



A GUIDE TO ADMINISTERING YOUR HEALTH PLAN

FOR EMPLOYERS

WELCOME TO



This administration guide is designed to help you deliver benefits to employees. Everyone involved in the administration of your health plan should become familiar with the information in this guide.

It's important to know this guide is subject to change. To ensure you are using the most up-to-date version, visit the **Employer Resources** page under the **Employer Plans** tab on networkhealth.com. Under **Employer Guides**, select **Administration Guide**.

For information specific to your company's health plan, refer to your Health Services Policy (HSP). If you have any questions, please call your Network Health Sales Client Manager.

If employees have questions, they can call our member experience department at 800-826-0940 or send us a message from the **Contact Us** page on networkhealth.com.

HMO and POS plans underwritten by Network Health Plan.
1014-05-0921



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THE NETWORK HEALTH DIFFERENCE

Organized by a group of Fox Valley doctors, we started small in 1982. Today, we provide health insurance to more than 110,000 members and we've earned a strong reputation for quality and personal service. We're a locally owned, Wisconsin-based company—accountable to our customers, not shareholders. For nearly 40 years we've been trusted experts in health insurance, offering a different kind of health insurance that puts customers first.

We bring you the best health insurance experience possible because our mission is to create healthy and strong Wisconsin communities. Being locally owned allows us to be flexible and responsive, helping us create custom, cost-saving solutions for our customers.

At Network Health, we do what's right because that is who we are. We do what's right, even when it isn't easy. That's why we take extra steps to make health insurance affordable and understandable, so you can make the most of your coverage.

AT YOUR SERVICE

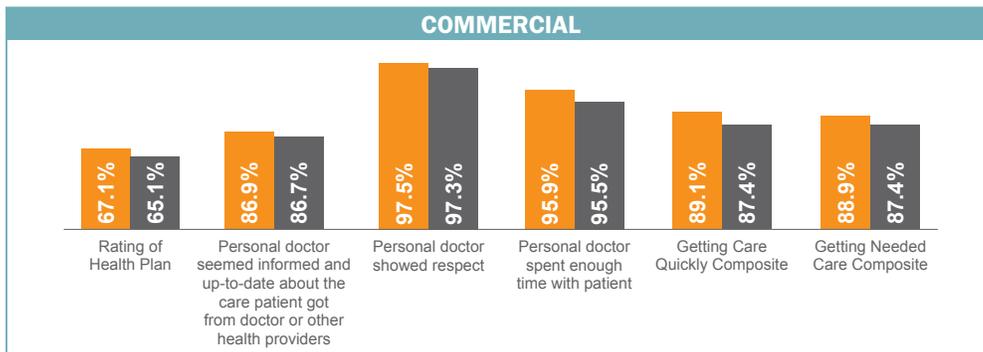
Some insurance companies bombard you with health insurance language. We talk like people, not insurance dictionaries. Our plain-language approach paired with highly rated service provides the ultimate customer support.

When our customers call, they quickly get a knowledgeable, caring team member with a straight answer that's easy to understand.

We offer an in-house team of member experience representatives to take care of our customers. Last year we answered 87.8 percent of calls within 30 seconds, quicker than the time it takes you to watch your favorite Super Bowl commercial.

What Our Customers Say

Our customers rate us higher than the national average in the following categories.



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What Our Providers Say

Providers rate Network Health well above other plans.

PROVIDERS		
Category	Network Health	
Would recommend Network Health to other providers	92.9%	
Category	Network Health	Next Highest Competitor
Overall provider satisfaction	82.7%	65.0%

ENROLLMENT

New employees and dependents enrolling with Network Health must do so within 31 days of becoming eligible for insurance coverage. Birth dates and Social Security numbers are required for everyone who enrolls.

We also encourage employees and dependents to choose a primary care physician during enrollment (see page 16 for more about choosing a primary care physician).

HOW TO ENROLL EMPLOYEES

There are four ways you can manage the enrollment of employees. Network Health strives to provide quick and accurate services to our customers during their enrollment. We process 95 percent of new applications within five days and mail member ID cards within 10 business days of receiving new or updated enrollment.

1. Log in to our [Employer Portal](#) and enroll employees online.

If you are using the portal for the first time please call our enrollment services department at 877-549-8793 to get a username and password. (See page 15 for more information about the portal.)

2. Mail completed [Membership Application and Change Form](#) to the address below.

Network Health
Attn: Enrollment Services Department
1570 Midway Pl.
Menasha, WI 54952

3. Fax completed [Membership Application and Change Form](#) to 920-720-1904.

4. Send a secure email with a completed [Membership Application and Change Form](#) to nhcommercialenrollment@networkhealth.com

EMPLOYEE MATERIALS

Once employees are enrolled, they will receive the following materials.

