



# AGENT GUIDE

*TO UNDERSTANDING OUR PRODUCTS*

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# MEET NETWORK HEALTH

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

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

## At Your Service

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

## CULTURE

### MISSION

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

### VISION

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

### BRAND POSITION

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

### VALUES



#### INNOVATION

Bringing **ideas** to life



#### SERVICE EXCELLENCE

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



#### INTEGRITY

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



#### COLLABORATION

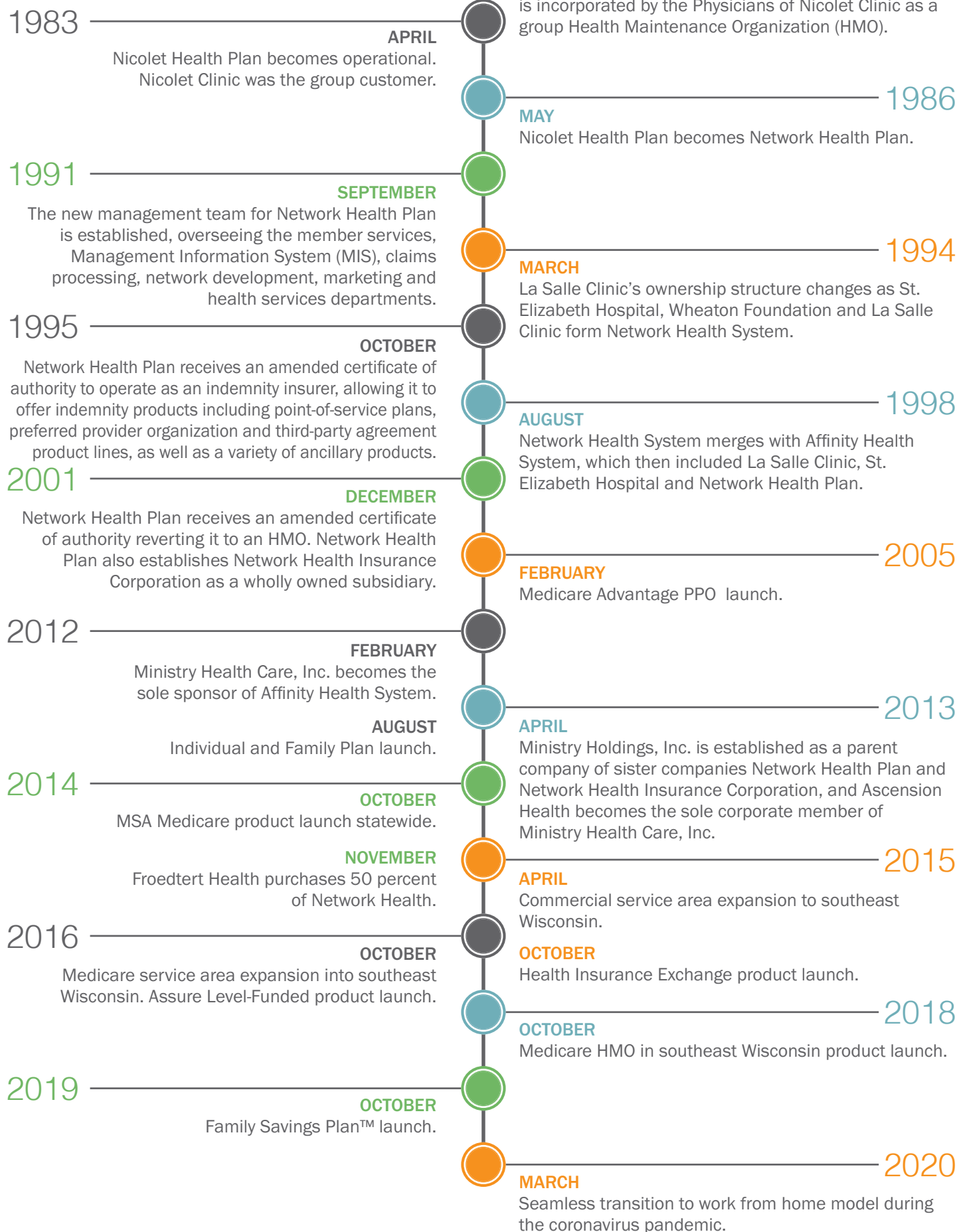
Working as **one team** toward a **common goal**



