# TABLE OF CONTENTS

## INDIVIDUAL AND FAMILY PLAN
- PRODUCTS ................................................. 11
- ELIGIBILITY ............................................. 11
- HOW TO OBTAIN A QUOTE ......................... 12
- APPLICATION/ENROLLMENT ...................... 12
- PAYMENT OF PREMIUMS .......................... 14
- MEMBER MATERIALS ................................. 15
- RENEWALS .............................................. 15
- CHANGES TO AN EXISTING CONTRACT ....... 15

## ASSURE LEVEL-FUNDED PRODUCT 2-100 EMPLOYEES
- PRODUCTS ................................................. 17
- ADVANTAGE OF LEVEL FUNDING ................ 17
- ELIGIBILITY ............................................. 18
- FIDUCIARY LIABILITY LANGUAGE ............... 19
- HOW TO OBTAIN A QUOTE ......................... 20
- APPLICATION/ENROLLMENT ...................... 21
- PAYMENT ................................................. 22
- PARTICIPANT MATERIALS ............................ 22
- RENEWALS .............................................. 22
- LOCAL CLIENT MANAGEMENT TEAM .......... 23
- CHANGES TO AN EXISTING CONTRACT ....... 23
- FORMS ................................................... 23

## SMALL GROUPS 2–50 employees
- PRODUCTS ................................................. 24
- ELIGIBILITY ............................................. 24
- HOW TO OBTAIN A QUOTE ......................... 26
- APPLICATION/ENROLLMENT ...................... 26
- PAYMENT OF PREMIUMS .......................... 27
- MEMBER MATERIALS ................................. 27
- RENEWALS .............................................. 27
- LOCAL CLIENT MANAGEMENT TEAM .......... 27
- CHANGES TO AN EXISTING CONTRACT ....... 28
- FORMS ................................................... 28

## MEDICARE
- MEDICARE ................................................. 41
- MEDICARE ELECTION PERIODS ................. 42
- FORMS ................................................... 53

## MID-SIZE GROUPS 51–100 employees
- PRODUCTS ................................................. 29
- ELIGIBILITY ............................................. 29
- HOW TO OBTAIN A QUOTE ......................... 31
- APPLICATION/ENROLLMENT ...................... 32
- PAYMENT OF PREMIUMS .......................... 32
- MEMBER MATERIALS ................................. 33
- RENEWALS .............................................. 33
- LOCAL CLIENT MANAGEMENT TEAM .......... 33
- CHANGES TO AN EXISTING CONTRACT ....... 33
- FORMS ................................................... 34

## LARGE GROUPS 101+ employees
- PRODUCTS ................................................. 35
- ELIGIBILITY ............................................. 36
- HOW TO OBTAIN A QUOTE ......................... 37
- APPLICATION/ENROLLMENT ...................... 37
- CARRIER PLAN OFFERINGS ....................... 38
- PAYMENT OF PREMIUMS .......................... 38
- MEMBER MATERIALS ................................. 38
- RENEWALS .............................................. 38
- LOCAL CLIENT MANAGEMENT TEAM .......... 39
- CHANGES TO AN EXISTING CONTRACT ....... 39
- FORMS ................................................... 40

## MEET NETWORK HEALTH ............................... 2
- CONTACTS .............................................. 4
- NETWORK HEALTH’S SERVICE AREA .......... 6
- AGENT INFORMATION ............................... 6
- MARKETING COMPLIANCE ......................... 54
- AGENT ORDERING SITE .............................. 55
- QUICKBASE ............................................ 64
- ADDITIONAL INFORMATION ...................... 76
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 member experience teams are based in Menasha and Brookfield, 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
1983

**APRIL**

Nicolet Health Plan becomes operational. Nicolet Clinic was the group customer.

---

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.

---

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.

---

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.

---

2012

**FEBRUARY**

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

---

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.

---

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.

---

2020

**MARCH**

Seamless transition to work from home model during the coronavirus pandemic.
**COMMERCIAL GROUP PRODUCTS**
Assure Level-Funded (2-99), Small Group ACA (2-50), Mid-Size Groups (51-100) and Large Groups (101+)

**NEW BUSINESS**
New Quotes, Product Questions, Alternative Plan Designs

<table>
<thead>
<tr>
<th>Travis Janssen</th>
<th>Dan Pecanac</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sr. Account Executive – Northeast Wisconsin</td>
<td>Account Executive – Southeast Wisconsin</td>
</tr>
<tr>
<td>Office: 920-720-1877</td>
<td>Office: 262-825-9768</td>
</tr>
<tr>
<td>Cell: 920-209-5812</td>
<td>Cell: 414-975-1652</td>
</tr>
<tr>
<td>Email: <a href="mailto:tjanssen@networkhealth.com">tjanssen@networkhealth.com</a></td>
<td>Email: <a href="mailto:dpecanac@networkhealth.com">dpecanac@networkhealth.com</a></td>
</tr>
</tbody>
</table>

**CLIENT SERVICE TEAM**
Renewals, Enrollment & Billing

<table>
<thead>
<tr>
<th>Sara Pergolski-Mickelson</th>
<th>Ann Sanders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Manager</td>
<td>Client Manager</td>
</tr>
<tr>
<td>Cell: 920-570-9910</td>
<td>Cell: 920-470-0516</td>
</tr>
<tr>
<td>Email: <a href="mailto:spergols@networkhealth.com">spergols@networkhealth.com</a></td>
<td>Email: <a href="mailto:ansander@networkhealth.com">ansander@networkhealth.com</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lavonne Simon</th>
<th>Ingrid Davis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Manager</td>
<td>Client Manager</td>
</tr>
<tr>
<td>Office: 920-720-1257</td>
<td>Office: 262-825-9774</td>
</tr>
<tr>
<td>Cell: 920-209-5631</td>
<td>Cell: 414-559-1904</td>
</tr>
<tr>
<td>Email: <a href="mailto:lsimon@networkhealth.com">lsimon@networkhealth.com</a></td>
<td>Email: <a href="mailto:idavis@networkhealth.com">idavis@networkhealth.com</a></td>
</tr>
</tbody>
</table>

**SALES MANAGEMENT**

<table>
<thead>
<tr>
<th>Jeff Lanser</th>
<th>Marty Brogaard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager of Client Management</td>
<td>Director of Sales and Service – Commercial and FSP</td>
</tr>
<tr>
<td>Cell: 920-213-1194</td>
<td>Cell: 920-585-0399</td>
</tr>
<tr>
<td>Email: <a href="mailto:jlanser@networkhealth.com">jlanser@networkhealth.com</a></td>
<td>Email: <a href="mailto:hbrogaard@networkhealth.com">hbrogaard@networkhealth.com</a></td>
</tr>
</tbody>
</table>

