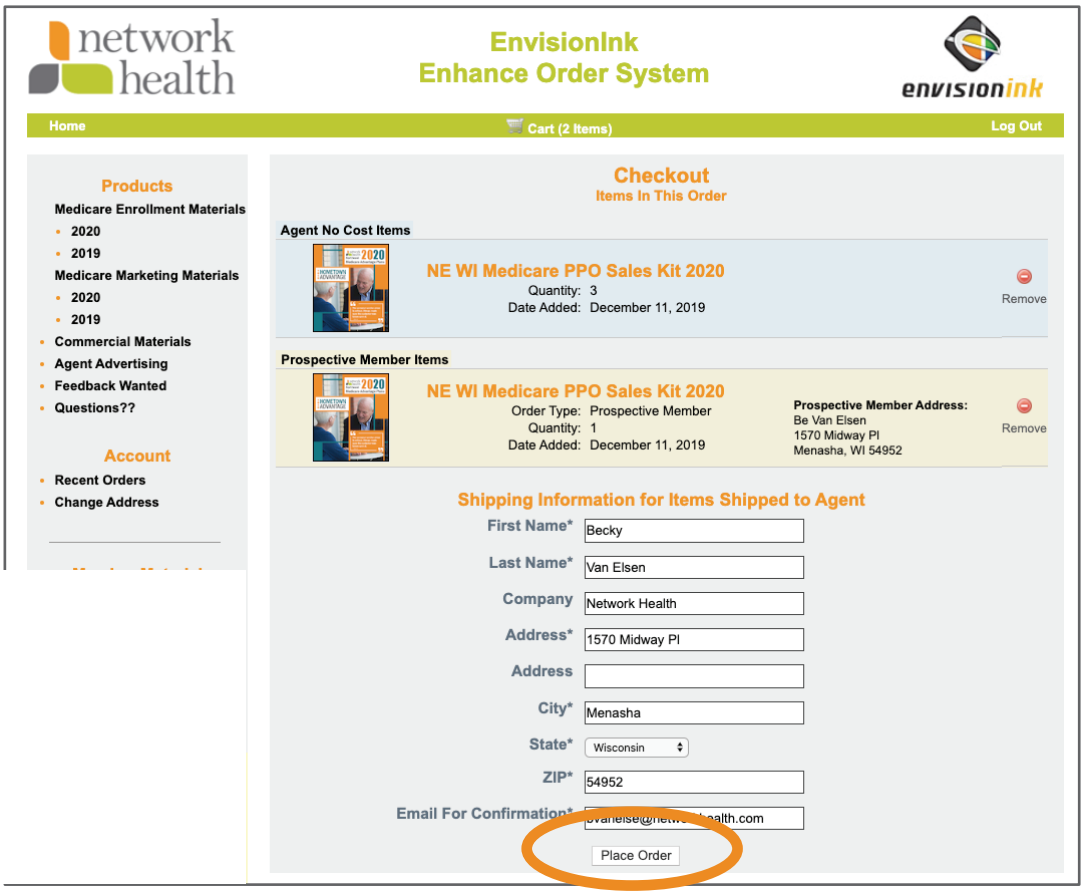
Your cart will be displayed, however this time you will see the address for your prospect kit.



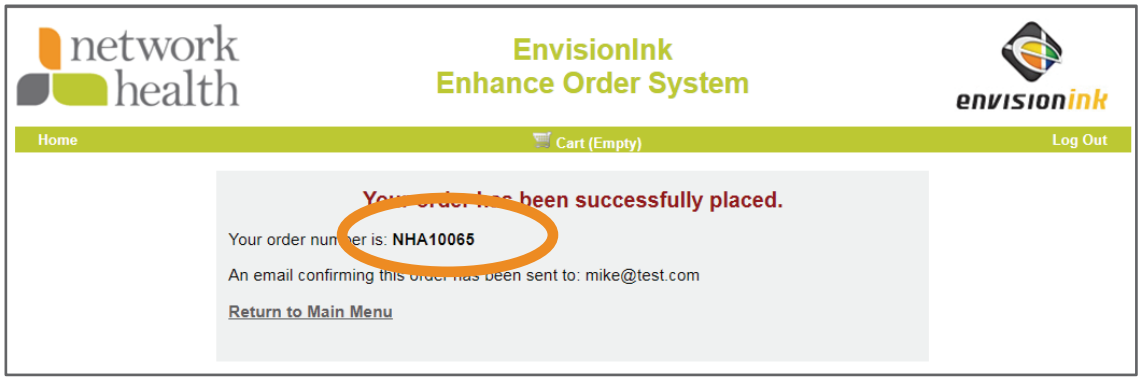
Agent orders and prospect orders can be combined in your shopping cart and each will be delivered as directed.

When you click **Checkout**, you will have the option to make changes to the agent address, as shown on the next page.