#### ACCOUNTABILITY

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

# NETWORK HEALTH'S HISTORY



## COMMERCIAL GROUP PRODUCTS

Assure Level-Funded (2-99), Small Group ACA (2-50), Mid-Size Groups (51-100) and Large Groups (101+)

### NEW BUSINESS

New Quotes, Product Questions, Alternative Plan Designs

#### Travis Janssen

Sr. Account Executive – Northeast Wisconsin  
Office: 920-720-1877  
Cell: 920-209-5812  
Email: tjanssen@networkhealth.com

#### Dan Pecanac

Account Executive – Southeast Wisconsin  
Office: 262-825-9768  
Cell: 414-975-1652  
Email: dpecanac@networkhealth.com

### CLIENT SERVICE TEAM

Renewals, Enrollment & Billing

#### Sara Pergolski-Mickelson

Client Manager  
Office: 920-720-1248  
Cell: 920-570-9910  
Email: spergols@networkhealth.com

#### Ann Sanders

Client Manager  
Office: 920-720-1264  
Cell: 920-470-0516  
Email: ansander@networkhealth.com

#### Lavonne Simon

Client Manager  
Office: 920-720-1257  
Cell: 920-209-5631  
Email: lsimon@networkhealth.com

#### Ingrid Davis

Client Manager  
Office: 262-825-9774  
Cell: 414-559-1904  
Email: idavis@networkhealth.com

### SALES MANAGEMENT

#### Jeff Lanser

Manager of Client Management  
Office: 920-720-1683  
Cell: 920-213-1194  
Email: jlanser@networkhealth.com

#### Marty Brogaard

Director of Sales and Service – Commercial and FSP  
Office: 920-628-7609  
Cell: 920-585-0399  
Email: hbrogaar@networkhealth.com

## INDIVIDUAL SALES

Medicare, Individual Family Plans, ACA

### SALES MANAGEMENT

#### John Whittemore

Vice President of Medicare & Individual Programs

Office: 262-825-9756  
Cell: 985-377-3986

jwhittem@networkhealth.com

#### Kimberly Gehrke

Manager of Individual Sales

Office: 920-720-1569  
Cell: 920-369-6318

kgehrke@networkhealth.com

#### Nichole Sprinkle

Supervisor of Individual Sales

Office: 920-628-7605  
Cell: 920-540-1232

nsprinkl@networkhealth.com

### ACCOUNT EXECUTIVES

New business, broker relationships

#### Penny Koehler

Senior Account Executive

Office: 920-720-1571  
Cell: 920-896-2255

pekoehle@networkhealth.com

#### Brian Vranek

Account Executive

Office: 262-825-9793  
Cell: 414-248-0685

bvraneke@networkhealth.com

#### Brooke Braemer

Account Executive

Office: 920-628-7610  
Cell: 920-858-6501

bbraemer@networkhealth.com

### AGENT ADVISORS

Enrollment support, eligibility questions, product questions

#### Becky Bascue

Agent Advisor

Office: 920-720-1260

rbascue@networkhealth.com

#### Mark Kretzmann

Agent Advisor

Office: 920-720-1260

mkretzma@networkhealth.com

## SALES ADVISORS AND MEDICARE SALES SPECIALIST

Assist members and prospects, back up agent advisors

<b>Matt Brunner</b> Sales Advisor	Office: 800-983-7587	individualsalesteam@networkhealth.com
<b>Chuck Davis</b> Sales Advisor	Office: 800-983-7587	individualsalesteam@networkhealth.com
<b>Kathy Krentz</b> Sales Advisor	Office: 800-983-7587	individualsalesteam@networkhealth.com
<b>Taylor Perry</b> Medicare Sales Specialist	Office: 800-983-7587	individualsalesteam@networkhealth.com
<b>Dawn Royak</b> Sales Advisor	Office: 800-983-7587	individualsalesteam@networkhealth.com