**INDIVIDUAL SALES**
Medicare, Individual Family Plans, ACA

**SALES MANAGEMENT**

<table>
<thead>
<tr>
<th>John Whittemore</th>
<th>Kimberly Gehrke</th>
<th>Nichole Sprinkle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vice President of Medicare &amp; Individual Programs</td>
<td>Manager of Individual Sales</td>
<td>Supervisor of Individual Sales</td>
</tr>
<tr>
<td><a href="mailto:jwhittem@networkhealth.com">jwhittem@networkhealth.com</a></td>
<td><a href="mailto:kgehrke@networkhealth.com">kgehrke@networkhealth.com</a></td>
<td><a href="mailto:nsprinkl@networkhealth.com">nsprinkl@networkhealth.com</a></td>
</tr>
</tbody>
</table>

**ACCOUNT EXECUTIVES**
New business, broker relationships

<table>
<thead>
<tr>
<th>Penny Koehler</th>
<th>Brian Vranek</th>
<th>Brooke Braemer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Account Executive</td>
<td>Account Executive</td>
<td>Account Executive</td>
</tr>
<tr>
<td><a href="mailto:pekoehle@networkhealth.com">pekoehle@networkhealth.com</a></td>
<td><a href="mailto:bvrane@networkhealth.com">bvrane@networkhealth.com</a></td>
<td><a href="mailto:bbraemer@networkhealth.com">bbraemer@networkhealth.com</a></td>
</tr>
</tbody>
</table>

**AGENT ADVISORS**
Enrollment support, eligibility questions, product questions

<table>
<thead>
<tr>
<th>Becky Bascue</th>
<th>Mark Kretzmann</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agent Advisor</td>
<td>Agent Advisor</td>
</tr>
<tr>
<td><a href="mailto:rbascue@networkhealth.com">rbascue@networkhealth.com</a></td>
<td><a href="mailto:mkretzma@networkhealth.com">mkretzma@networkhealth.com</a></td>
</tr>
</tbody>
</table>
### SALES ADVISORS AND MEDICARE SALES SPECIALIST

Assist members and prospects, back up agent advisors

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Office Number</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matt Brunner</td>
<td>Sales Advisor</td>
<td>800-983-7587</td>
<td><a href="mailto:individualsalesteam@networkhealth.com">individualsalesteam@networkhealth.com</a></td>
</tr>
<tr>
<td>Chuck Davis</td>
<td>Sales Advisor</td>
<td>800-983-7587</td>
<td><a href="mailto:individualsalesteam@networkhealth.com">individualsalesteam@networkhealth.com</a></td>
</tr>
<tr>
<td>Kathy Krentz</td>
<td>Sales Advisor</td>
<td>800-983-7587</td>
<td><a href="mailto:individualsalesteam@networkhealth.com">individualsalesteam@networkhealth.com</a></td>
</tr>
<tr>
<td>Taylor Perry</td>
<td>Medicare Sales Specialist</td>
<td>800-983-7587</td>
<td><a href="mailto:individualsalesteam@networkhealth.com">individualsalesteam@networkhealth.com</a></td>
</tr>
<tr>
<td>Dawn Royak</td>
<td>Sales Advisor</td>
<td>800-983-7587</td>
<td><a href="mailto:individualsalesteam@networkhealth.com">individualsalesteam@networkhealth.com</a></td>
</tr>
</tbody>
</table>

### NETWORK HEALTH RESOURCES – MEDICARE ADVANTAGE PLANS

<table>
<thead>
<tr>
<th>Online Agent Guide</th>
<th>networkhealth.com/agents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Experience Team (PPO, HMO and MSA)</td>
<td>800-378-5234 (TTY 800-947-3529) Monday–Friday, 8 a.m. to 8 p.m.</td>
</tr>
<tr>
<td>Member Experience Team (PPO D-SNP)</td>
<td>855-653-4636 (TTY 800-947-3529) Monday–Friday, 8 a.m. to 8 p.m.</td>
</tr>
<tr>
<td>Member Wellness</td>
<td>Network Health Coaches 800-236-0208</td>
</tr>
<tr>
<td>Care Management</td>
<td>Network Health Care Management Team 866-709-0019</td>
</tr>
<tr>
<td>Caregiver Support</td>
<td>Network Health Care Management Team 866-709-0019</td>
</tr>
<tr>
<td>Medication Therapy Management Program</td>
<td>To make an appointment to speak one-on-one with a pharmacist, members can call the Network Health Member Experience Team at 800-378-5234, Monday-Friday from 8 a.m. to 8 p.m.</td>
</tr>
</tbody>
</table>

### EMPLOYER GROUP DEPARTMENT CONTACTS

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

**INDIVIDUAL PLAN CUSTOMER SERVICE**

| Toll Free: 855-275-1400 |

---

**network health**
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**

* Only employer group plans available
** Individual and family plans also available

See page 50 for our Medicare Advantage service area.

Agent Licensing

Network Health establishes 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

Network Health pays agencies commissions monthly for active members who are assigned to the agencies. Payment is typically paid by the 20th of the month and deposited via ACH into the designated bank account. To update a bank account, email AgentManagementSpecialists@networkhealth.com. Commission statements are viewable in the ICM Commission portal by the agency owner or authorized representative.

On an annual basis, Network Health will mail 1099 forms showing the annual commission amount for tax purposes. This statement will be sent during the month of January for the previous year.

Commission payment may be held for several reasons, some of which include expired Error and Omissions (E&O) coverage, expired health insurance license, if agent is part of lawsuit, discrepancy between agent and agency, garnishment or tax levy is received.

Network Health does not share or split commission payments between agents. Agencies should review the statement and alert Network Health of any commission questions or disputes within 90 days of payment.

Commissions listed are for the 2022 calendar year. Commission schedules, rates and policies may be revised and changed annually by Network Health and will be reflected in subsequent versions of the Agent Guide.

Individual Family Plans
On-Exchange, Off-Exchange and Grandmothered plans

- The commission for the first year is $18 per member per month (PMPM); commissions for each subsequent renewal year is $18 PMPM.
- Commissions paid monthly following receipt of premium payment from the insured.
- Members may pay premiums monthly, quarterly, semi-annually or annually. If a member pays quarterly, semi-annually or annually, commissions will be paid monthly as they are earned.
- Agents must have completed the Federally Facilitated Marketplace (FFM) training, which must be done on an annual basis, to receive commissions for on-exchange members.

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

<table>
<thead>
<tr>
<th>Employer Plan Type</th>
<th>Number of Subscribers in Month</th>
<th>Monthly Commission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully Insured (Beginning July 1, 2015)</td>
<td>1–3</td>
<td>$10 PEPM</td>
</tr>
<tr>
<td></td>
<td>Next 4–50</td>
<td>$25 PEPM</td>
</tr>
<tr>
<td></td>
<td>Next 51 +</td>
<td>$28 PEPM</td>
</tr>
<tr>
<td>Assure Level-Funded (Beginning May 1, 2019)</td>
<td>2–100 enrolled</td>
<td>$60 PEPM for new groups,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$45 PEPM for renewals</td>
</tr>
</tbody>
</table>

- 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.
- This commission schedule will be superseded by an agreement between an employer group and a broker which specifies a different commission payment.
**AGENT OF RECORD CHANGES**

**COMMERCIAL GROUP PLANS**

An Agent of Record (AOR) is an individual who is authorized by Network Health to represent its members in the sale, maintenance and servicing of its members. To be an AOR for Network Health, the agent is required to have a contract with Network Health. All requests for a change of AOR status are subject to Network Health’s review and approval, which approval will be granted in Network Health’s sole discretion. A request to change an AOR may be initiated by sending a request to Network Health. The AOR letter must be written on the group’s letterhead and signed by an authorized employer representative. Network Health requires the requests to include the following information.