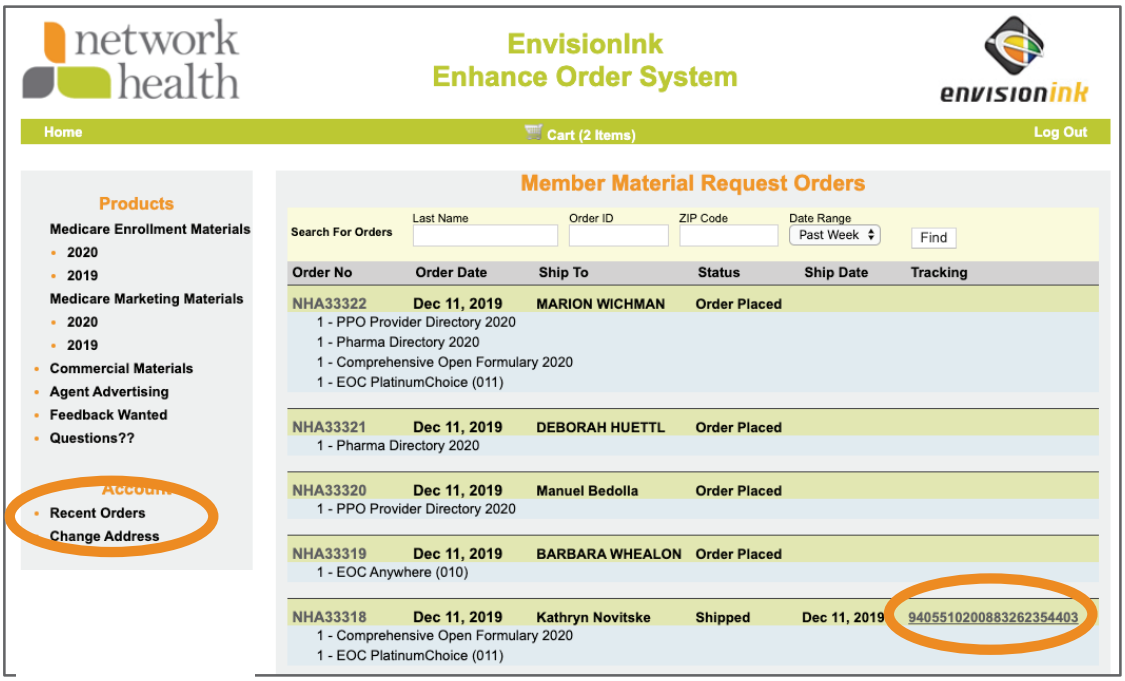
Any changes made on this page are only for that specific order. If you need to change your address permanently, please contact your account executive.



If everything is correct, click **Place Order**. A confirmation number will be displayed and a confirmation email will be sent to you.



You can track the status of your orders. On the welcome page in the left panel under Account, click **Recent Orders**.

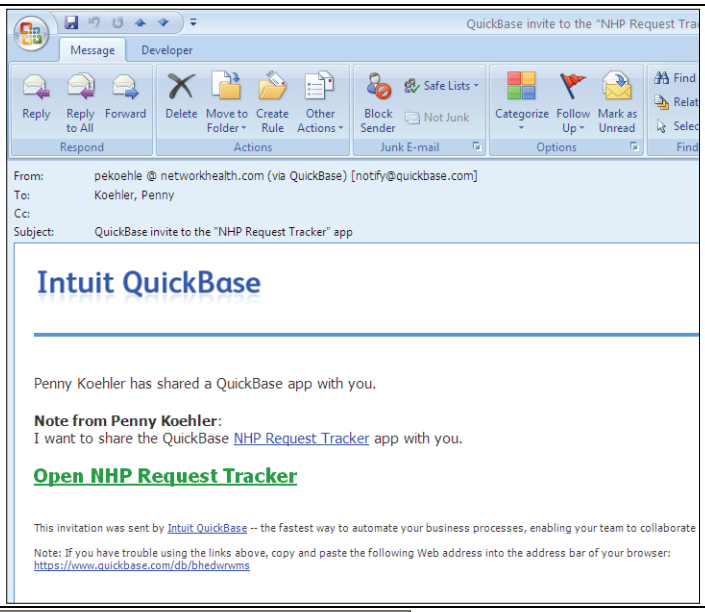
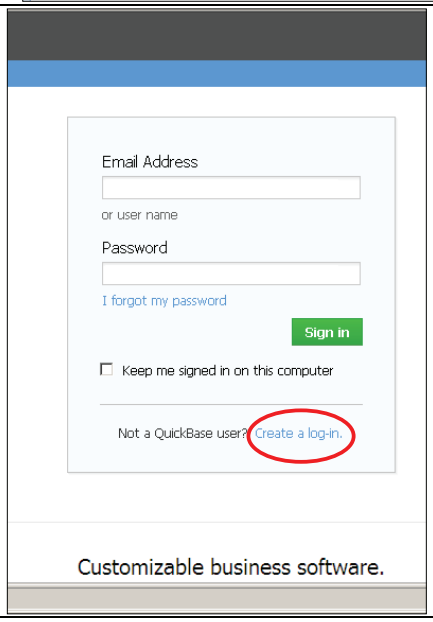


Agent kits will have tracking information added once the order has shipped. Individual kits shipped to prospects will not have tracking numbers, but you can see when it shipped.

NETWORK HEALTH QUICKBASE

Register to Use Quickbase

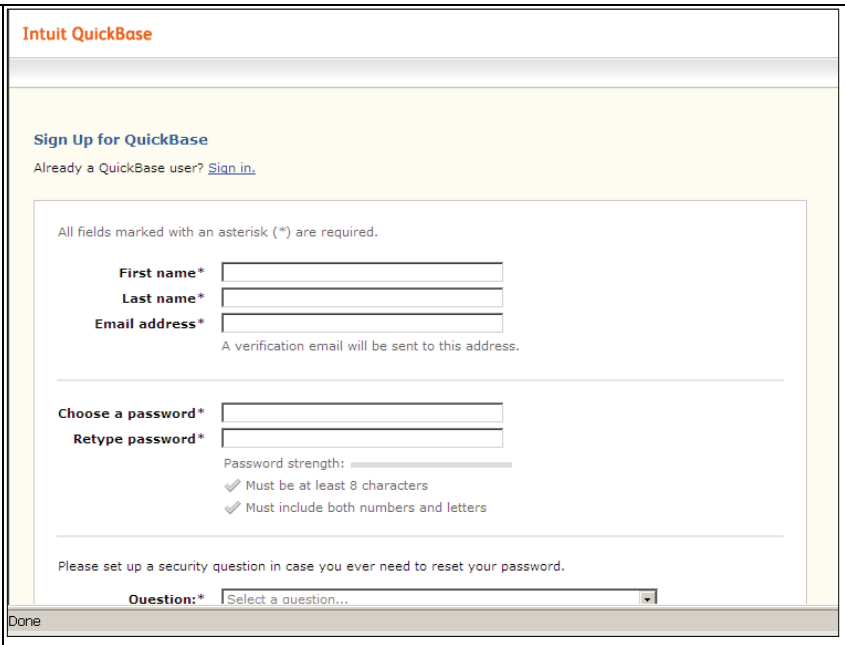
https://nhpexternalrealm.quickbase.com

You will be sent an email invitation to the QuickBase application. Click on the Open NHP Request Tracker link contained in the email.	
To register, click the **Create a log-in** link at the bottom of the page.	