## NETWORK HEALTH RESOURCES – MEDICARE ADVANTAGE PLANS

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

## EMPLOYER GROUP DEPARTMENT CONTACTS

ENROLLMENT SERVICES	CUSTOMER SERVICE	SALES AND SERVICE
Phone: 920-720-1350 Toll Free: 877-549-8793 Fax: 920-720-1904	Phone: 920-720-1300 Toll Free: 800-826-0940 Fax: 920-720-1909	Phone: 920-720-1250 Toll Free: 800-276-8004 Fax: 920-720-1256
<b>Questions regarding. . .</b> Subscriber eligibility <ul style="list-style-type: none"> <li>• Out-of-service area</li> <li>• Addition of new members</li> <li>• Effective dates</li> <li>• Reinstatement issues</li> <li>• Term questions</li> </ul> Name changes Address changes ID cards New member packets Billing Electronic funds transfer (EFT)	<b>Questions regarding. . .</b> Benefits Coordination of benefits PCP changes Claims questions Duplicate ID cards Duplicate member packets Out-of-area coverage Term dates Subscriber address changes <b>INDIVIDUAL PLAN CUSTOMER SERVICE</b> Toll Free: 855-275-1400	<b>Questions regarding. . .</b> Group and Individual supplies <ul style="list-style-type: none"> <li>• Enrollment forms</li> <li>• Change forms</li> <li>• Enrollment packets</li> </ul> Administrative materials <ul style="list-style-type: none"> <li>• Summary Plan Description (SPD)</li> <li>• Summary Benefit Coverage (SBC)</li> <li>• Health service policies</li> <li>• Certificate of coverage</li> <li>• Renewals</li> </ul> Agent licensing



# LOCATIONS



1570 Midway Place, Menasha



16960 W. Greenfield Ave., Suite 5, Brookfield

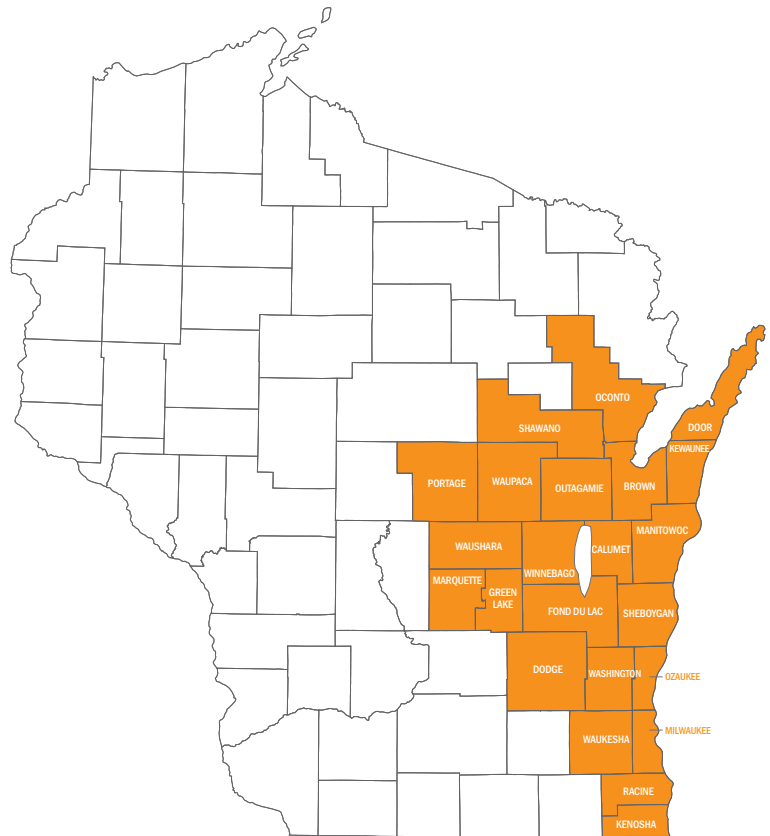
## NETWORK HEALTH'S SERVICE AREA

### COUNTIES

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

\* Only employer group plans available

\*\* Individual and family plans also available



See page 50 for our Medicare Advantage service area.