- Group Number
- Effective date of AOR transfer
- Name of Agent and Agency

AOR requests must be mailed to - Network Health, Attn: Sales, PO Box 120, Menasha, WI 54956.

Network Health will consider a number of factors in determining whether to grant a change in AOR, including the following.

1. Whether the Agent to whom the transfer is proposed (“Proposed Agent”) has an Agency Agreement or is affiliated with an agency that has a Group Marketing Agreement (Agency Agreement and Group Marketing Agreement are referred to collectively as “Agency Agreements”) with Network Health; and

2. Whether the Proposed Agent is in full compliance with all applicable provisions of the Agency Agreement.

Network Health reserves the right to contact the group in order to validate all AOR changes.

Requests for changes in AOR received on or before the 25th calendar day of the month which are approved by Network Health will be processed in the month in which the request was received. Requests received after the 25th of the month will be effective the first day of the second month following. For example, requests received by the 25th of October will be effective November 1. Requests received on October 26 would be processed effective December 1. A confirmation letter containing the effective date of the change will be sent to the newly assigned AOR and to the terminating AOR.

<table>
<thead>
<tr>
<th>Type of Agent Commission</th>
<th>2022 Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial – one time annual payment</td>
<td>$573</td>
</tr>
<tr>
<td>Renewal – monthly</td>
<td>$23.92</td>
</tr>
</tbody>
</table>

- To be eligible for initial and renewal commissions, agents must pass yearly certifications and testing and follow all Network Health and Medicare Marketing Guidelines. No commission will be paid on any Enrollment application written by an agent who was not fully certified at the time the enrollment application was written.
- CMS determines if an enrollment qualifies for initial year or renewal year payment and Network Health pays commissions in accordance with CMS’s determination. In compliance with the CMS Medicare Manual Marketing Guidelines, Network Health may pay the full year initial compensation amount or a pro-rated amount based on the number of months the beneficiary is enrolled.
- Member disenrollment within the first 90 days of enrollment will result in full chargeback of commissions paid in accordance with CMS’s requirements.
- Members with original enrolled effective dates prior to January 1, 2017, will be paid renewal commissions based on the commission schedule that was in effect the year the policy was written. For example, commissions for business written in 2012 will be paid according to the 2012 commission schedule.
- Actively enrolled members who were initially written in 2017 and forward will be paid at the current market renewal rates and paid monthly.
- You must comply with State of Wisconsin and CMS regulations related to compensation limits, commission splitting, and/or payments to non-licensed/appointed agents.

**Medicare Plans**

<table>
<thead>
<tr>
<th>Type of Agent Commission</th>
<th>2022 Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial – one time annual payment</td>
<td>$573</td>
</tr>
<tr>
<td>Renewal – monthly</td>
<td>$23.92</td>
</tr>
</tbody>
</table>

- To be eligible for initial and renewal commissions, agents must pass yearly certifications and testing and follow all Network Health and Medicare Marketing Guidelines. No commission will be paid on any Enrollment application written by an agent who was not fully certified at the time the enrollment application was written.
- CMS determines if an enrollment qualifies for initial year or renewal year payment and Network Health pays commissions in accordance with CMS’s determination. In compliance with the CMS Medicare Manual Marketing Guidelines, Network Health may pay the full year initial compensation amount or a pro-rated amount based on the number of months the beneficiary is enrolled.
- Member disenrollment within the first 90 days of enrollment will result in full chargeback of commissions paid in accordance with CMS’s requirements.
- Members with original enrolled effective dates prior to January 1, 2017, will be paid renewal commissions based on the commission schedule that was in effect the year the policy was written. For example, commissions for business written in 2012 will be paid according to the 2012 commission schedule.
- Actively enrolled members who were initially written in 2017 and forward will be paid at the current market renewal rates and paid monthly.
- You must comply with State of Wisconsin and CMS regulations related to compensation limits, commission splitting, and/or payments to non-licensed/appointed agents.
INDIVIDUAL FAMILY PLANS

On Exchange

Only members may request to change their AOR. All requests for a change of AOR status are subject to Network Health’s review and approval, which approval will be granted in Network Health’s sole discretion. Network Health will only accept member-initiated requests for change of AOR for on-exchange members when submitted via healthcare.gov (the marketplace).

Off Exchange and Grandmothered plans

Only members may request to change their AOR. All requests for a change of AOR status are subject to Network Health’s review and approval, which approval will be granted in Network Health’s sole discretion. A request to change an AOR may be initiated by sending a handwritten request including their member identification number, reason for change and signature to Network Health. Form letters and letters on agent letter head will not be accepted.

AOR requests must be mailed to - Network Health, Attn: Individual Sales, PO Box 120, Menasha, WI 54956.

Network Health reserves the right to contact the member in order to validate all AOR changes. If Network Health approved the request for AOR, so long as the request was received by the 10th of the month, it will be processed as effective the first of that month (month of receipt). For example, an AOR request received April 9 will be processed effective April 1. An AOR request received April 11 will be processed for May 1. AOR requests will not be backdated if received after the 10th of the month. AOR changes will only be changed after 13 months of enrollment or 12 months after any previous requests.

MEDICARE ADVANTAGE

Notwithstanding AOR changes due to Assignment and Transfer of Businesses (explained below), only members may request to change their AOR. All requests for a change of AOR status are subject to Network Health’s review and approval, which approval will be granted in Network Health’s sole discretion. A request to change an AOR may be initiated by sending a handwritten request to Network Health. The request must include the member identification number, reason for change and signature. Form letters and letters on agent letter head will not be accepted.

AOR requests must be mailed to - Network Health, Attn: Individual Sales, PO Box 120, Menasha, WI 54956.

Network Health reserves the right to contact the member to validate all AOR changes. The AOR request may be denied due to lack of confirmation. If Network Health approved the request for AOR, so long as the request was received by the 10th of the month, it will be processed as effective the first of that month (month of receipt). For example, an AOR request received April 9 will be processed effective April 1. An AOR request received April 11 will be processed for May 1. AOR requests will not be backdated if received after the 10th of month. AOR changes will only be changed after 13 months of enrollment or 12 months after any previous requests.

ASSIGNMENT AND TRANSFER OF BUSINESS

All requests for assignment or transfer of AOR status are subject to Network Health’s review and approval, which approval will be granted in Network Health’s sole discretion.

Network Health will consider a number of factors in determining whether to grant a change in AOR, including the following.