Register to Use Quickbase

Registration Page

- Enter **your first and last name** in the fields provided.
- In the **Email address** field, enter a valid email address. A verification email will be sent to this address.
- In the **Choose a password** field, enter the password you'll use to access your QuickBase account. The password must be 8-20 characters, and contain both numeric and non-numeric characters. Enter the same password in the **Retype password** field.
- Set up a security question using the **Question** and **Answer** fields, in case you ever need to reset your password.
- Read the **Terms of Service** and indicate that you agree to them by clicking the check box.
- Click the **Register** button. QuickBase will send a verification email to the email address you provided. You must click the link in the email to activate your account.
- Open your email inbox and locate the **QuickBase Registration** email.



I never received my verification email. What do I do?

Sometimes, verification emails get snagged by spam filters. Check your junk email folder. To avoid this problem, add the **corpsales@quickbase.com** email address to your safe senders list or email address book.

Click the link provided in the email message to open your web browser and display the QuickBase Sign In page.

Enter your password to display the My Apps page.

Register to Use Quickbase

https://nhpexternalrealm.quickbase.com

Sign In to QuickBase

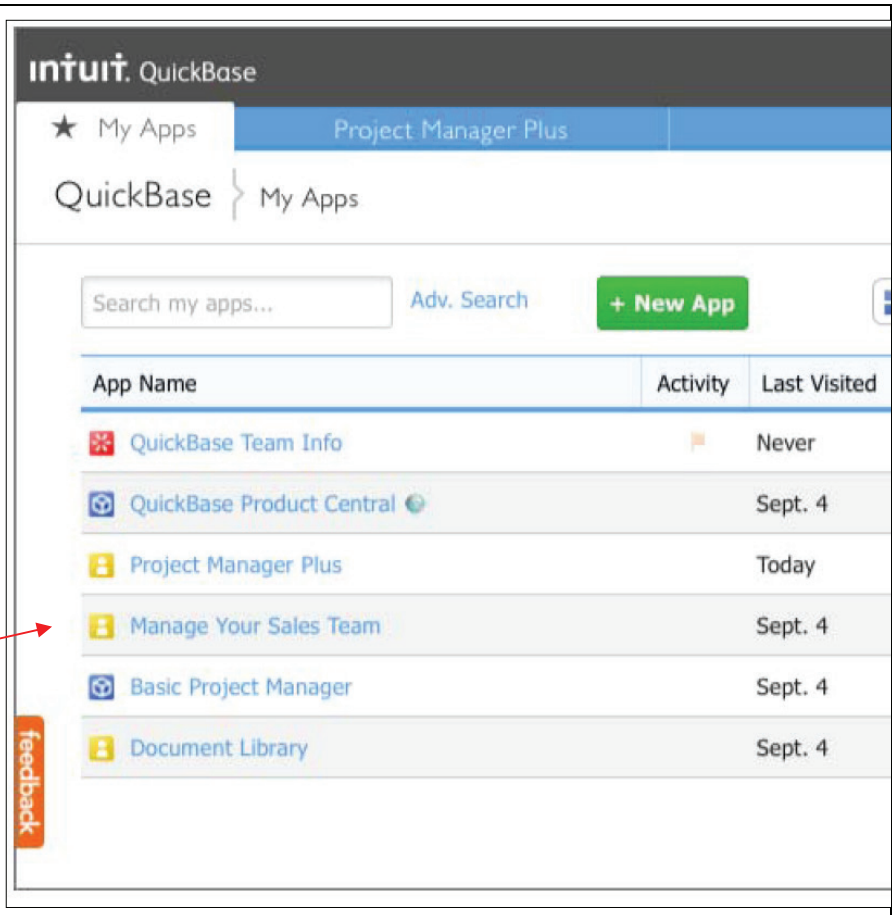
On the QuickBase home page www.networkhealth.quickbase.com, click Sign In at the top of the page.

We recommend adding this page to your Favorites bar on your web browser.

Enter your email address or user name in the Email Address field.

Enter your password in the Password field, then click Sign In.

The My Apps page displays.

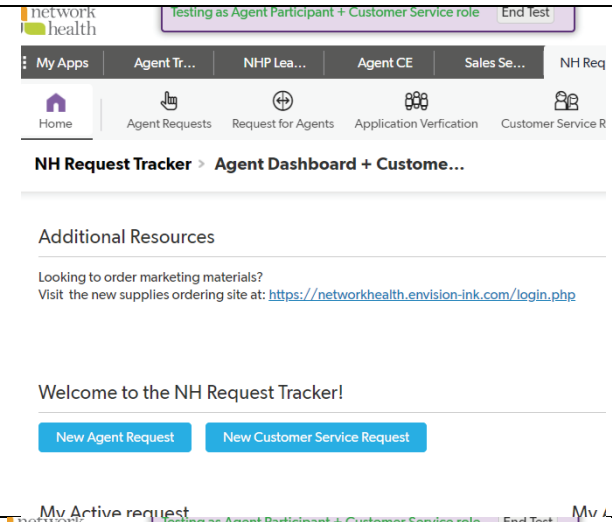


NH Request Tracker + Customer Service

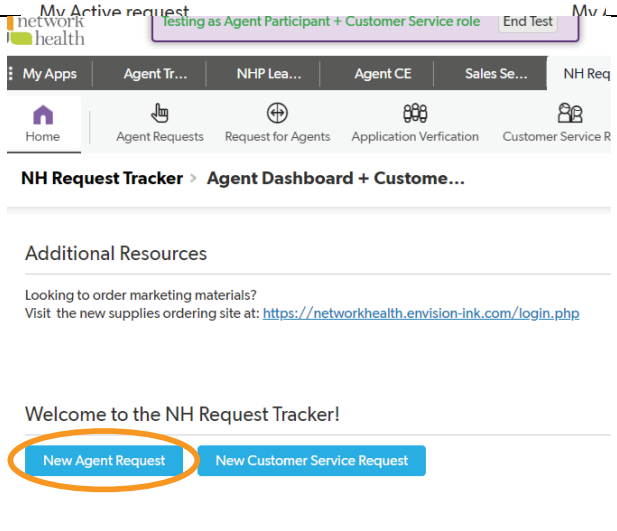
Welcome screen from
nhpexternalrealm.quickbase.com

NH Request Tracker Home page

https://nhpexternalrealm.quickbase.com



Click **New Agent Request**.