- Network Health ID card
- How to Use Your Health Care Plan guide

When an employee receives their member ID cards, he or she needs to verify the name and address are correct. If the information is incorrect, employees should call our member experience department at the number listed on the back of their insurance card to update their information.





networkhealth.com

Line of Business: LF_OPT_LLC
Group Name: GroupName
Group Number: GroupNumber

Participant #:	Participant Name:	What Member Pays:	Network In:	Out:
MemberID01	MemberName01	Individual	CopayXX	CopayXX
MemberID02	MemberName02	Family	CopayXX	CopayXX
MemberID03	MemberName03	Individual	CopayXX	CopayXX
MemberID04	MemberName04	Family	CopayXX	CopayXX
MemberID05	MemberName05	Individual	CopayXX	CopayXX
MemberID06	MemberName06	Family	CopayXX	CopayXX
MemberID07	MemberName07	Emergency Room Services	CopayXX	
MemberID08	MemberName08	Urgent Care	CopayXX	
		PCP Office Visit	CopayXX	
		Specialist Office Visit	CopayXX	
		Preventive	CopayXX	

Pharmacy Information: Rx BIN: 003858 RxPCN: A4 RxGrp: WAEA



ORDERING ADDITIONAL ID CARDS

There are two ways to order additional Network Health ID cards.

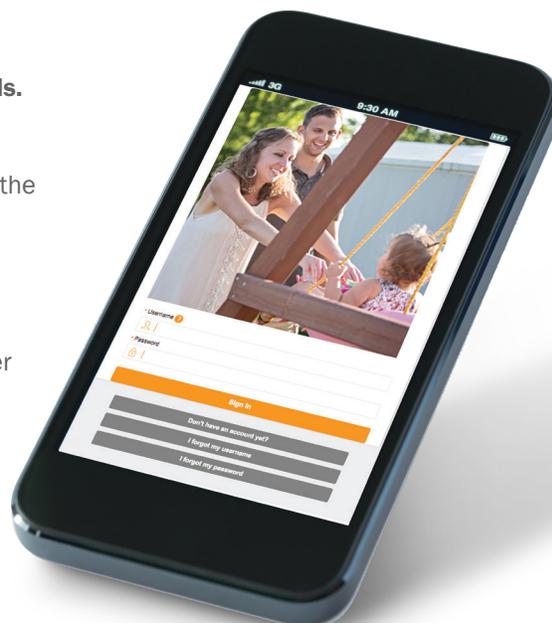
- You can order online through the [Employer Portal](#)
- An employee can call our member experience department at the number listed on the back of their member ID card.

MEMBER PORTAL

Your employees can use their phone, tablet or personal computer to view and print a copy of their ID card from the member portal.

Members can sign in to the portal at

login.networkhealth.com.



ADDITIONAL ENROLLMENT INFORMATION

LATE ENROLLMENT

Eligible employees or dependents are considered late enrollees if both the following are true.

- He or she did not enroll when first eligible for coverage.
- He or she is not eligible under a special enrollment period (see special enrollment period below).

Late enrollees will have a 90-day waiting period before they are covered by insurance. This waiting period starts on the signature date on the employee's [Membership Application and Change Form](#).

IMPORTANT NOTE: When an employee changes from non-eligible to eligible status, he or she must follow the employer's rules for a waiting period. An example would be changing from part-time to full-time work status.

ENROLLMENT CHANGES

All enrollment changes must be made within 31 days of the change. There are four ways you can make these changes.

1. Log in to the [Employer Portal](#) and make the changes.
2. Submit paper [Membership Application and Change Form](#) to our enrollment services department (see our address on page 5).
3. Fax completed [Membership Application and Change Form](#) to 920-720-1904.
4. Send a secure email with a completed [Membership Application and Change Form](#) to nhcommercialenrollment@networkhealth.com

SPECIAL ENROLLMENT PERIOD

Eligible employees or dependents who did not enroll when they were first eligible may be able to enroll for coverage during a special enrollment period. To qualify, the applicant must have originally declined coverage because he or she was covered by another health plan. Special enrollment applies to the following situations.

- Employee, spouse and newly eligible dependents who are the result of a qualifying event (e.g., marriage or newborn/adopted children). Other dependents are not eligible as a result of the qualifying event.
- Coverage effective date for loss of coverage or marriage will be no later than the first of the month following the qualifying event.
- Coverage effective date for birth or adoption is the date of the qualifying event.
- Enrollment must be requested within 31 days of the loss of other coverage or qualifying event.



DEPENDENT SPECIAL ENROLLMENT PERIOD

If a dependent is not enrolled during the 31-day period, enrollment must take place during your company's annual open enrollment period or under a special enrollment period (see page 7). If you do not have an annual open enrollment period, enrollment will be limited to the special enrollment period or as a late enrollee.

A dependent becomes eligible for coverage at the following times.

- The date the employee is eligible for coverage.
- The date of marriage for an employee's new spouse and stepchildren.
- The date of birth of the employee's natural-born child.
- The date a child is placed in the employee's home for adoption or the date a court issues a final order granting adoption of the child to the employee (whichever occurs first).
- The date of birth of a child born to the employee's covered dependent child who is under the age of 18. Coverage of the grandchild ends when the grandchild's parent reaches age 18.
- The date of a court order requiring the employee to provide health care coverage for a dependent child.

A special enrollment period of 60 days begins for an employee's newborn child on the date of birth. Coverage starts on the child's date of birth. If the employee doesn't enroll the child within 60 days, he or she can enroll the child within one year of birth by making all past-due payments (which includes annual interest of 5.5 percent).

A special enrollment period of 60 days begins for an employee's adopted child at the adoption or placement date (whichever is first). Proof of adoption papers are required.

AFFORDABLE CARE ACT (ACA) SPECIAL ENROLLMENT PERIODS

The chart below outlines the special enrollment periods for the ACA and applies only to ACA plans for small group employers (2-50 employees).