1. Whether the Proposed Agent has an Agency Agreement or is affiliated with an agency that has a Group Marketing Agreement (Agency Agreement and Group Marketing Agreement are referred to collectively as “Agreements”) with Network Health; and

2. Whether the Proposed Agent is in full compliance with all applicable provisions of the Agreement.

Any assignments or transfers of AOR must comply with the procedures and requirements outlined in the Agent Agreements of both the transferring and receiving agent. All requests for review and approval of an assignment or transfer of AOR status must be submitted in writing for approval to Network Health in the timeframe stated in the Agency Agreement. If no timeframe for such requests is indicated the Agency Agreement, requests must be submitted not less than 90 days in advance of the requested transfer date. Failure to submit requests at least 90 days prior to the requested effective date may result in requests being effective beyond the date requested, if approved. For example, a request to transfer an agency effective November 1, 2021, would need to be received by August 1, 2021, to ensure we are able to review and process for the November 1, 2021 effective date.

(Continued on next page)
The following information should be submitted with the request for the assignment or transfer.

- A list of all agents who are designated as AOR for commissions being assigned or otherwise transferred, and the name of the agency to which those agents are transferring;
- The representations and warranties of the transferring agency pertaining to the full payment of any commissions owed to the agents affiliated with the transferring agency;
- Proof that such agents have in fact been paid in full for all Network Health commissions owed through the closing date;
- The representations and warranties of the agency regarding payment of taxes and compliance with all other material conditions of closing for the proposed transfer; and
- A fully executed Irrevocable Assignment of Commissions from all AORs for any Network Health products.

Failure to submit all required documents in legible form not less than 90 days prior to the requested effective date may result in delays in processing and/or denial of the request.

GROUP TERMINATIONS

Termination letters must include the following and be written on the group’s letterhead with company logo and signed by authorized employer representative.

- Group Number
- Effective date of Termination

Termination letters should be sent to your Client Manager and Account Executive.
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–January 15.
• The effective date of coverage will be January 1 if you select coverage between November 1–December 15.
• The effective date of coverage will be February 1 if you select coverage between December 16–January 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:

<table>
<thead>
<tr>
<th>Life Event</th>
<th>SEP Window</th>
<th>Effective Date (subject to change)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth or Adoption</td>
<td>60 days from event</td>
<td>Date of Birth or Adoption</td>
</tr>
<tr>
<td>Marriage</td>
<td>60 days from event</td>
<td>1st of the following month from application submission</td>
</tr>
<tr>
<td>Loss of employer sponsored health insurance, as a result of</td>
<td>60 days from event</td>
<td>1st of the following month from application submission</td>
</tr>
<tr>
<td>- Termination of employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Employer reduces work hours to the point where no longer covered by the health plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Employer’s plan decides it will no longer offer coverage to a certain group of individuals (for example, those who work part time)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Termination of employer contributions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of coverage for a dependent child who has reached the dependent limiting age</td>
<td>60 days from event</td>
<td>1st of the following month from application submission</td>
</tr>
<tr>
<td>Exhaustion of COBRA</td>
<td>60 days from event</td>
<td>1st of the following month from application submission</td>
</tr>
<tr>
<td>Loss of eligibility for Medicaid or CHIP</td>
<td>60 days from event</td>
<td>1st of the following month from application submission</td>
</tr>
<tr>
<td>Divorcée/Legal Separation</td>
<td>60 days from event</td>
<td>1st of the following month from application submission</td>
</tr>
<tr>
<td>Loss of retiree coverage due to former employer filing for bankruptcy protection</td>
<td>60 days from event</td>
<td>1st of the following month from application submission</td>
</tr>
<tr>
<td>Death of the policyholder</td>
<td>60 days from event</td>
<td>1st of the following month from application submission</td>
</tr>
<tr>
<td>Incur a claim that meets or exceeds a lifetime limit on all benefits under existing coverage</td>
<td>60 days from event</td>
<td>1st of the following month from application submission</td>
</tr>
<tr>
<td>Gaining status as a citizen, national or lawfully present individual</td>
<td>60 days from event</td>
<td>1st of the following month from application submission</td>
</tr>
<tr>
<td>No longer incarcerated</td>
<td>60 days from event</td>
<td>1st of the following month from application submission</td>
</tr>
<tr>
<td>Loss of coverage due to a permanent move outside of the plan’s service area</td>
<td>60 days from event</td>
<td>- 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</td>
</tr>
<tr>
<td>Plan is due for renewal outside of open enrollment</td>
<td>30 days from event</td>
<td>1st of the following month from application submission</td>
</tr>
</tbody>
</table>
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
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)
Off-Exchange 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. On-Exchange renewals should be accepted via healthcare.gov.

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.

CHANGES TO AN EXISTING CONTRACT
The following chart outlines the requirements for making a change to the contract after issue.

<table>
<thead>
<tr>
<th>Change</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addition of an adopted child or a court-ordered legal guardianship</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>

(Continued on next page)
### 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-FUNDDED
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.
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 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.

(Continued on next page)
• 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 smallgroupquotes@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. Quick Quotes can also be run in JET with the following information.
• Group name, county, zip code, and industry code (SIC)
• Requested effective date
• Agency name and agent name, along with contact information, such as name, email address and phone number of the person you would like us to follow up with for additional information or questions.
• Census – make sure to include employees’ date of birth or age, gender and type of coverage, such as EE, ES, EC, FAM (a quick quote census template is available in the agent portal on our website)
• Requested benefit plans

GUIDELINES FOR ASSURE PROPOSAL SUBMISSION

With the following information, Network Health will provide an Assure Proposal for groups with 2–100 enrolled employees.
• All the information mentioned above for a Quick Quote
• Assure enrollment forms for all full-time employees, including waivers
• Most recent quarterly Wage and Tax report (UCT-101 with employment status – FT, PT, Termed)
• Most recent carrier renewal
• Most recent carrier invoice
• Completed eligibility certification form (ECF) 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 GRx UNDERWRITING

Network Health can offer final proposals to midsize Assure groups with 20-100 people enrolled using risk score in place of applications. To qualify for GRx census-underwriting, a group must meet the following requirements.

NOTE: If the most recent renewal cannot be provided, the previous two years of renewals would be needed to provide an offer.

• The previous two years of renewals would also apply if the request is for an off-cycle renewal (e.g., group renews 1/1 but are requesting a 7/1 or 10/1 effective date.

20-50 ENROLLED
• Include a member-level census for all employees and dependents (DOB, gender, zip code, coverage type such as EE, ES, EC, FAM)
• Employer name, address, SIC code and effective date
• Renewal with an increase less than 20%
• Employer Attestation Form

51-100 ENROLLED
• Include a member-level census for all employees and dependents (DOB, gender, zip code, coverage type such as EE, ES, EC, FAM)
• Employer name, address, SIC code and effective date
• Renewal with an increase less than 40%
• Employer Attestation Form

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 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 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
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

<table>
<thead>
<tr>
<th>Eligible Employees</th>
<th>Number That Must Enroll</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 - 4</td>
<td>2</td>
</tr>
<tr>
<td>5 - 6</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>8-9</td>
<td>5</td>
</tr>
<tr>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>11 - 50</td>
<td>70 percent</td>
</tr>
</tbody>
</table>

PARTICIPATION REQUIREMENTS
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](http://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

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.