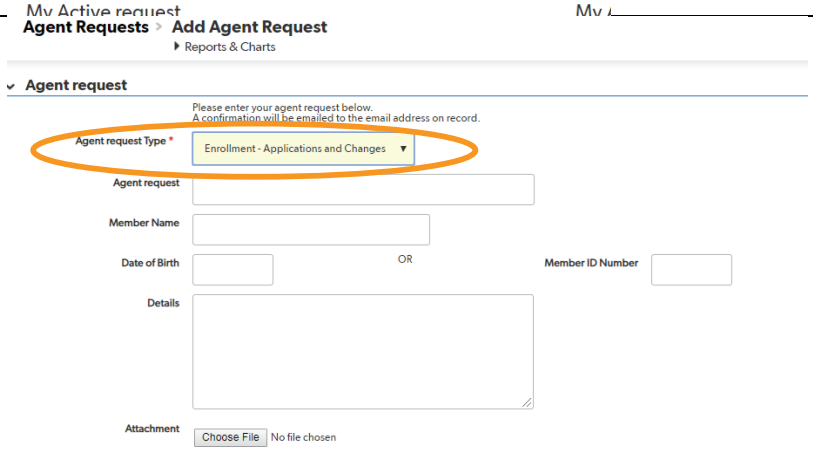


Determine request type from the following options.

Enrollment
Application or short enrollment forms.

Sales Team
LIS checks, Medicaid inquiry.

Commissions
Questions or issues with commission statements.



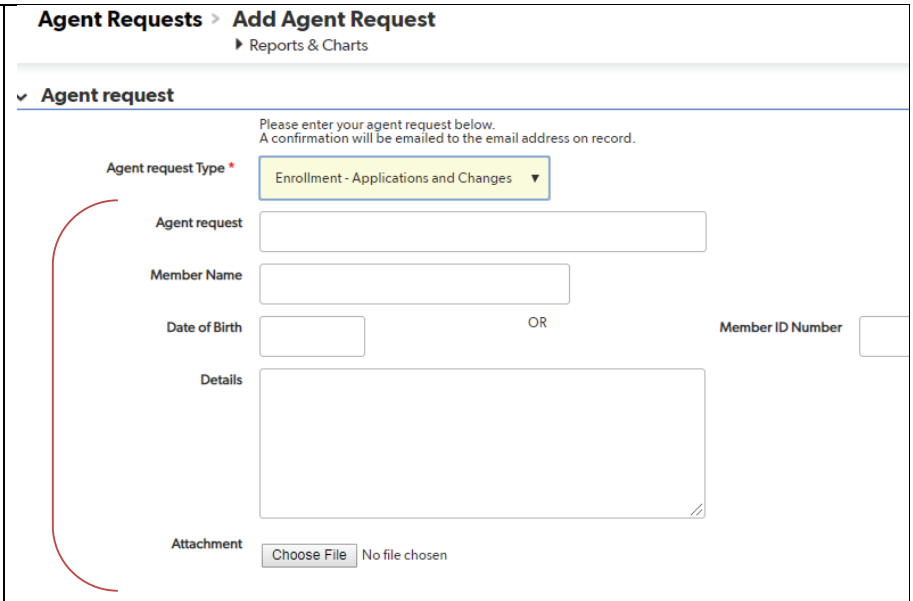
NH Request Tracker + Customer Service

Agent Request
Enter subject, title or request.

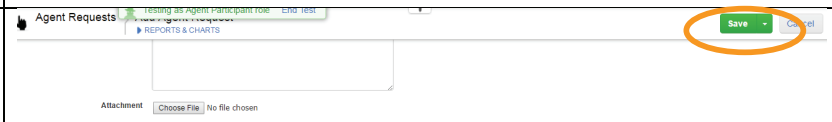
Member Name
Enter either **Date of birth** or **Member ID number** for identification purposes.

Details
Enter specific information on what questions or concerns you have.

Attachment
Attach a file like an application or supporting document.