## AGENT LICENSING

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

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

Please contact agent management at 800-276-8004 or email [AgentManagementSpecialists@networkhealth.com](mailto:AgentManagementSpecialists@networkhealth.com).

# COMMISSIONS

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

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

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

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

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

## Individual Family Plans

### On-Exchange, Off-Exchange and Grandmothered plans

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

## Group Policies

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

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

- 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.



## Medicare Plans

Type of Agent Commission	2022 Rates
	(payable on actively enrolled members with effective dates of January 1, 2017 and beyond)
Initial – one time annual payment	\$573
Renewal – monthly	\$23.92

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

# AGENT OF RECORD CHANGES

## COMMERCIAL GROUP PLANS

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

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

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

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

1. Whether the Agent to whom the transfer is proposed ("Proposed Agent") has an Agency Agreement or is affiliated with an agency that has a Group Marketing Agreement (Agency Agreement and Group Marketing Agreement are referred to collectively as "Agency Agreements") with Network Health; and
2. Whether the Proposed Agent is in full compliance with all applicable provisions of the Agency Agreement.

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

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

## INDIVIDUAL FAMILY PLANS

### On Exchange

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

### Off Exchange and Grandmothered plans

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

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

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

## MEDICARE ADVANTAGE

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

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

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

# ASSIGNMENT AND TRANSFER OF BUSINESS

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

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

1. Whether the Proposed Agent has an Agency Agreement or is affiliated with an agency that has a Group Marketing Agreement (Agency Agreement and Group Marketing Agreement are referred to collectively as "Agreements") with Network Health; and
2. Whether the Proposed Agent is in full compliance with all applicable provisions of the Agreement.

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

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The following information should be submitted with the request for the assignment or transfer.

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

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

## GROUP TERMINATIONS

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

- Group Number
- Effective date of Termination

Termination letters should be sent to your Client Manager and Account Executive.

# INDIVIDUAL AND FAMILY PLAN PRODUCTS

## ACA-COMPLIANT PLANS

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

Please click [here](#) to see the available plans.

## ELIGIBILITY

### Dependent Eligibility Requirements

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

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

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

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

## CHILD(REN) - ONLY POLICIES

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

## RESIDENCY REQUIREMENTS

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

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

## CITIZENSHIP STATUS

### Policies with effective dates of January 1, 2014, and beyond

Most people in the following groups are eligible for coverage:

- U.S. Citizens
- Lawfully present immigrants

Find out more about other eligibility requirements by contacting us at 844-635-1322.

Refer to the policy language for policies with effective dates prior to January 1, 2014.

## SOCIAL SECURITY NUMBER REQUIREMENT

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

## TOBACCO USE

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

## APPLICANTS NOT ELIGIBLE TO APPLY

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

- Currently receiving Medicare
- Currently incarcerated

## HOW TO OBTAIN A QUOTE

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

## APPLICATION/ENROLLMENT

### COMPLETION OF THE APPLICATION

The following information will be needed to complete the application.

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

### ENROLLMENT

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

For coverage during open enrollment November 1–January 15.

- The effective date of coverage will be January 1 if you select coverage between November 1–December 15.
- The effective date of coverage will be February 1 if you select coverage between December 16–January 15.

### Special Enrollment Periods

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

**Qualifying events include the following.**

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

**Their effective date of coverage will be:**

Life Event	SEP Window	Effective Date (subject to change)
Birth or Adoption	60 days from event	Date of Birth or Adoption
Marriage	60 days from event	1st of the following month from application submission
Loss of employer sponsored health insurance, as a result of <ul style="list-style-type: none"> <li>• Termination of employment</li> <li>• Employer reduces work hours to the point where no longer covered by the health plan</li> <li>• Employer's plan decides it will no longer offer coverage to a certain group of individuals (for example, those who work part time)</li> <li>• Termination of employer contributions</li> </ul>	60 days from event	1st of the following month from application submission
Loss of coverage for a dependent child who has reached the dependent limiting age	60 days from event	1st of the following month from application submission
Exhaustion of COBRA	60 days from event	1st of the following month from application submission
Loss of eligibility for Medicaid or CHIP	60 days from event	1st of the following month from application submission
Divorcée/Legal Separation	60 days from event	1st of the following month from application submission
Loss of retiree coverage due to former employer filing for bankruptcy protection	60 days from event	1st of the following month from application submission
Death of the policyholder	60 days from event	1st of the following month from application submission
Incur a claim that meets or exceeds a lifetime limit on all benefits under existing coverage	60 days from event	1st of the following month from application submission
Gaining status as a citizen, national or lawfully present individual	60 days from event	1st of the following month from application submission
No longer incarcerated	60 days from event	1st of the following month from application submission
Loss of coverage due to a permanent move outside of the plan's service area	60 days from event	<ul style="list-style-type: none"> <li>- If application is submitted between the 1st and the 15th of the month effective date=1st of the following month</li> <li>- If application is submitted between the 16th and the end of the month effective date=1st of the subsequent month</li> </ul>
Plan is due for renewal outside of open enrollment	30 days from event	1st of the following month from application submission