LIFE EVENT (KNOWN AS QUALIFYING EVENT)	SPECIAL ENROLLMENT PERIOD	EFFECTIVE DATE (SUBJECT TO REVIEW)
Birth or adoption	60 days from event	Date of birth or adoption
Marriage	60 days from event	First day of the following month from application submission
Loss of employer-sponsored health insurance because of any of the following. <ul style="list-style-type: none"> • Employment ending • Employer reduces work hours to the point where an employee is no longer covered by the health plan • Employer's plan no longer offers coverage to certain individuals (eg., part-time employees) • Termination of employer contributions 		First day of the following month from application submission
Loss of coverage for a dependent child who has reached the age of 26	60 days from event	First day of the following month from application submission
Exhaustion of COBRA	60 days from event	First day of the following month from application submission
Loss of eligibility for Medicaid or Children's Health Insurance Program (CHIP)	60 days from event	First day of the following month from application submission
Divorce or legal separation	60 days from event	First day of the following month from application submission
Loss of retiree coverage due to former employer filing for bankruptcy protection	60 days from event	First day of the following month from application submission
Death of the policyholder	60 days from event	First day of the following month from application submission
Having a claim that meets or exceeds a lifetime limit on all benefits under existing coverage	60 days from event	First day of the following month from application submission
Gaining status as a citizen, national or lawfully present individual	60 days from event	First day of the following month from application submission
No longer incarcerated	60 days from event	First day of the following month from application submission
Loss of coverage due to a permanent move outside of Network Health's service area	60 days from event	<p>If application is submitted between the 1st and 15th day of the month, the effective date will be the 1st day of the following month.</p> <p>If application is submitted between the 16th day and the last day of the month, the effective date will be the 1st day of the subsequent month.</p> <p>For example, if submitted on or before March 15, the effective date would be April 1. If submitted on or after March 16, the effective date would not be until May 1.</p>
Plan is due for renewal outside of open enrollment	30 days from event	First day of the following month from application submission

ENDING COVERAGE

Coverage ends if one of the following occurs.

- Network Health or your company ends the group policy.
- An employee is no longer an eligible subscriber, as specified on the [Employer Group Application](#).
- An employee requests to cancel enrollment with a [Membership Application and Change Form](#).
- Death of the employee.

IMPORTANT NOTE: A dependent's coverage ends when he or she is no longer considered a dependent (e.g. divorce occurs or a dependent child reaches maximum age).

Network Health will cancel employee or dependent coverage for the reasons listed below.

- An employee does not work or live in the Network Health service area. If you have employees outside Network Health's service area, please contact your client manager to learn more about your options.
- An employee or dependent commits an act of physical or verbal abuse that poses a threat to provider personnel, members or Network Health associates.
- An employee or dependent knowingly provides false information in an application for coverage.
- An employee or dependent allows another person to use their Network Health ID card.

IMPORTANT NOTE: When Network Health cancels an employee or dependent, we will either provide coverage until new coverage is found or until the end of the current benefit year.



CONTINUING COVERAGE

Network Health does not administer COBRA/State continuation rights.

Some federal and state laws may give an employee the right to continue coverage with Network Health if he or she would otherwise lose coverage. While an employee is entitled to all the benefits under the federal or state laws that apply, he or she is not entitled to a duplication of those benefits.

**Network Health
does not administer
COBRA/State
continuation rights.**

STATE CONTINUATION

(State continuation rules applies to employer groups with less than 20 employees.)

This option is available only if the employee has been covered under Network Health for at least three consecutive months. He or she may elect this option if any of the following are true.

- Eligibility for group coverage ends because of the employee's loss of eligibility, other than gross misconduct on the job.
- He or she is the former spouse of the employee and the marriage ended due to divorce or annulment while the dependent was covered.
- He or she is a surviving dependent, spouse or child of an employee who dies while dependent coverage was in effect.

As the employer, you are required to give the employee written notice of these rights. He or she must receive the notice within five days of the date the group knows the employee's eligibility for coverage will end.

The employee has 30 days from the date of the notice to elect the continuation option and pay the premium due to the employer. As the employer, you'll need to inform the employee of the premium amount due and the date it must be paid, and send payment to Network Health. The employee must complete a new enrollment form if he or she is a former spouse or a surviving dependent spouse or child.

Coverage under Network Health continues under this option until the earliest of the following.

- The end of 18 consecutive months from the date the applicant elected this option. Upon completion of the 18 months, Network Health may require the applicant to move to individual coverage.
- The date the applicant is eligible for similar coverage under another group medical plan.
- The end of the last month for which premium was paid by the applicant when due.
- The date the employee is no longer covered by the plan or replacement group policy, if the applicant is the former spouse of an employee.
- The applicant establishes residence outside Wisconsin.
- The date on which the group ends coverage under the policy.

For more information about state continuation, please contact your agent or visit the [Office of Commissioner of Insurance website](#).

FEDERAL CONTINUATION

The Federal *Consolidate Omnibus Budget Reconciliation Act* (COBRA) applies to employers with 20 or more employees.

COBRA entitles an employee or dependent to continuation of coverage under the policy if he or she is any of the following.

- A surviving dependent, spouse or child of an employee who dies while dependent coverage was in effect.
- A dependent child who is no longer considered eligible for coverage.

