network health

AGENT GUIDE

COMMERCIAL EMPLOYER GROUP PLANS

TABLE OF CONTENTS

4552-02-0925

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 40 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

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**.

MISSION

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

VISION

Your **local**, **reliable** partner delivering an **exceptional** health insurance experience.

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

HISTORY

1982

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

1995

Network Health Plan receives an amended certificate of authority, allowing it to offer products such as point-of-service and preferred provider organization (PPO) plans.

1998

Network Health System merges with Affinity Health System.

2005

Medicare Advantage PPO launches.

2013

Ascension

Ministry Holdings, Inc. becomes parent of Network Health. Ascension Health becomes the sole corporate member of Ministry Health Care, Inc.

2014

Froedtert & Medical College of Wisconsin

Froedtert Health purchases 50 percent of Network Health and Medicare Medical Savings Account plan launches.

2015

ACA

Affordable Care Act individual and family plan product launches on the health insurance exchange.

2016

Medicare Advantage expands into southeast Wisconsin and Assure level-funded product launches.

2019

Family Savings Plan launches.
Network Health's second office in Brookfield opens to the community.

★★★★★ 2021

Network Health Medicare Advantage PPO Plans receive a 5 out of 5 Star quality rating*—Medicare's highest rating.

★★★★★ 2022

40 YEARS 1982 network health 2022 OF DOING THE RIGHT THING

Network Health celebrates a PPO Medicare 5 Star rating* for the second year in a row, 70,000 Medicare Advantage members and 40 years of doing the right thing.

LOCATIONS

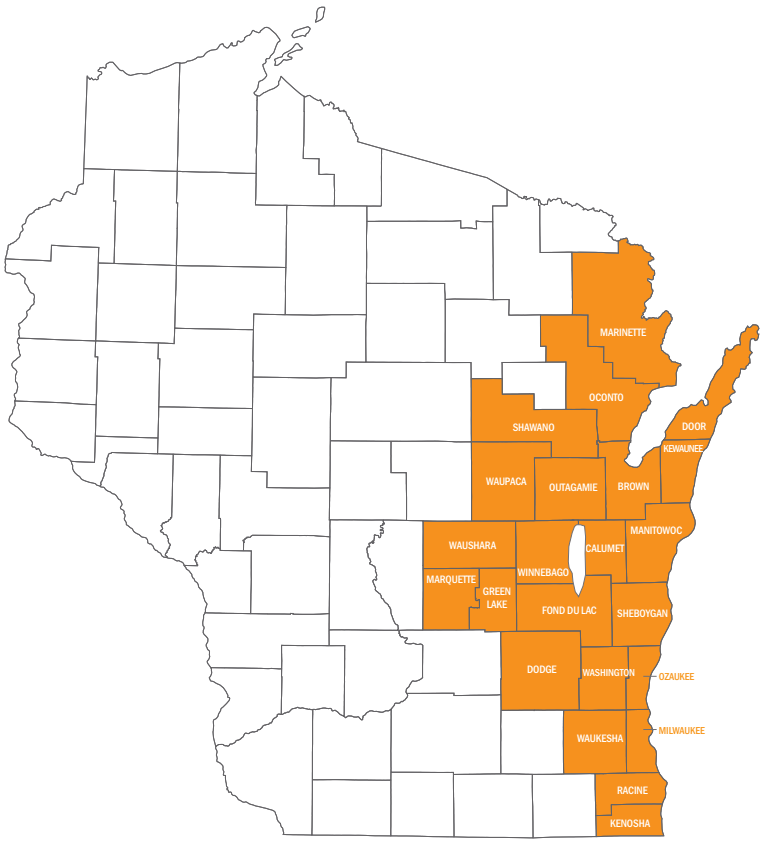
1570 Midway Place, Menasha

16960 W. Greenfield Ave., Suite 5, Brookfield

NETWORK HEALTH'S SERVICE AREA

COUNTIES

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



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

AGENT LICENSING

Network Health establishes long-term relationships with our agents.

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.

NETWORK HEALTH CONTRACTING

Here are the steps for new and returning producers to become Network Health Approved and Ready to Sell.

NEW AGENTS FOLLOW THESE 5 STEPS

1. Contact a Network Health Account Executive
2. Receive an electronic on-boarding invitation for the following
   - Licensing
   - Background check
   - Commissions payment
   - Active Errors and Omissions (E&O) Insurance
3. Onboarding approval or denial by Network Health
4. Appointed and Ready to Sell Network Health

RETURNING PRODUCERS – FOLLOW THESE FOUR STEPS

Step 1: Active E&O

- You must maintain active E&O Insurance with a minimum of $1 million in coverage for each claim
- If you have any changes to your current E&O, upload in the Network Health Agent Portal using the secure messaging feature

Step 2: Keep Your Info Current

- Changes such as name, address, SSN, health insurance license and Tax ID changes require that you complete a W-9 form through the Network Health Agent Portal secure messaging feature

IMPORTANT FOR ALL PRODUCERS

- Your information must be current in our system for tax and communication purposes.
- Producers are required to keep their electronic funds transfer current for commissions payments.