## OTHER MEDICAL INSURANCE

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

## REPLACEMENT OF EXISTING INSURANCE

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

## RIGHT TO RETURN POLICY / NOT-TAKEN POLICIES

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

## PAYMENT OF PREMIUMS

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

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

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

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

## PAYMENT/BILLING SCHEDULE INFORMATION

### ACH

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

### Statements

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

### Recurring credit card payments

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

### Recurring payments (ACH and credit card) automatically pull the entire balance due on the account

- If the previous month's premium payment is declined, the next month two months of premium are pulled

## MEMBER MATERIALS

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

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

Additional information is available through the member portal at [login.networkhealth.com](https://login.networkhealth.com). This is detailed in the How to Use Your Health Plan Guide.

## RENEWALS

### INDIVIDUAL RENEWALS

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

### RENEWING CURRENT OR ALTERNATE PLAN(S)

Off-Exchange renewal acceptance and enrollment changes can be made on the Agent portal. When renewal acceptance and enrollment changes are received by the 6th of the month prior to the renewal, Network Health is able to process the renewal timely. On-Exchange renewals should be accepted via [healthcare.gov](https://healthcare.gov).

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

## CHANGES TO AN EXISTING CONTRACT

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

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

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

# ASSURE LEVEL-FUNDED

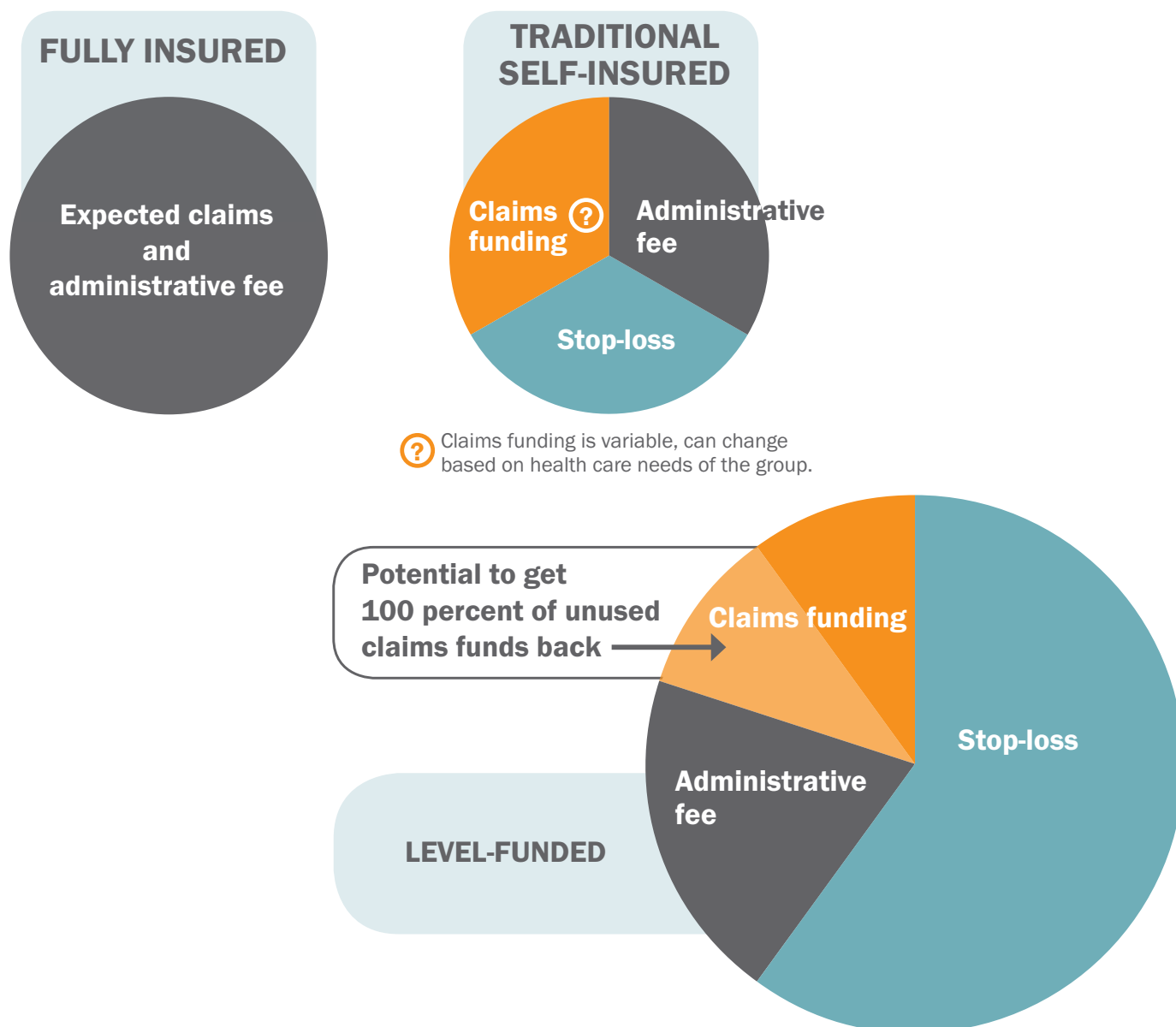
2–100 Total Enrolled Employees

## PRODUCT DESCRIPTION

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

## ADVANTAGE OF LEVEL FUNDING

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



## **PRESCRIPTION DRUG COVERAGE**

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