COBRA also entitles a member to continuation of coverage under the policy if eligibility for group coverage ends because of any of the following.

- The employee's work hours are reduced or the employee is terminated for reasons other than gross misconduct.
- If divorce or legal separation occurs while dependent coverage was in effect.
- The employee becomes eligible for Medicare, unless the member is covered by Medicare prior to retirement.

Employees are responsible for notifying their employer within 60 days of a divorce, legal separation or a child losing dependent status. If the employee wishes to continue coverage, he or she must complete an election form and submit it to their employer within 60 days of the following (whichever is later).

- The member is no longer covered.
- The member is notified of the right to elect COBRA continuation.

As the employer, you're required to provide the employee with a written notice of these rights. The employee must receive the notice within 14 days of the date you learn that the employee's eligibility for coverage will end.

You'll need to inform the employee of the premium due and send payment to Network Health. The back premium must be paid within 45 days from the date of election. The employee must complete a new enrollment form if he or she is a former spouse or a surviving dependent spouse or child.

The employee or dependent will be responsible for paying any premiums to you (the employer) for continuation of coverage.

The employee may continue coverage for up to 18 or 36 months, depending on the qualifying event. An employee who is disabled under the Social Security Act, within 60 days of the qualifying event, may be eligible to continue coverage for up to 29 months. COBRA coverage will end at the earliest of the following.

- The last day of the 18, 29 or 36 month maximum coverage period, whichever is applicable.
- The first day (including grace periods, if applicable) on which the employee fails to make timely payment.
- The date on which the employer doesn't have a group health plan (including successor plans).
- The first day on which any other group health plan actually covers the employee.
- The date the member is eligible for Medicare benefits.

USERRA COVERAGE

Network Health fully adheres to the *Uniform Services Employment and Re-employment Rights Act* (USERRA), which requires all employers to provide health care coverage during all active military leave to current employees and their dependents as required by law.

CLAIMS PROCESSING

When it comes to claims processing, we put over 39 years of experience to work to maintain a standard of excellence for our customers. Claims are processed in under 30 days and at 99.7 percent accuracy.

Your employees should not have to file a claim for services from a provider within our network. However, there are times when an employee might have to submit bills to Network Health for certain services when any of the following occur.

- Network Health is not the primary insurance carrier
- An employee or dependent receives medical care from providers outside our network
- Services might be covered under workers' compensation
- Care is received in a foreign country

In these cases, itemized medical bills should be sent within 90 days of the date of service to Network Health at the address below. All bills submitted must be in English.

**Network Health
P.O. Box 568
1570 Midway Pl.
Menasha, WI 54952**

If you or your employees have any questions about claims, please call our member experience department at the number on the back of the member ID card.

MEDICARE SECONDARY PAYER REQUESTS

Medicare secondary payer requests are processed by our claims department if you are a fully insured employer group.

NEW YORK AND MASSACHUSETTS SURCHARGE PAYMENT

A monthly surcharge is required to be paid by all insurance carriers who pay claims to providers in New York and Massachusetts. New York also requires a surcharge for covered lives. The surcharge is based on employees and dependents that live in New York.

RESOURCES

- Learn more about how the claims process works. See Appendix A.
- Reference quick tips for understanding an explanation of benefits (EOB). See Appendix B.

IMPORTANT NOTE: Claims will be denied if they are received 15 months or more after the date of service.

BILLING

Your company receives a monthly bill around the 20th day of each month. Your bill will be available in your online group portal. A monthly email will be sent to notify you when your latest invoice is available. You can also receive your bill by mail if you choose. Payment is due on the first day of the month of coverage being billed. To ensure your billing statement is accurate, make sure any enrollment changes are made prior to the 10th day of the month.

Additional Information



Your bill can be paid through electronic fund transfer (EFT). Not only is it convenient, but it saves your company \$25 per month on administration fees. To set up EFT, please call our enrollment services department at 877-549-8793 or complete and return the [EFT Form](#) and fax it to 920-720-1904.

- Employees will appear in alphabetical order on your bill.
- We will only go back three billing cycles when returning premiums for any terminated employees.

CHANGES

If there are changes in your enrollment that will affect your billing, do not adjust your premium bill on your own. The changes need to be submitted to Network Health using the [Membership Application and Change Form](#). It should include all additions, deletions and contract changes.

Once the form is complete, fax a copy to 920-720-1904, or mail it to the address below. You can also send a secure email with the completed [Membership Application and Change Form](#) to nhcommercialenrollment@networkhealth.com.