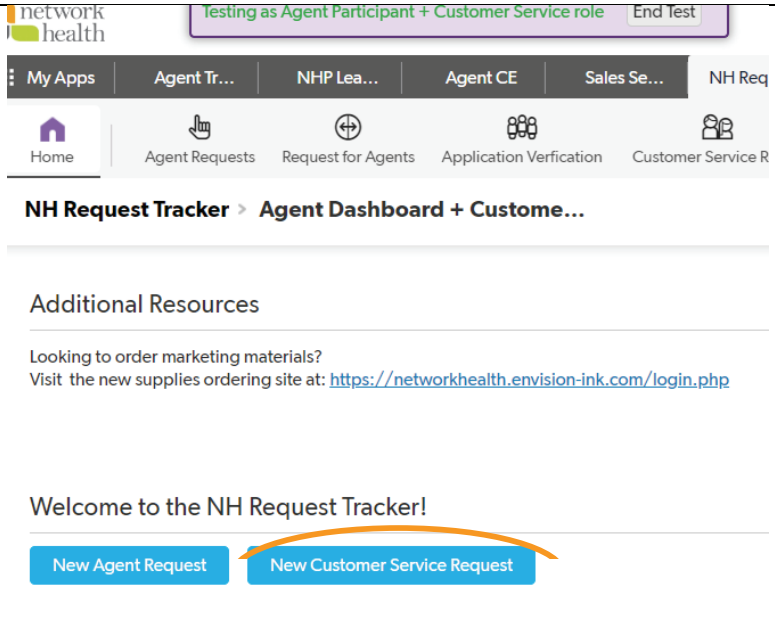


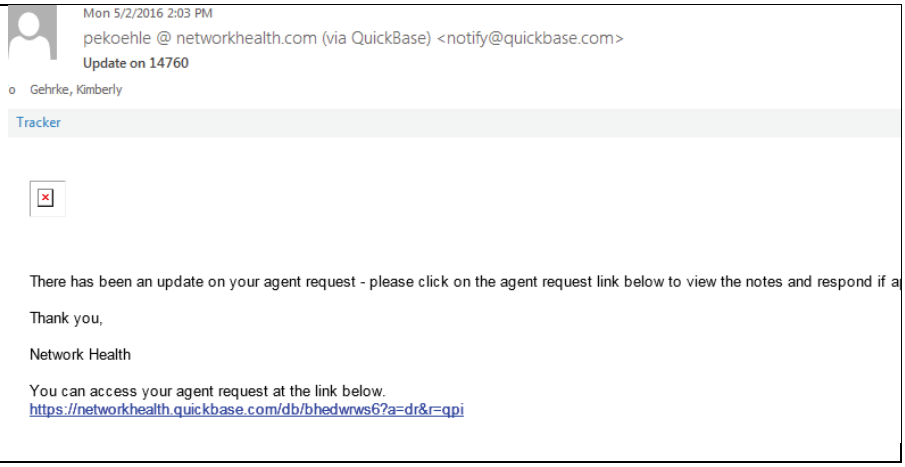
Click **Save** in the upper right had corner.



For customer service inquires, click **New Customer Service Request**.

Customer Service can help with the following.
Claims questions, billing questions, ID card reorder.



You will receive email notification when information on your requests have been updated.	

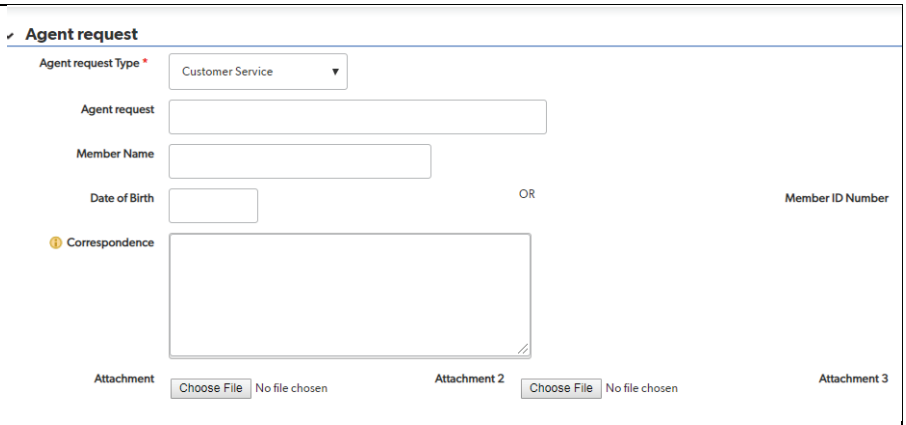
NH Request Tracker + Customer Service

Agent Request
Enter subject or title or request.

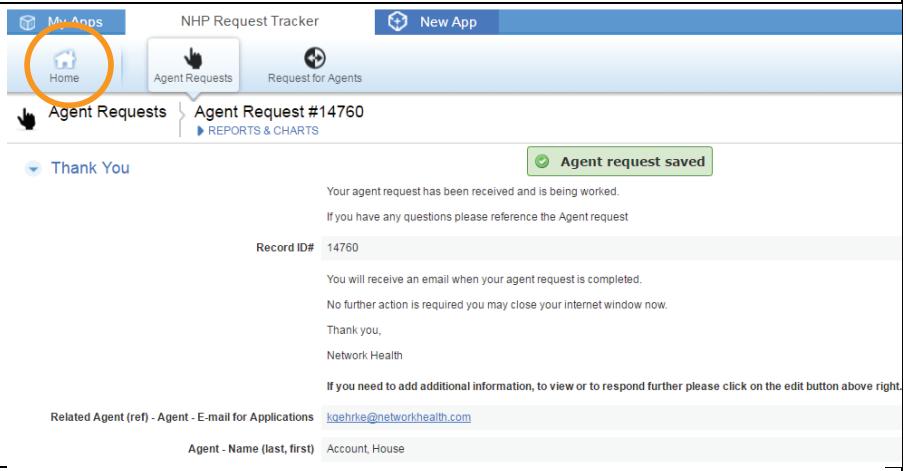
Member Name
Enter either **Date of birth** or **Member ID number** for identification purposes.

Correspondence
Enter specific information on what questions or concerns you have. Document the outcome are you looking for. If you are you asking customer service to call directly, please provide the phone number.

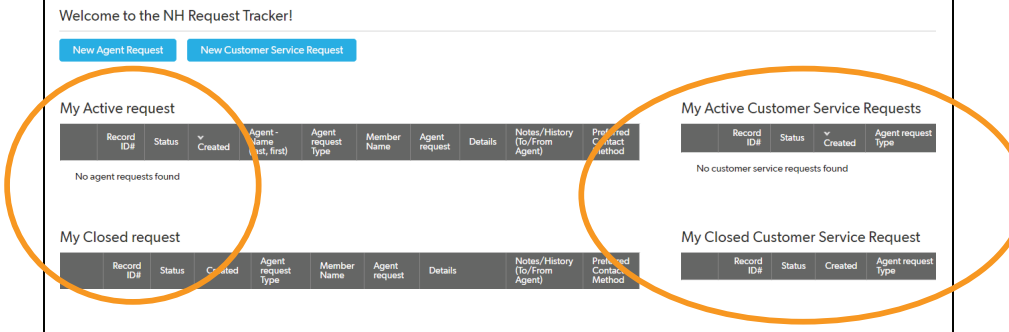
Attachment
Attach up to three files (such as copies of the EOC or provider bills).