**View Network Health's Preferred Drug List at**

**<https://networkhealth.com/look-up-medications>**

## **PRIOR CARRIER DEDUCTIBLE CREDIT FOR PREVIOUSLY ENROLLED EMPLOYEES ONLY**

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

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

## **OUT-OF-AREA COVERAGE**

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

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

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

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

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

## **ELIGIBILITY**

### **GROUP ELIGIBILITY**

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

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

### **24-HOUR COVERAGE**

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

### **PARTICIPANT ELIGIBILITY**

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

## DEPENDENT ELIGIBILITY

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

## EARLY RETIREE ELIGIBILITY

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

## WAITING PERIODS FOR NEW HIRES

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

## LATE ENROLLMENT

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

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

## SPECIAL ENROLLMENT

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

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

## EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

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

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

## FIDUCIARY LIABILITY LANGUAGE

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

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

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

## THE PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE

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

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

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

## HOW TO OBTAIN A QUOTE

Submit the information listed below to [smallgroupquotes@networkhealth.com](mailto:smallgroupquotes@networkhealth.com), using a secure email.

You can also mail the forms to: **Network Health**  
**Attn: Underwriting**  
**1570 Midway Place**  
**Menasha, WI 54952**

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

## GUIDELINES FOR ASSURE QUICK QUOTE SUBMISSION

With the following information, Network Health will provide an Assure quick quote for groups with 2–100 enrolled employees. Quick Quotes can also be run in JET with the following information.