Network Health
ATTN: Enrollment Services
1570 Midway Pl.
Menasha, WI 54952

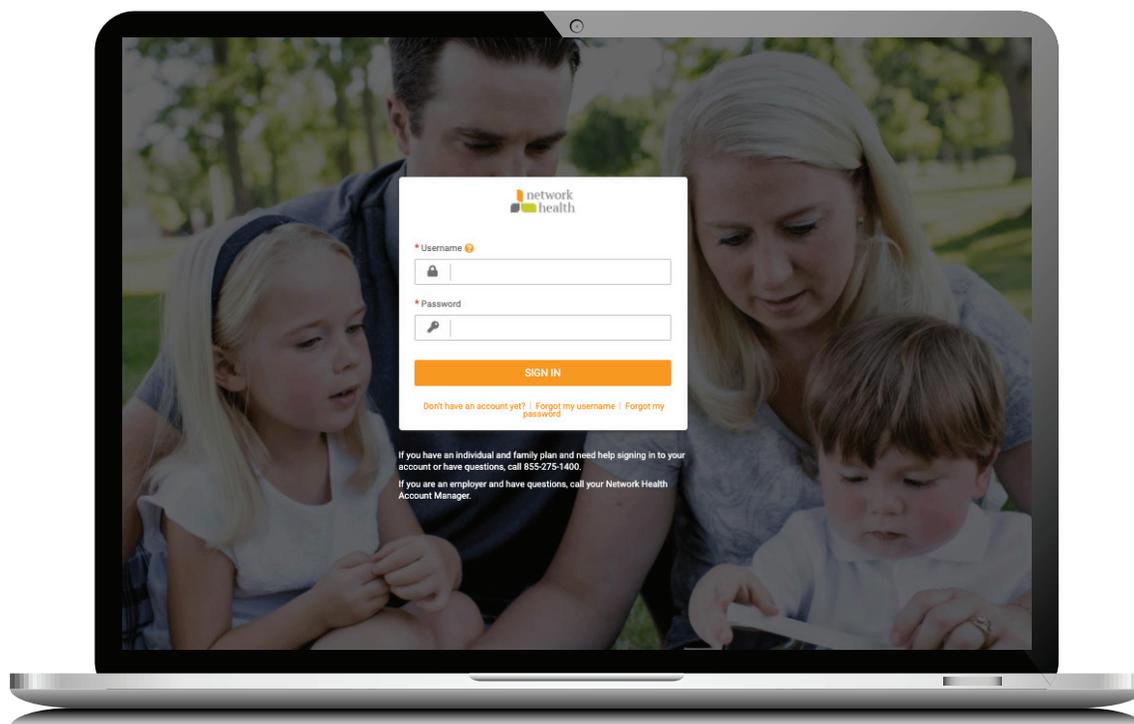
MAILING PAYMENT

Checks should be made payable to Network Health and mailed with your remittance copy of the group statement page of your bill to the following address.

Network Health
P.O. Box 78021
Milwaukee, WI 53278-0021

If you have any questions about billing, call our enrollment services department at 877-549-8793, select option 2.

EMPLOYER PORTAL



Our [Employer Portal](#) is designed to help you manage benefits, coverage and any changes to employee or dependent enrollment.

IN THE PORTAL, YOU CAN DO THE FOLLOWING

- Enroll employees during the initial enrollment period
- Update coverage for employees in case of a qualifying event (for example, marriage or the birth of a child)
- End coverage for employees as needed
- Track profile and benefit changes for each employee or dependent
- Track employer profile changes
- Submit enrollment change requests to Network Health for approval and updating
- Order Network Health ID cards

HOW TO LOG IN

The primary contact person for your company is the administrator for your [Employer Portal](#). This administrator account is established when the group initially applies for a health insurance quote.

The username is the administrator's email address and the default password is Pass@word1. Make sure to set up security questions in the event you forget your login. This will enable you to easily reset your password.

Once you log in for the first time you will be required to change the password. If you forget your password, please contact your Network Health Client Manager to have the password reset.

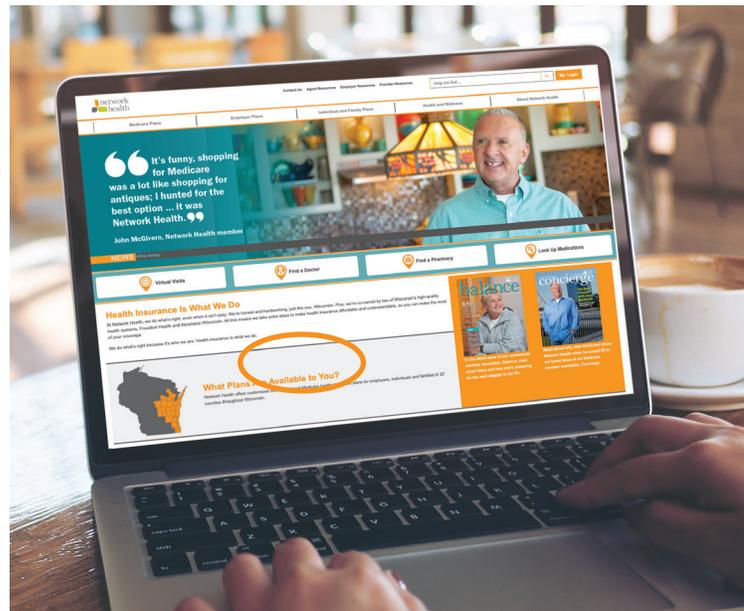
FINDING DOCTORS AND HOSPITALS

Network Health has a large network of high-quality doctors and hospitals for your employees to choose from, making it easy to find primary doctors and specialists close to home.

SEARCH FOR DOCTORS AND HOSPITALS ONLINE

- Go to networkhealth.com
- Click **Find a Doctor** in the middle of the screen. In the **Plan Type** dropdown, select **HMO/POS/EPO (I get coverage through my employer)**.
- Click **Search**

You can also look at our complete list of doctors by going to the **Find a Doctor** page and clicking **Printable Directory** on bottom.