FINAL PROPOSALS WITH RAPID GRx UNDERWRITING

Network Health can offer final proposals on midsize groups using risk score in place of applications. To qualify for GRx census-underwriting, a group must meet the following requirements. NOTE: If the most recent renewal cannot be provided, the previous two years of renewals would be needed to provide an offer.

- The previous two years of renewals would also apply if the request is for an off-cycle renewal (e.g., group renews 1/1 but are requesting a 7/1 or 10/1 effective date.

20-50 ENROLLED
- Include a member-level census for all employees and dependents (DOB, gender, zip code, coverage type such as EE, ES, EC, FAM)
- Employer name, address, SIC code and effective date
- Renewal with an increase less than 20%
- Employer Attestation Form

51-100 ENROLLED
- Include a member-level census for all employees and dependents (DOB, gender, zip code, coverage type such as EE, ES, EC, FAM)
- Employer name, address, SIC code and effective date
- Renewal with an increase less than 40%
- Employer Attestation Form

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.

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
• 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
• Three-page Network Health application for all full-time employees, including waivers (to include reason for waiving)
• Most recent quarterly Wage and Tax report (UCT-101 with employment status - FT, PT, Termed)
• Most recent carrier renewal
• Most recent carrier invoice

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

PARTICIPTION 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
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

(Continued on next page)
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)
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](http://www.dol.gov/ebsa/cobra.html) for details on COBRA.

Visit Wisconsin Department of Health Services website at [www.dhs.wisconsin.gov](http://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
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
- 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®
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

<table>
<thead>
<tr>
<th>#</th>
<th>POPULATION</th>
<th>CODING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>NEW TO MEDICARE</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Newly Eligible IEP for Part D/ICEP</td>
<td>ICEP: MA Election IEP for Part D: MAPD Election</td>
</tr>
<tr>
<td>2</td>
<td>Opted out of Medicare Part B when first eligible and then later enrolled in Part B</td>
<td>ICEP/IEP for Part D</td>
</tr>
<tr>
<td>3</td>
<td>Enrolled Into Part B During the Part B General Enrollment</td>
<td>ICEP/IEP for Part D</td>
</tr>
<tr>
<td>4</td>
<td>Newly Eligible for Part D not eligible to enroll during their IEP for Part B</td>
<td>IEP for Part D: MAPD Election</td>
</tr>
<tr>
<td>5</td>
<td>Eligible for Medicare prior to 65 turning 65</td>
<td>IEP2: MAPD Election</td>
</tr>
<tr>
<td></td>
<td><strong>ANNUAL ELECTION PERIOD (AEP)</strong></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>All Beneficiaries</td>
<td>AEP</td>
</tr>
<tr>
<td></td>
<td><strong>OPEN ENROLLMENT PERIOD (OEP)</strong></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Already enrolled in a Medicare Advantage plan</td>
<td>OEP</td>
</tr>
<tr>
<td></td>
<td><strong>BENEFICIARIES WHO MOVE</strong></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Change in Permanent Residence</td>
<td>MOV</td>
</tr>
<tr>
<td>9</td>
<td>Change in Residence Returning to the U.S.</td>
<td>RUS</td>
</tr>
<tr>
<td>10</td>
<td>Released from incarceration</td>
<td>INC</td>
</tr>
<tr>
<td></td>
<td><strong>INSTITUTIONALIZED BENEFICIARIES</strong></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Institutionalized Beneficiaries</td>
<td>LTC</td>
</tr>
<tr>
<td></td>
<td><strong>LOW INCOME BENEFICIARIES</strong></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>LIS (Non-Medicaid)</td>
<td>HLP</td>
</tr>
<tr>
<td>13</td>
<td>LIS (gain, lose, or have a change in Status)</td>
<td>NLS</td>
</tr>
<tr>
<td>14</td>
<td>Dual Eligible</td>
<td>MDE</td>
</tr>
<tr>
<td>15</td>
<td>Dual Eligible (gain, lose, or have a change in Status)</td>
<td>MCD</td>
</tr>
<tr>
<td>16</td>
<td>Enrolled in Employer Sponsored Group plan</td>
<td>EGHP</td>
</tr>
<tr>
<td></td>
<td><strong>CREDITABLE COVERAGE AND EMPLOYER GROUP PLANS</strong></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Loss of Employer Group Coverage</td>
<td>LEC</td>
</tr>
<tr>
<td>18</td>
<td>Involuntary Loss of Creditable Coverage</td>
<td>LCC</td>
</tr>
<tr>
<td></td>
<td><strong>TERMINATION OF PLAN CONTRACT</strong></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Termination of Plan Contract with Medicare with Mutual Consent</td>
<td>NON</td>
</tr>
<tr>
<td>20</td>
<td>Mid-year Termination of Contract with or without Consent</td>
<td>OTH</td>
</tr>
<tr>
<td>21</td>
<td>Termination of Contract due to Misconduct/Or other problems</td>
<td>OTH</td>
</tr>
<tr>
<td></td>
<td><strong>STATE PHARMACEUTICAL ASSISTANCE PROGRAMS</strong></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>State Pharmaceutical Assistance Program (SPAP) Wisconsin Senior Care</td>
<td>PAP</td>
</tr>
<tr>
<td></td>
<td><strong>5-STAR PLAN</strong></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Enroll Into 5-Star Plan</td>
<td>5ST</td>
</tr>
<tr>
<td></td>
<td><strong>DISENROLLMENT ELECTIONS</strong></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Gain or Maintain Other Creditable Coverage</td>
<td>OCC</td>
</tr>
<tr>
<td>25</td>
<td>Trial Period</td>
<td>12G</td>
</tr>
<tr>
<td>26</td>
<td>Enrolled during IEP for Part D/ICEP at 65th birthday and dropping within 1st 12 months (other than an MSA plan)</td>
<td>12J</td>
</tr>
<tr>
<td>#</td>
<td>POPULATION QUALIFICATION REFERENCE TIME FRAME EFFECTIVE DATE CODING</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>1</td>
<td>Newly Eligible (IEP for Part D/ICEP)</td>
<td>Has both Medicare Parts A and B for the first time. Either you are turning 65 or you are in month 25 of receiving Social Security or Rail Road Retirement Disability Benefits.</td>
</tr>
<tr>
<td>2</td>
<td>Opted out of Medicare Part B when first eligible and then later enrolled in Part B, Delays Part B enrollment beyond their IEP for Medicare Part B</td>
<td>Entitled to Medicare Part A. Newly enrolled to Part B.</td>
</tr>
<tr>
<td>3</td>
<td>Enrolled into Part B during the Part B General Enrollment</td>
<td>Entitled to Medicare Part A. Adding Part B during the General Enrollment Period Jan. 1 - Mar. 31.</td>
</tr>
</tbody>
</table>