Once you save a request, you can view any working request by selecting **Home**.

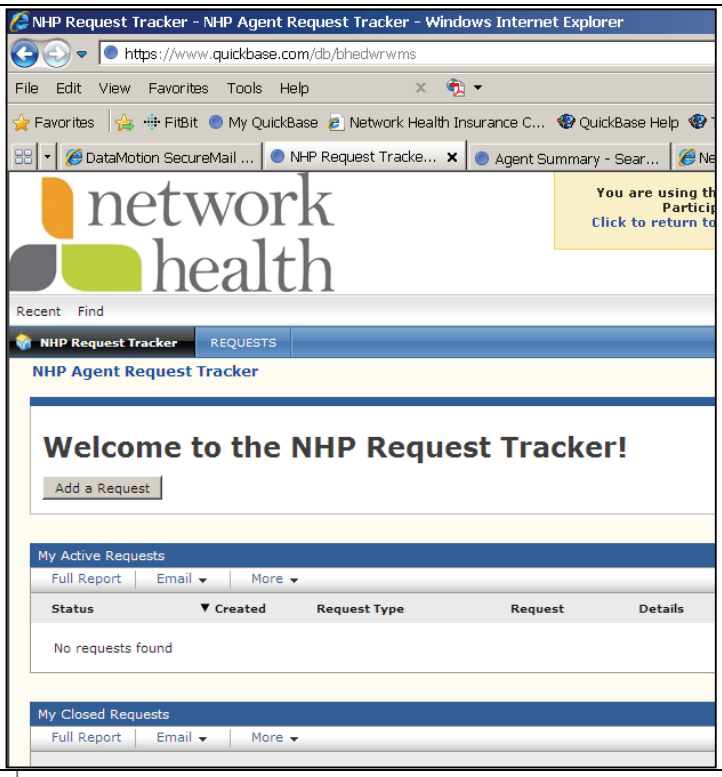


From your home dashboard you can view active and closed requests.

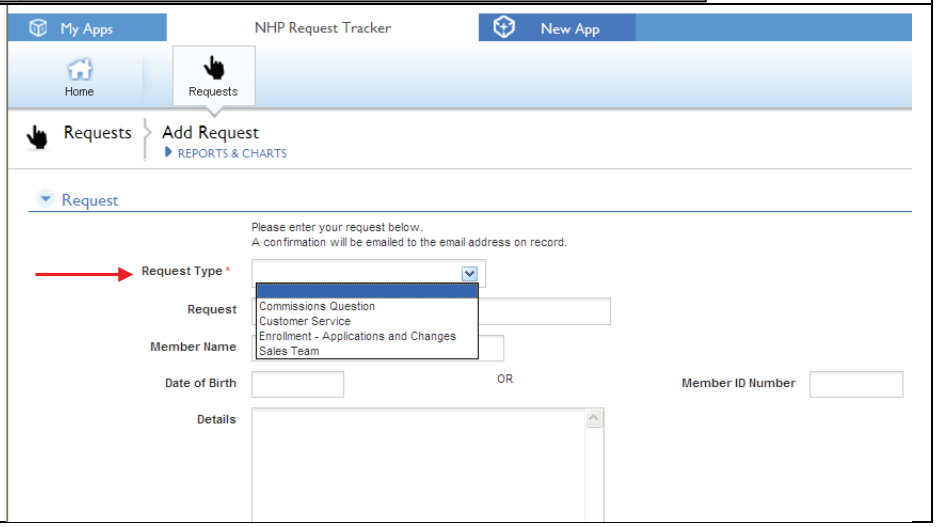


Submitting an Application via NHP Request Tracker

From the **Welcome** screen of the NHP Request tracker, click **Add a Request.**



Use the **Request Type** drop-down and select **Enrollment-Applications & Changes.**



Submitting an Application via NHP Request Tracker

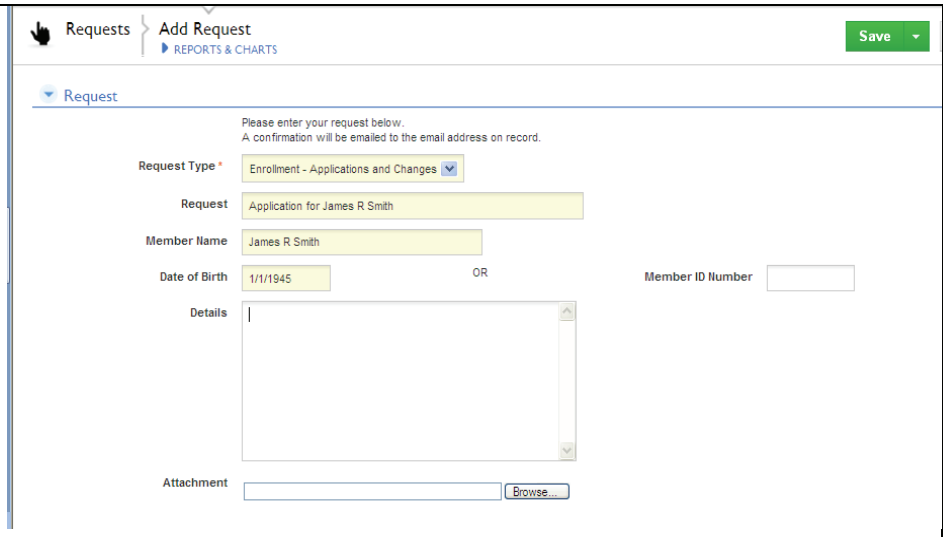
Request Field
Indicate that you are submitting either an application (or short enrollment form).

Member Name
Enter name.