CHOOSE A PERSONAL DOCTOR

An employee's personal doctor is called a primary care practitioner (PCP). It's important to pick one doctor to coordinate all care. Because this doctor will become familiar with the employee, he or she can help make sure your employee gets the care they need, and can make it easier to keep tabs on their overall health. PCPs can also recommend the best treatment if care is needed from other doctors. It's important that each member of each employee's family has one main doctor. Family members don't have to have the same doctor, and each person can designate a different doctor if needed.

If an employee already has a personal doctor, it is important for the employee to confirm each year whether he or she still has the same doctor or if they've changed doctors.

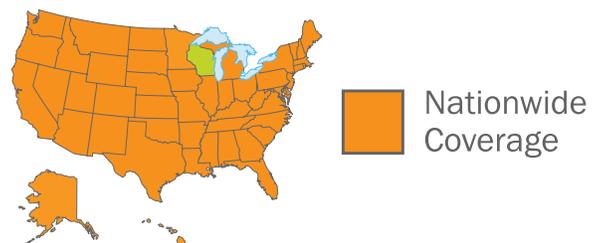
Employees have two ways to choose or change a primary care physician.

1. Employees can visit login.networkhealth.com to log in to their Network Health portal. Then select **Change My Personal Doctor** and follow the steps to choose or change their doctor.
2. Call our member experience team at the number on the back of the member ID card.

NATIONWIDE COVERAGE

Network Health also provides coverage for people who live outside our service area. Your out-of-state employees can receive affordable care from thousands of doctors and hospitals across the country.

Contact your Network Health client manager for more information.



PHARMACY BENEFITS

Our partnership with Express Scripts, Inc.® (ESI) gives you access to an extensive pharmacy network, so your employees will have the convenience of a pharmacy near their home or workplace. ESI works to provide innovative and accessible prescription benefits while keeping costs low. A prescription drug mail-order program is also available.

Below are some of the useful online tools.

- A [mobile app](#) to check or refill prescriptions on-the-go
- A search tool to get directions and maps to pharmacies
- Ask-a-pharmacist messaging to get confidential and reliable answers to prescription drug questions

ESI's customer service center is also open 24 hours a day, seven days a week to answer questions about prescription drug coverage. To reach ESI, employees can call the number on the back of their participant ID card.

[Read more about your pharmacy benefits at networkhealth.com.](#)

SAVEONSP PROGRAM

Network Health is partnering with ESI to bring you the SaveOnSP program to help save money on eligible specialty prescriptions by offering eligible specialty medications at no cost (\$0). The SaveOnSP program will be available to members upon your benefit renewal date.

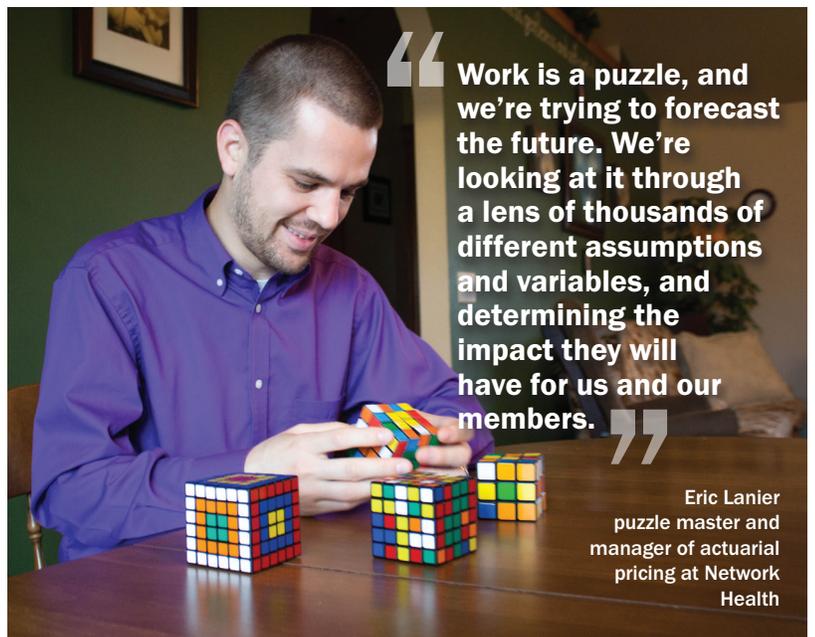
- Medications included in the SaveOnSP program are classified as Non-Essential Health Benefits under the Affordable Care Act
- View the SaveOnSP Drug List at [networkhealth.com/saveon-drug-list](#)
- Prescriptions will be filled through participants' approved specialty pharmacy
- Participants can contact SaveOnSP at 800-683-1074 prior to your benefit renewal date to avoid delays in obtaining prescription(s) after the program starts
- If employees do not participate in the SaveOnSP program, they will be responsible for the cost share listed on the SaveOnSP Drug List
- These medications will not count toward deductibles or out-of-pocket maximums

OUT-OF-POCKET PROTECTION

Out-of-pocket protection maximizes assistance programs from manufacturers. It tracks copayment assistance as secondary insurance at the specialty pharmacy and adjusts accumulators accordingly. This helps prevent participants from artificially reaching out-of-pocket maximums and helps reduce copayment assistance from impacting benefit design.