NO PAPER CHECKS ARE ISSUED

- It is your responsibility to upload your current E&O certificate each year.
- Missing information will result in commissions not being paid. **NO EXCEPTIONS**.
- Be sure to add your agent ID to all applications and change forms in order to receive proper commissions.

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 2026 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.

Group Policies

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

Employer Plan Type	Number of Subscribers in Month	Monthly Commission Rate
Fully Insured (Beginning January 1, 2026)	1–3	$30 PEPM
	Next 4–50	$30 PEPM
	Next 51 +	$30 PEPM
Assure Level-Funded (Beginning January 1, 2026)	2-100 enrolled	$45 PEPM for new groups, $45 PEPM for renewals

- 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.

(Continued on next page)

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 a Producer Agreement or is affiliated with an agency that has a Producer Agreement and 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 Producer 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.

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 a Producer Agreement or is affiliated with an agency that has a Producer Agreement 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 Producer 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 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 would need to be received by August 1 to ensure we are able to review and process for the November 1 effective date.

To submit your request, reach out to the Director of Sales and Client Management or the Vice President of Commercial Sales. In most situations a Book of Business Transfer form will need to be completed.

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.

ASSURE LEVEL-FUNDED

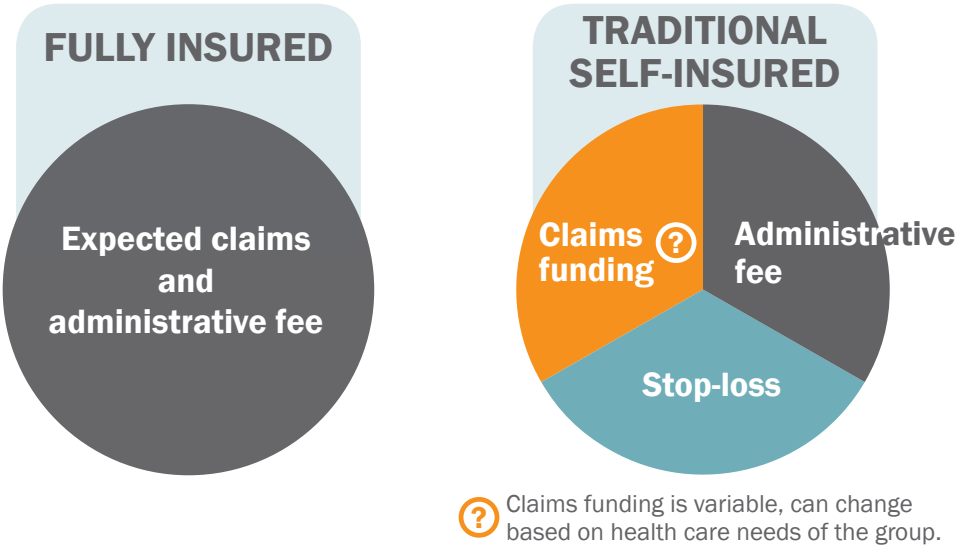
2–100 Total Enrolled Employees

PRODUCT DESCRIPTION

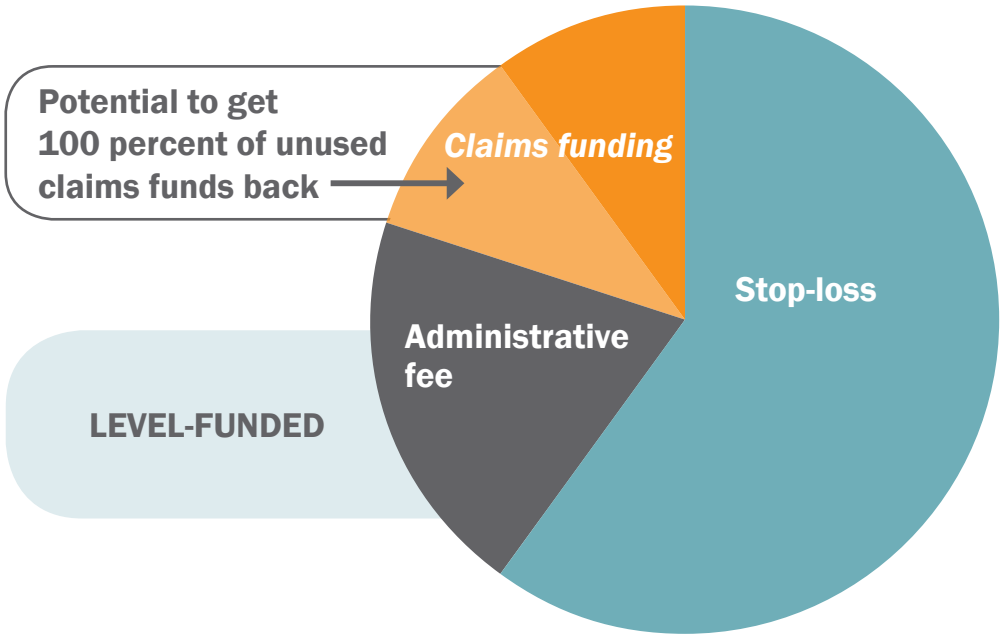
Our Assure level-funded plan is a hybrid of a traditional self-insured plan and a fully insured plan. The group funds the health plan and Network Health Administrative Services (NHAS) administers the plan. Employer groups can enjoy all the benefits of a fully insured product (health management, wellness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

ADVANTAGE OF LEVEL FUNDING

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



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



PRESCRIPTION DRUG COVERAGE

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

View Network Health's Preferred Drug List at
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 (Point of Service) 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
  - 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. Domestic partners are not eligible.