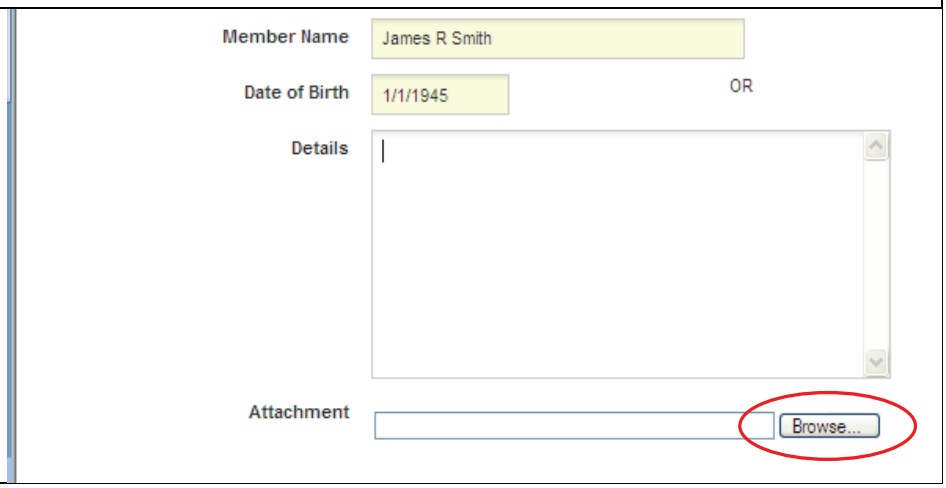
Date of Birth
Enter date of birth.

Member ID Number
If this is for an application, you will not have a member ID number, so leave this blank. If this is for a short enrollment form enter the member ID number.

Details
Any additional information you would like enrollment to have about the application.

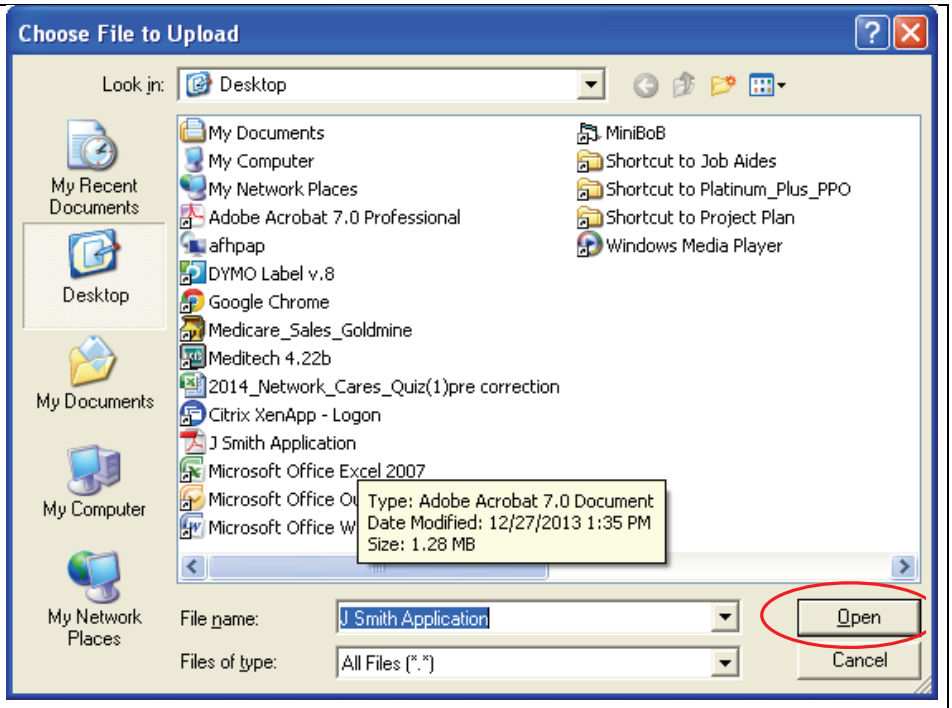


To attach the application or change form click **Browse.**



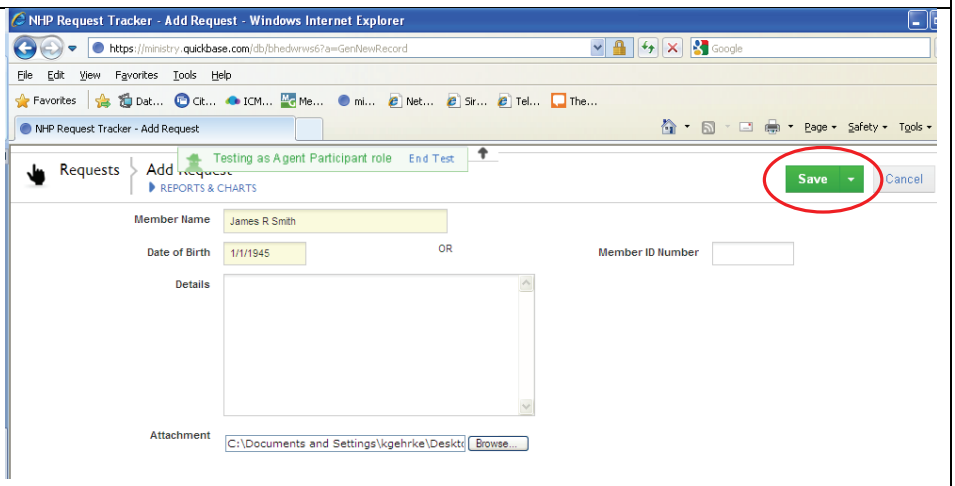
Submitting an Application via NHP Request Tracker