MSA Eligible
<table>
<thead>
<tr>
<th>#</th>
<th>POPULATION</th>
<th>QUALIFICATION</th>
<th>REFERENCE</th>
<th>TIME FRAME</th>
<th>EFFECTIVE DATE</th>
<th>CODING</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Newly Eligible for Part D but not eligible to enroll in a Part D plan at any time during their Initial Enrollment Period for Medicare Part B</td>
<td>Initially eligible to enroll in a Medicare Advantage Part D plan (MA-PD) when he or she is entitled to both Medicare Part A and B, and permanently resides in the service area of a Part D plan.</td>
<td>Ultimately CMS provides a Part D effective date and maintains it in the CMS systems, Medicare Advantage Prescription Drug (MARx).</td>
<td>If the Part D effective date is outside of the Initial Enrollment Period for Medicare Part B and an individual is not eligible to enroll in a Part D plan at any time during their Initial Enrollment Period for Medicare Part B then the IEP for Part D window is then a seven month period including the 3 months before becoming eligible for Part D, the month of eligibility, and the three months following eligibility for Part D.</td>
<td>First of the month following receipt of application, but not earlier than Part D effective date maintained in MARx.</td>
<td>IEP for Part D if outside of ICEP MSA Not Eligible</td>
</tr>
<tr>
<td>5</td>
<td>Eligible for Medicare prior to age 65, attaining age 65</td>
<td>Have Part A and B due to disability and are turning 65.</td>
<td>Individual’s 65th Birthday</td>
<td>Begins three months before month of birthday. Includes birthday month.</td>
<td>Ends last day of the third month after the month they attain age 65.</td>
<td>MSA Not Eligible</td>
</tr>
</tbody>
</table>

**ANNUAL ELECTION PERIOD (AEP)**

| 6 | All Beneficiaries | Annual Election Period (AEP) | Begins October 15 | Ends December 7 | January 1 | AEP MSA Eligible |

**OPEN ENROLLMENT PERIOD (MA-OEP)**

| 7 | Enrolled in a Medicare Advantage plan (MA/MAPD) | Must be active in a Medicare Advantage plan. | MARx | Enrolled as of January 1. | First day of the month following receipt of the enrollment request. | MA-OEP MSA Not Eligible |

<p>| 8 | New Medicare Advantage enrollees | New Medicare Advantage enrollees following IEP/ICEP Medicare entitlement. | MARx | New ICEP enrollees Begins Month of entitlement to A and B. | First of the month following receipt of application. | MA-OEP New MSA Not Eligible |</p>
<table>
<thead>
<tr>
<th>#</th>
<th>POPULATION</th>
<th>QUALIFICATION</th>
<th>REFERENCE</th>
<th>TIME FRAME</th>
<th>EFFECTIVE DATE</th>
<th>CODING</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Change in Permanent Residence</td>
<td>Permanently moved inside plan’s service area with new plan options available.</td>
<td>Beneficiary’s Attestation Before Move Begins the month before month of permanent move.</td>
<td>Ends two months after the move.</td>
<td>After the Move Begins month beneficiary notified plan of the move.</td>
<td>Ends two months after notification of the move.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Permanently moved outside plan’s service area.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Change in Residence</td>
<td>Returning to the U.S. after permanently living outside the U.S.</td>
<td>Beneficiary’s Attestation Before Move Begins the month before month of permanent move.</td>
<td>Ends two months after the move.</td>
<td>After Move Begins month beneficiary notified plan of the move.</td>
<td>Ends two months after notification of the move.</td>
</tr>
<tr>
<td>11</td>
<td>Released from incarceration</td>
<td>Released from incarceration.</td>
<td>Beneficiary’s Attestation As early as month before release, lasts up to two months after release.</td>
<td></td>
<td>First of the month following receipt of enrollment request, but not earlier than release date.</td>
<td>INC</td>
</tr>
<tr>
<td>12</td>
<td>Institutionalized Beneficiaries</td>
<td>Resides in skilled nursing facility, intermediate care facility, psychiatric, rehab, long-term care, or swing-bed hospital.</td>
<td>Beneficiary’s Attestation Begins first day Institutionalized. Ends two months after discharge.</td>
<td></td>
<td>First of the month following receipt of the enrollment request.</td>
<td>LTC</td>
</tr>
<tr>
<td>13</td>
<td>LIS (Non-Medicaid)</td>
<td>Have Part D subsidy.</td>
<td>Beneficiary’s Attestation LIS validated in CMS Portal MARx Begins the month the individual qualifies for LIS. Can only be used once during each of the following time periods: • January – March, • April – June, and • July – September. It may not be used in the 4th quarter of the year (October – December).</td>
<td></td>
<td>First of the month following receipt of the enrollment request.</td>
<td>HLP</td>
</tr>
<tr>
<td>#</td>
<td>POPULATION</td>
<td>QUALIFICATION</td>
<td>REFERENCE</td>
<td>TIME FRAME</td>
<td>EFFECTIVE DATE</td>
<td>CODING</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>14</td>
<td>LIS (gain, lose, or have a change in Status)</td>
<td>Have gain, lose or change of Low Income Subsidy (LIS).</td>
<td>Beneficiary’s Attestation&lt;br&gt;Gain, lose, or change validated in CMS Portal MARx</td>
<td>Begins within three months of change, or notification of such a change, whichever is later. Use of this SEP does not count towards the once per calendar quarter limitation. <strong>Ends</strong> three months after the change or notification of change, whichever is later.</td>
<td>First of the month following receipt of the enrollment request.</td>
<td>NLS&lt;br&gt;MSA Not Eligible</td>
</tr>
<tr>
<td>15</td>
<td>Dual Eligible</td>
<td>Have Medicaid.</td>
<td>Medicaid validated using the ForwardHealth Portal.</td>
<td>Begins the month the individual qualifies for Medicaid. Can only be used once during each of the following time periods: • January - March, • April - June, and • July - September. It may not be used in the 4th quarter of the year (October - December). <strong>Ends</strong> three months after the change or notification of change, whichever is later.</td>
<td>First of the month following receipt of the enrollment request.</td>
<td>MDE&lt;br&gt;MSA Not Eligible</td>
</tr>
<tr>
<td>16</td>
<td>Dual Eligible (gain, lose, or have a change in Status)</td>
<td>Have gain, lose or change of Medicaid benefits.</td>
<td>Gain, lose, or change of Medicaid validated using the ForwardHealth Portal.</td>
<td>Begins within three months of change, or notification of such a change, whichever is later. Use of this SEP does not count towards the once per calendar quarter limitation. <strong>Ends</strong> three months after the change or notification of change, whichever is later.</td>
<td>First of the month following receipt of the enrollment request.</td>
<td>MCD&lt;br&gt;MSA Not Eligible</td>
</tr>
</tbody>
</table>