How it works

1. Prescription is processed at the specialty pharmacy
2. Participant responsibility for deductible and out-of-pocket is accumulated
3. Specialty pharmacy applies the copayment assistance
4. Participant copayment assistance is tracked by the specialty pharmacy
5. ESI removes any participant copayment assistance from the deductible (if applicable) and out-of-pocket amounts

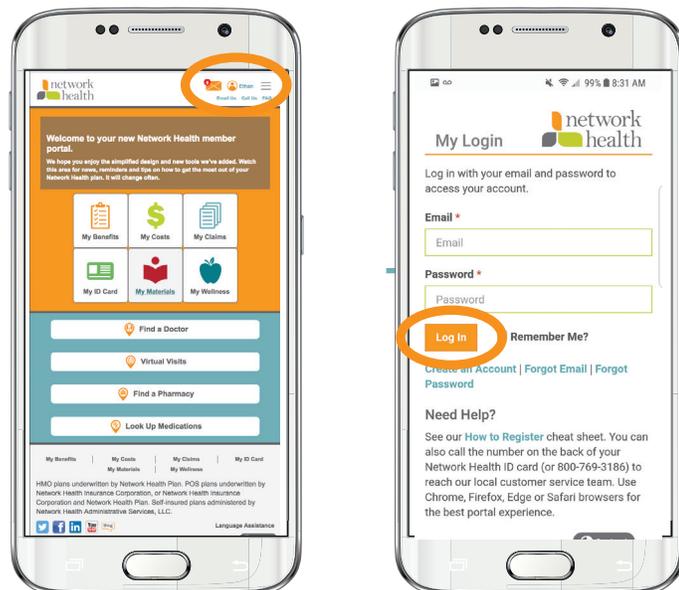


USING MY ACCOUNT FOR EMPLOYEES

For plan information that is specific to your company's plan, employees can log in to the member portal account at login.networkhealth.com. See our [How to Register](#) cheat sheet for first time login instructions.

This mobile responsive portal is viewable from any device at any time and allows employees to access information about their plan, benefits, claims and more. Once signed in, he or she has access to the following.

- Benefits and coverage overview
- Claims detail and status
- Out-of-pocket expenses tracker
- Compare prescription drug costs and find information about specific drugs
- Secure messaging with our local member experience team



TOOLS FOR BETTER HEALTH

After signing in to the member portal, employees can click on the Health Information Library and WebMD® links for the great tools below.

- **Health Assessment (WebMD® Health Assessment)**

This tool asks general questions about health habits and lifestyle to build a personal health summary and a plan for how employees can reduce health risks, adopt healthier habits and live better.

- **Health Information Library**

An employee can research health topics, explanations of health problems, information about medical tests and procedures, as well as thousands of other common health and wellness topics.

- **Health Management Centers**

Employees can use these to learn more about making changes so they're less likely to develop a serious health problem.

- **Alerts and Reminders**

Allows employees to schedule email reminders about appointments, activities and upcoming screenings.

REWARDS FOR HEALTHY CHOICES*

There is more than one way to wellness. Network Health's WellnessWays program gives your employees just that, a variety of tools, resources and services needed to improve their overall health.

WELLNESSWAYS

WellnessWays is the new wellness program offered by Network Health in partnership with WebMD®. It rewards participants for completing activities that support a healthy lifestyle. Participants can complete a range of activities throughout their plan year to earn prepaid VISA gift cards. Some of the wellness activities that can be completed for rewards include the following.

- Volunteering
- CPR/First Aid Certification
- Donating blood
- Sports league participation
- Buying an annual State Park pass
- Getting preventive screenings and vaccinations
- And more

Other resources and tools available include the following.

- Wellbeats OnDemand fitness app
- Ability to sync tracking devices to track your fitness goals
- Access to wellness program materials in one online portal
- Wellness challenges
- On-site lunch and learns
- Coordination of on-site health screenings and other wellness activities

Participants can access their wellness portal anywhere or anytime with the Wellness At Your Side app. This app can be downloaded for free on various smart phone devices and tablets.

If you have questions about the WellnessWays program and rewards, please email wellnessways@networkhealth.com.

WELLBEATS FITNESS BENEFIT

Included with the WellnessWays program is the **Wellbeats fitness benefit**. It delivers online, on-demand fitness classes, nutrition demos, recipes, goal-based challenges and fitness assessments anywhere or anytime, at no cost to participants. No matter where participants are at in their fitness journey, Wellbeats can help them feel happier, healthier and stronger.

- 600+ online classes, including yoga
- HIIT, strength training, mindfulness, running and more
- Easy-to-use navigation and interface
- Recommended classes base on personal preferences
- Goal-based challenges
- Easily track progress and personal statistics

*If your company is using our wellness program.



IMPORTANT CONTACTS

EMPLOYER CONTACTS

SALES AND SERVICE

Phone: 920-720-1250 or 800-276-8004

Fax: 920-720-1256

- Group supplies
 - Enrollment forms
 - Change forms
 - Enrollment packets
- Administrative materials
 - Health Services Policy
 - Certificate of coverage
 - Renewals

ENROLLMENT SERVICES

Phone: 920-720-1350 or 877-549-8793

Fax: 920-720-1904

Email: nhcommercialenrollment@networkhealth.com

- Eligibility issues
- Premium billing
- Payments
- Member materials

EMPLOYEE CONTACTS

CUSTOMER SERVICE

Phone: 920-720-1300 or 800-826-0940

Fax: 920-720-1909

- Benefits
- Coordination of benefits
- Primary care physician changes
- Claims questions
- ID cards
- Member packets
- Dependent status
- Out-of-area coverage
- Coverage end dates
- Address changes