Select the file from your computer. Click **Open.**



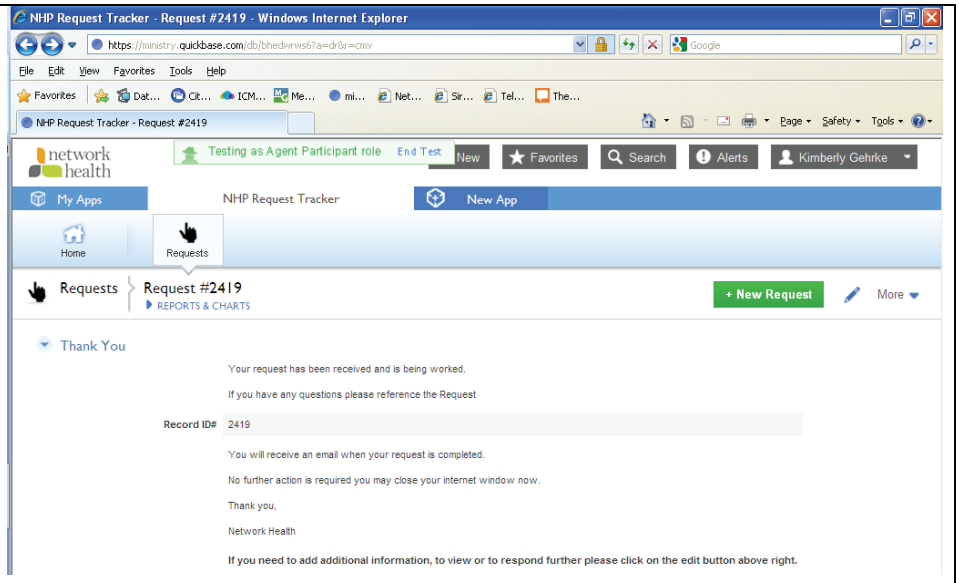
Click the **Save** button to save the request.

If you are submitting applications for a husband and a wife, you must create two different requests which list each new application separately. **Do not attach more than one application per request.**



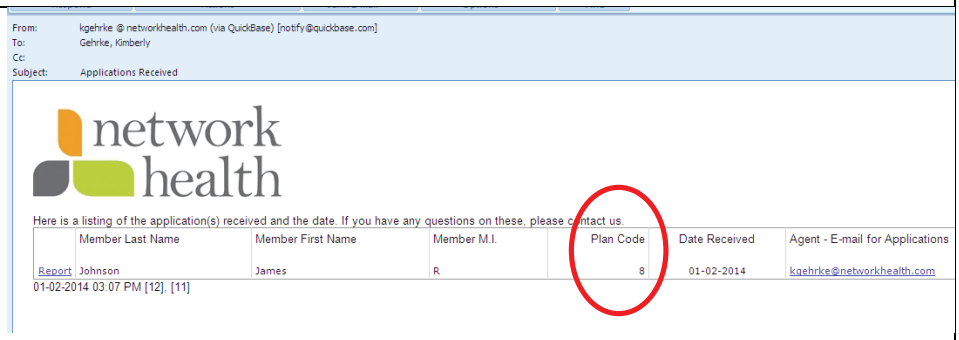
Submitting an Application via NHP Request Tracker

When you receive the thank you message, you know your request is being worked on.



Within 48 hours of submitting an application, you will receive an email from Network Health confirming we have received it and the plan the member has elected.

You must confirm the information in this email is correct. Please verify the plan code matches the intended plan. This verification email process is in place to help Network Health achieve our 5 Star rating. Even if you send the application via fax and the machine states the fax was successfully sent, you must have this email to confirm Network Health has the application and that it was properly processed. If you do not receive the email please contact your account executive.

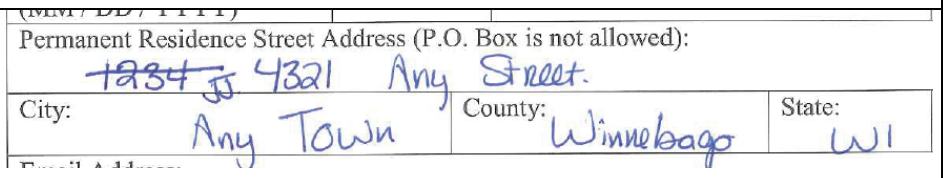


Plan Verification Codes

Plan Code	Plan Name	New Plan Code
NPP10005	Network PlatinumPlus (PPO)	001
NPP20000	Network PlatinumPlus with Pharmacy (PPO)	002
NPP50000	Network Platinum*Premier* with Pharmacy (PPO)	005
NPP60005	Network Platinum*Premier* (PPO)	006
NPP70000	Network*Cares* (PPO SNP)	007
NPP80000	Network Platinum*Select* (PPO)	008
NPP90000	Network Health Medicare Go (PPO)	009
NPP01000	Network Health Medicare Anywhere (PPO)	010
NPP11000	Network Platinum*Choice* (PPO)	011
NHPMSA1A	Network*Prime* (MSA)	001
NHPHMO02	Network Health Medicare Explore (HMO)	002

Application Tips

- Please **write legibly** on all applications.
- If you make an **error on an application** correct it by crossing out the error with one line and making the correction above or below.
- Make sure to include **APT numbers** when the member resides in an apartment.
- **Phone numbers** are required for the verification phone call.



Submitting an Application via NHP Request Tracker

NHP Request Tracker Tips Use one of these headings as the **Request Types** to get your answers in the NHP Request Tracker.	**Commission Questions** • Question on Commissions • Needing your log in information **Customer Service** • Member's balance questions • Questions on explanation of benefits • Request new member ID Cards • Information about other creditable drug coverage • Request health care concierge to call a member • Questions on prescription drug coverage **Enrollment Application and Changes** • Applications • Changes **Sales Team** • Confirm Network*Cares* eligibility • More sales kits and other supplies • Request a copy of application • Request for marketing pieces

ADDITIONAL INFORMATION

All agents must recognize that Network Health is subject to regulation by the Office of the Commissioner of Insurance as well as other regulatory bodies. In no event will Network Health interpret any term of this guide that is against the recommendation of any regulatory agency.

All established practices and standards are subject to change at Network Health's sole discretion without prior notice.

NOTES

NOTES