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)

(Continued from previous 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 following up with a 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 using risk score in place of applications to midsize Assure groups with 10-100. 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 January 1 but are requesting a July 1 or October 1 effective date.)

10-50 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 40 percent
- Employer Attestation Form
- Mid-size groups with 2-9 applying for coverage must complete health statements.

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 percent
- 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 no 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 electronic funds transfer (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/agencies/ebsa/laws-and-regulations/laws/cobra** 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

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

PRODUCTS

MEDICAL PLANS

- Network Health offers 31 ACA-compliant HMO plans
- 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.

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 copayment 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 within our service area
- 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, 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
- 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. Domestic partners are not eligible.

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

PARTICIPATION REQUIREMENTS

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

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

PAYMENT OF PREMIUMS

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

PREMIUM WHEN ADDING OR TERMING COVERAGE MID-MONTH

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

NETWORK HEALTH TERMINATION OF A GROUP PLAN

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

MEMBER MATERIALS

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

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

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

RENEWALS

SMALL 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 plan changes can be made in 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. If multiple plans are offered, employees are allowed to change between plan offerings at renewal time without a qualifying event.

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 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)

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 as follows.

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 AND RESOURCES

Eligibility Certification Form

51-100 Enroll Application

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 copayment 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 (Point of Service) 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. Domestic partners are not eligible.

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 who 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 using risk score in place of applications to midsize groups with 10-100. 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 January 1 but are requesting a July 1 or October 1 effective date.)

10-50 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 40 percent
- Employer Attestation Form
- Mid-size groups with 2-9 applying for coverage must complete health statements

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 percent
- 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 Network Health application for all full-time employees, including waivers (to include reason for waiving)
- 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
- 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.

PARTICIPATION REQUIREMENTS

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

APPLICATION/ENROLLMENT

CASE SUBMISSION

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 or a completed **Enrollment Template**
- 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 electronic funds transfer (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)

(Continued from previous page)

- Mail to:
  Network Health
  Enrollment Services
  1570 Midway Place
  Menasha, WI 54952

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

COBRA

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

1. Employee's death (36 months)
2. Termination of employment or retirement (18 months)
3. Reduction of hours causing loss of coverage (18 months)
4. Entitlement of Medicare by employee (dependents only, 36 months)
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/agencies/ebsa/laws-and-regulations/laws/cobra** for details on COBRA.
Visit Wisconsin Department of Health Services website at **www.dhs.wisconsin.gov** for details on state continuation rights.

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

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

FORMS AND RESOURCES

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

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 copayment 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 (Point of Service) 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 (101 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 (101 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 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

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 electronic funds transfer (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 AND RESOURCES

Eligibility Certification Form

51-100 Enroll Application

EFT Enrollment and Change Form

Employer Group Application

Express Scripts, Inc. Mobile Application Download

Preferred Drug List

MDLive®

Enrollment Template

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.

BROKER BONUS PROGRAM

COMMERCIAL BUSINESS

AGENCY LEVELS	
Agency Level	Bonus Payout
Associate	100 subscribers or more = 50%
Executive	200 subscribers or more = 75%
Presidential	300 subscribers or more = 100%
BOOK OF BUSINESS BONUS PAYOUT DETAILS	
Book Of Business Retention/Growth Factor	Qualifying Percentage
110% or greater	20% of reporting period commissions
105% to 109.9%	15% of reporting period commissions
100.1% to 104.9%	10% of reporting period commissions

Bonus calculation is based on the block of business size as measured from January 31 of the base year through January 31 of the following year. This bonus rewards agencies for their net growth due to organic in-force growth and new groups to Network Health. Therefore, an agency's subscriber count may be adjusted if a disproportionate amount of their growth is due to Agent of Record changes.

- Agencies must meet the following requirements.
  - Have a minimum of 100 subscribers when the reporting calculation period ends
  - End the reporting period with a book of business retention/growth factor that is 100.1 percent or greater
  - Minimum of three in-force groups with Network Health
- Bonus is based on a percentage of commercial commissions for the reporting period. Payments will be made in March of the following year.
- Calculation and payments are based on the overall agency results. If agencies are involved in a merger or acquisition activity involving a change of ownership, then those agencies will be combined when calculating bonus eligibility.
- Agencies are encouraged to track their bonus eligibility.

Network Health reserves the right to revise or terminate this program at any time without advance notice. Administration of the program is at the sole discretion of Network Health.