**CREDITABLE COVERAGE AND EMPLOYER GROUP PLANS**

<table>
<thead>
<tr>
<th>#</th>
<th>POPULATION</th>
<th>QUALIFICATION</th>
<th>REFERENCE</th>
<th>TIME FRAME</th>
<th>EFFECTIVE DATE</th>
<th>CODING</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Current Employer/Union Group Coverage</td>
<td>Have creditable group coverage including COBRA.</td>
<td>Beneficiaries’ Attestation</td>
<td>Anytime while enrolled in group coverage.</td>
<td>Can choose a future effective date up to three months after the month of application, but effective date cannot be earlier than the first of the month following month in which the request is made.</td>
<td>EGHP&lt;br&gt;MSA Not Eligible</td>
</tr>
<tr>
<td>18</td>
<td>Loss of Employer Group Coverage</td>
<td>Voluntary or involuntary termination of group coverage.</td>
<td>Beneficiary’s Attestation</td>
<td>Begins month group allows or disenrollment or date COBRA ends. <strong>Ends</strong> two months after group coverage ends.</td>
<td>Can choose a future effective date up to three months after the month of application, but effective date cannot be earlier than the first of the month following month in which the request is made.</td>
<td>LEC&lt;br&gt;MSA Not Eligible</td>
</tr>
<tr>
<td>#</td>
<td>POPULATION</td>
<td>QUALIFICATION</td>
<td>REFERENCE</td>
<td>TIME FRAME</td>
<td>EFFECTIVE DATE</td>
<td>CODING</td>
</tr>
<tr>
<td>----</td>
<td>------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>19</td>
<td>Involuntary Loss of Creditable Prescription Drug Coverage</td>
<td>Involuntary loss of coverage. Coverage is no longer creditable. This does not include loss due to nonpayment of premium. *Enrollment into MAPD.</td>
<td>Beneficiaries’ Attestation Letter stating loss of creditable coverage</td>
<td>Begins either month of notice or month the loss or reduction of coverage occurs, whichever is later. Ends two months later.</td>
<td>First of the month following receipt of the enrollment request, permits enrollment in a MAPD/PDP only.</td>
<td>LCC</td>
</tr>
<tr>
<td>20</td>
<td>Termination of plan contract with Medicare with mutual consent</td>
<td>Contract with Medicare is ending with mutual consent.</td>
<td>Beneficiaries’ Attestation Letter of Notification Medicare Advantage Plan must notify Beneficiary by October 1 if it won’t offer health coverage next year, and it must continue to provide coverage through the end of the current calendar year.</td>
<td>Lasts from December 8 of that year through the last day of February of the next year. (This SEP is in addition to the Fall Open Enrollment period from October 15 through December 7, can switch Medicare health coverage and enroll or disenroll from Part D drug coverage.</td>
<td>Enrollments made from October 15 through December 31 are effective January 1.</td>
<td>NON</td>
</tr>
<tr>
<td>21</td>
<td>Mid-year plan closes or changes its contract (forced disenrollment) Mutual termination of contract with CMS or CMS terminates the plan’s contract(s)</td>
<td>Contract with Medicare is ending with or without mutual consent.</td>
<td>Member Attestation Notice of Termination Medicare Advantage Plan must notify 60 days before the proposed date of termination or modification.</td>
<td>Begins two months before termination. Ends one month after effective termination.</td>
<td>Can request new Medicare Advantage Plan coverage start the month after notice and up to two months after old Medicare Advantage Plan or Part D plan coverage ends.</td>
<td>OTH</td>
</tr>
<tr>
<td>22</td>
<td>CMS terminates Medicare Advantage Plan’s contract because of misconduct or other problems.</td>
<td>Contract with Medicare is ending without mutual consent.</td>
<td>Member Attestation Termination Letter (plan must give 30 days notice before the termination date).</td>
<td>Begins one month before the termination occurs and lasts for two months afterward.</td>
<td>Can choose to have new Medicare Advantage Plan coverage begin up to three months after the month your old coverage ended.</td>
<td>OTH</td>
</tr>
</tbody>
</table>

**TERMINATION OF PLAN CONTRACT**

- Involuntary Loss of Creditable Prescription Drug Coverage
- Termination of plan contract with Medicare with mutual consent
- Mid-year plan closes or changes its contract (forced disenrollment) Mutual termination of contract with CMS or CMS terminates the plan’s contract(s)
- CMS terminates Medicare Advantage Plan’s contract because of misconduct or other problems.
<table>
<thead>
<tr>
<th>#</th>
<th>POPULATION</th>
<th>QUALIFICATION</th>
<th>REFERENCE</th>
<th>TIME FRAME</th>
<th>EFFECTIVE DATE</th>
<th>CODING</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>Belongs to a State Pharmaceutical Assistance Program (SPAP) Wisconsin Senior Care</td>
<td>Wisconsin Senior Care at any level. Senior Care ending. (Loss of Senior Care due to failure to pay premium is not considered involuntary.)</td>
<td>Wisconsin Senior Care award letter State of Wisconsin ForwardHealth Portal Member/Applicant Attestation</td>
<td>Begins Immediately. <strong>For Loss:</strong> begins either the month of lose eligibility or notification of the loss, whichever is earlier, and ends two months after either the month of the loss of eligibility or notification of the loss, whichever is later. This election can only be used once per year.</td>
<td>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.</td>
<td>PAP</td>
</tr>
</tbody>
</table>

| 24 | 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    |

| 25 | 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 election is for disenrollment from a MAPD plan It can also be used to change from MAPD to MA. | OCC    |

<p>| 26 | Trial Period                     | Individuals who terminated a Medicare Supplement (Medigap) plan when they enrolled in an MA/MAPD for the first time, and who are still in the “Trial Period.” | Must receive written request to disenroll and be in first 12 months of an MA/MAOD plan. *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. They may go back to original Medicare and have a guaranteed issue to return to the Medicare Supplement (same Supplement and same company). | Begins upon enrollment in the MA plan. <strong>Ends</strong> after 12 months of enrollment or when the beneficiary disenrolls from the MA plan, whichever is earlier. | First of the month following receipt of the written disenrollment request. | 12G    |</p>
<table>
<thead>
<tr>
<th>#</th>
<th>POPULATION</th>
<th>QUALIFICATION</th>
<th>REFERENCE</th>
<th>TIME FRAME</th>
<th>EFFECTIVE DATE</th>
<th>CODING</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>Enrolled in a MA/MAPD during the IEP/ICEP at 65th birthday and dropping it within 1st 12 months (other than an MSA plan)</td>
<td>MA eligible individuals who elect an MA plan (other than an MSA plan) during the initial enrollment period (IEP) for Part B surrounding their 65th birthday (Individuals entitled to Medicare prior to age 65 are NOT eligible for this SEP).</td>
<td>Elected a MA/MAPD plan during IEP/ICEP surrounding 65th birthday. CMS MARx</td>
<td>Anytime during the 12 month period that begins on the effective date of coverage in the MA/MAPD plan.</td>
<td>Termination date is first day of the month following the month of written notice.</td>
<td>12J</td>
</tr>
</tbody>
</table>