CARE MANAGEMENT

Phone: 920-720-1602 or 866-709-0019

Fax: 920-720-1916

- Help with coordination of complex health care needs

CONDITION MANAGEMENT

Phone: 920-720-1602 or 866-709-0019

Fax: 920-720-1916

- Help with chronic conditions
- Request resources about a condition

WELLNESS/HEALTH PROMOTION

Phone: 920-720-1602 or 866-709-0019

Fax: 920-720-1916

- Rewards for healthy choices
- Access to wellness tools and resources





How Claims Work

STEP
1

Your Doctor



It all begins with your doctor. Your doctor's office files a claim for the service they provided you. Each service has a procedure and diagnosis code. The procedure code tells us what was done during the visit, and the diagnosis code tells us why.

STEP
2

Filing



Next, your claim gets filed with us electronically or by paper. Your claim is dated when we receive it, then entered into our system. Paper claims are manually entered into our claims processing system, while electronic claims are loaded directly.

STEP
3

Processing



To ensure accuracy, your claim then goes through auditing. Our claims processing system is set up to correspond with your benefits. This allows your claim to process without anyone manually looking at it. Claims not automatically processed are reviewed by a claims analyst.

STEP
4

Verification



When your claim is processed, we verify that your insurance coverage was effective on the date you received the service. Our processing system automatically checks that the service is covered, and we will check that the doctor you saw is in our network.

STEP
5

Review



We then review your claim against your benefits. This determines if you have out-of-pocket costs, like a deductible. If your doctor is in our network, we pass on discounts to you and you'll owe less. Our system will then apply your deductible to your claim and notify your doctor what you owe.

STEP
6

Explanation of Benefits

If you've already reached your deductible for the year, we pay the amount directly to the provider. You'll get an explanation of benefits document showing how your claim was processed. The explanation of benefits is not a bill.

STEP
7

Billing

Once payment is made by your doctor, it's posted to your account. Your doctor's office then sends you a statement indicating any remaining amount you owe.

HOW TO READ YOUR EXPLANATION OF BENEFITS (EOB)

An EOB is a statement sent to members listing health care services you received, the amount billed and payment made.

Network Health issues an EOB after every claim has been processed, whether or not payment is due. It is important to know this is not a bill you have to pay. Please refer to the example below for locating important information.

EOBs are also available online through the secure [Member Portal](#).

1 - SERVICE DATE

This is the date you received health care services.

2 - PAID BY US

Network Health paid this amount to the provider.

3 - YOUR RESPONSIBILITY

This is the amount you owe.

Patient: SMITH, JOHN A

Member ID: 123456789

Provider: DOE, JANE B			Claim Number: 1234567890			Process Date: 01/18/2012							
Dates of Service: 01/16/2012 - 01/16/2012			Insured: SMITH, JOHN A			Employer Group: MERCY MEDICAL CENTER SF							
Patient Account #: 123456789													
Service Date	Procedure	Billed Amount	Provider Responsibility		Allowed Amount	Network Health Paid	Other Insurance	Your Responsibility					Message ID
			Amount	Reason				Deductible	Co-Ins	Co-Pay	Other	Reason	
01/16/2012	99214 - OFFICE/OUTPATIENT VISIT EST	228.00	35.80	45	192.20	172.20				20.00			
TOTALS		228.00	35.80		192.20	172.20				20.00			

Please remit to AFFINITY MEDICAL GROUP your Total Member Responsibility: \$20.00

Patient: SMITH, JOHN A

Member ID: 123456789

Provider: DOE, JANE B			Claim Number: 1234567890			Process Date: 01/20/2012							
Dates of Service: 01/16/2012 - 01/16/2012			Insured: SMITH, JOHN A			Employer Group: MERCY MEDICAL CENTER SF							
Patient Account #: 123456789													
Service Date	Procedure	Billed Amount	Provider Responsibility		Allowed Amount	Network Health Paid	Other Insurance	Your Responsibility					Message ID
			Amount	Reason				Deductible	Co-Ins	Co-Pay	Other	Reason	
01/16/2012	87186 - MICROBE SUSCEPTIBLE MIC	37.00	8.58	45	28.42			28.42					
01/16/2012	87077 - CULTURE AEROBIC IDENTIFY	11.37			11.37			11.37					
TOTALS		48.37	8.58		39.79			39.79					

Please remit to AFFINITY MEDICAL GROUP your Total Member Responsibility: \$39.79

Summary						
Payee	Billed	Paid	Your Responsibility			
AFFINITY MEDICAL GROUP	385.37	172.20	96.70			
Reason and Messages						
Code	Reason					
45	Charges exceed fee schedule/maximum allowable or contracted/legislated fee arrangement.					
Benefit Accumulators for Plan Year Starting: 01/01/2012						
Description	Individual			Family		
	Plan Limit	Applied	Remaining	Plan Limit	Applied	Remaining
DEDUCTIBLE	2,000.00	224.34	1,775.66	4,000.00	224.34	3,775.66
OUT OF POCKET	3,500.00	224.34	3,275.66	7,000.00	224.34	6,775.66

4 - PROVIDER

This is the provider who will be billing you directly.

5 - BENEFIT ACCUMULATORS

This is the amount applied toward your deductible as of the date the claim was processed.