**CANCELLING APPLICATIONS**

<table>
<thead>
<tr>
<th>#</th>
<th>POPULATION</th>
<th>QUALIFICATION</th>
<th>REFERENCE</th>
<th>TIME FRAME</th>
<th>EFFECTIVE DATE</th>
<th>CODING</th>
</tr>
</thead>
<tbody>
<tr>
<td>28</td>
<td>First time MSA enrollees (during AEP)</td>
<td>First time MSA application.</td>
<td>Return to original Medicare</td>
<td>After December 7 and up to December 15.</td>
<td>Verbal or written request.</td>
<td>MSA Not Eligible</td>
</tr>
<tr>
<td>29</td>
<td>New applications to Network Health</td>
<td>Prior to plan effective date.</td>
<td>Return to prior plan or original Medicare</td>
<td>Prior to plan effective date.</td>
<td>Verbal or written request.</td>
<td></td>
</tr>
</tbody>
</table>

**NETWORK HEALTH MEDICARE ADVANTAGE SERVICE AREA**

- **NORTHEAST PPO SERVICE AREA**
  - Network PlatinumSelect (PPO)
  - Network PlatinumChoice (PPO)
  - Network PlatinumPlus (PPO)
  - Network PlatinumPlus Pharmacy (PPO)
  - Network PlatinumPremier (PPO)
  - Network PlatinumPremier Pharmacy (PPO)
  - NetworkCares (PPO SNP)

- **NORTHEAST PPO SERVICE AREA**
  - Network PlatinumZero (PPO)

- **NORTHEAST and SOUTHEAST MSA SERVICE AREA**
  - NetworkPrime (MSA)

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

- **SOUTHEAST HMO SERVICE AREA**
  - Medicare Explore (HMO)
What Are the Different Medicare Coverage Options Offered by Network Health?

Network Health offers a variety of Medicare plan options.

**Preferred Provider Organization – PPO***
- Includes a network of providers
- Members can go out-of-network
- Plans may include prescription drug coverage

Learn more about our PPO plans.

**Health Maintenance Organization – HMO***
- Includes a network of providers
- Must stay in-network or pay the full cost of services (except emergency and urgent care)
- Must select a personal doctor (also referred to as a primary care practitioner or PCP)
- Generally need a referral to see a specialist

Learn more about our HMO plans.

**Special Needs Plan – SNP***
Networks Health only offers a D-SNP.
- The member is eligible for both Medicare and Medicaid

Learn more about our SNP plans.

**Medical Savings Account – MSA**
Combines a high deductible Medicare Advantage plan and a medical savings account
- The MSA plan deposits money into the members account
- Members use this money to pay for health care until the high deductible is met (only Part A and Part B expenses count towards this deductible)
- Once the deductible is met, the plan pays the expenses related to covered services
- Members can see any doctor in any service area
- May not include prescription drug coverage

Learn more about our MSA plan.

*Available in specific counties. See previous page for service areas.
Top EIGHT Things to Know About an MSA BenefitWallet Account

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.

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.

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.

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.

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 receive letters from BenefitWallet requesting documentation to verify their identities
   - Soft transfer the call to BenefitWallet.
   - Members should speak with a BenefitWallet representative for additional information.
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.

- A scope of appointment form must be completed by the beneficiary prior to discussing any topics agreed upon in the scope of 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).

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 Appointment Documents should be retained for 10 years by the agent.
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 Network Health’s agent advisors at 920-720-1260 to validate if the application was received.

Sample Verification email

Form

To find the most up to date forms visit networkhealth.com/agent-resources/index.

Individual Enrollment Request Agent Agreement

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.
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.

Agents are prohibited in engaging actives which mislead, confuse or misrepresent Network Health and available plans.

Agents are prohibited from using the Network Health name, brand and logo without permission from Network Health.
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 2021 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.
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 login link at the bottom of the page.
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.
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.
**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 hand corner.

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

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

Additional Resources
Looking to order marketing materials? Visit the new supplies ordering site at: [https://networkhealth.envision-ink.com/login.php](https://networkhealth.envision-ink.com/login.php)

Welcome to the NH Request Tracker!

- New Agent Request
- New Customer Service Request
You will receive email notification when information on your requests have been updated.

---

There has been an update on your agent request - please click on the agent request link below to view the notes and respond if appropriate.

Thank you,

Network Health

You can access your agent request at the link below.
https://networkhealth.quickbase.com/d/dbbe5bed/a-a-a-a
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 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.
From the **Welcome** screen of the NHP Request tracker, click **Add a Request**.

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

<table>
<thead>
<tr>
<th>Plan Contract</th>
<th>Plan Name</th>
<th>New Plan Benefit Package</th>
</tr>
</thead>
<tbody>
<tr>
<td>H5215</td>
<td>Network PlatinumPlus (PPO)</td>
<td>001</td>
</tr>
<tr>
<td>H5215</td>
<td>Network PlatinumPlus with Pharmacy (PPO)</td>
<td>002</td>
</tr>
<tr>
<td>H5215</td>
<td>Network PlatinumPremier with Pharmacy (PPO)</td>
<td>005</td>
</tr>
<tr>
<td>H5215</td>
<td>Network PlatinumPremier (PPO)</td>
<td>006</td>
</tr>
<tr>
<td>H5215</td>
<td>Network Cares (PPO SNP)</td>
<td>007</td>
</tr>
<tr>
<td>H5215</td>
<td>Network PlatinumSelect (PPO)</td>
<td>008</td>
</tr>
<tr>
<td>H5215</td>
<td>Network Health Medicare Go (PPO)</td>
<td>009</td>
</tr>
<tr>
<td>H5215</td>
<td>Network Health Medicare Anywhere (PPO)</td>
<td>010</td>
</tr>
<tr>
<td>H5215</td>
<td>Network PlatinumChoice (PPO)</td>
<td>011</td>
</tr>
<tr>
<td>H5215</td>
<td>Network PlatinumZero (PPO)</td>
<td>012</td>
</tr>
<tr>
<td>H1181</td>
<td>Network Prime (MSA)</td>
<td>001</td>
</tr>
<tr>
<td>H5644</td>
<td>Network Health Medicare Explore (HMO)</td>
<td>002</td>
</tr>
</tbody>
</table>

## 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.
NHP Request Tracker Tips
Use one of these headings as the Request Types to get your answers in the NHP Request Tracker.

<table>
<thead>
<tr>
<th>Commission Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Question on Commissions</td>
</tr>
<tr>
<td>• Needing your log in information</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Customer Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Member’s balance questions</td>
</tr>
<tr>
<td>• Questions on explanation of benefits</td>
</tr>
<tr>
<td>• Request new member ID Cards</td>
</tr>
<tr>
<td>• Information about other creditable drug coverage</td>
</tr>
<tr>
<td>• Request health care concierge to call a member</td>
</tr>
<tr>
<td>• Questions on prescription drug coverage</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enrollment Application and Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Applications</td>
</tr>
<tr>
<td>• Changes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sales Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Confirm NetworkCares eligibility</td>
</tr>
<tr>
<td>• More sales kits and other supplies</td>
</tr>
<tr>
<td>• Request a copy of application</td>
</tr>
<tr>
<td>• Request for marketing pieces</td>
</tr>
</tbody>
</table>

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.