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

## GUIDELINES FOR ASSURE PROPOSAL SUBMISSION

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

- All the information mentioned above for a Quick Quote
- Assure enrollment forms for all full-time employees, including waivers
- Most recent quarterly Wage and Tax report (UCT-101 with employment status – FT, PT, Termed)
- Most recent carrier renewal
- Most recent carrier invoice
- Completed eligibility certification form (ECF) listing any eligible applicants or waivers who do not appear on the most recent Wage and Tax report

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

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

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

## FINAL PROPOSALS FOR MIDSIZE ASSURE GROUPS WITH RAPID GRx UNDERWRITING

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

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

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

### 20-50 ENROLLED

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

### 51-100 ENROLLED

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

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

## PARTICIPATION REQUIREMENTS

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

## APPLICATION/ENROLLMENT ITEMS NEEDED TO ISSUE A GROUP

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

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

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

Additional documents that will require signature

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

## PAYMENT

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

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

### PAYMENT WHEN ADDING OR TERMING COVERAGE MID MONTH

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

### NETWORK HEALTH TERMINATION OF A GROUP PLAN

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

## PARTICIPANT MATERIALS

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

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

## RENEWALS

### GROUP RENEWALS

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

### RENEWING CURRENT OR ALTERNATE PLAN(S)

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

### ELIGIBILITY REQUIREMENT CHANGES

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

### ITEMS NEEDED TO RENEW A GROUP

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

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

### BUY DOWN IN BENEFITS OFF RENEWAL

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

## LOCAL CLIENT MANAGEMENT TEAM

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

## CHANGES TO AN EXISTING CONTRACT

### PLAN AND ELIGIBILITY REQUIREMENT CHANGES

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

### EMPLOYEE AND DEPENDENT CHANGES

Administration of the group plan (such as employee additions, terminations or changes) can take place by submitting a completed "Participant Application and Change Form."

### CONTINUING COVERAGE – COBRA

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

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

All other groups can purchase EBC COBRA administrative services at competitive rates.

Visit the United States Department of Labor website at [www.dol.gov/ebsa/cobra.html](http://www.dol.gov/ebsa/cobra.html) for details on COBRA.

Visit Wisconsin Department of Health Services website at [www.dhs.wisconsin.gov](http://www.dhs.wisconsin.gov) for details on state continuation rights.

## FORMS AND RESOURCES

[Assure Enrollment Application](#)

[Eligibility Certification Form](#)

Change Healthcare

[Assure Group Application](#)

[Assure ACH Form](#)

[Express Scripts, Inc., Mobile Application Download](#)

[Preferred Drug List](#)

[MDLive®](#)

# SMALL GROUPS

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

## PRODUCTS

### MEDICAL PLANS

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

Please click on the link to view the available plans: [HMO](#)

### PRESCRIPTION DRUG COVERAGE

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

View Network Health's [Preferred Drug List](#).

### PRIOR CARRIER DEDUCTIBLE CREDIT

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

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

## ELIGIBILITY

### GROUP ELIGIBILITY

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

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

## 24-HOUR COVERAGE

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

## MEMBER ELIGIBILITY

### Employee Eligibility

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

## DEPENDENT ELIGIBILITY

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

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

## WAITING PERIODS FOR NEW HIRES

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

## OPEN ENROLLMENT

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

## LATE ENROLLMENT

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

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

## SPECIAL ENROLLMENT

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

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

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



# HOW TO OBTAIN A QUOTE

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

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

Agents and agency staff can generate ACA quotes at your convenience through Network Health's broker portal at [networkhealth.com](http://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](mailto: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](mailto:smallgroupquotes@networkhealth.com) or

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

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

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

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

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

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

## REQUIRED FORMS NEEDED

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

## PARTICIPATION REQUIREMENTS

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

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

## PAYMENT OF PREMIUMS

**Premium is required at time of application, in the form of check or EFT form and voided check.**

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

### PREMIUM WHEN ADDING OR TERMING COVERAGE MID-MONTH

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

### NETWORK HEALTH TERMINATION OF A GROUP PLAN

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

## MEMBER MATERIALS

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

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

Additional information is available through the member portal at [login.networkhealth.com](https://login.networkhealth.com). This is detailed in the How to Use Your Health Care Guide.

## RENEWALS

### SMALL GROUP RENEWALS

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

### RENEWING CURRENT OR ALTERNATE PLAN(S)

**Renewal acceptance and plan changes can be made on the Agent portal or by contacting your client manager.**

When renewal acceptance and plan changes are received by the 10th of the month prior to the renewal, Network Health is able to process the renewal timely.

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

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

### ELIGIBILITY REQUIREMENT CHANGES

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

## LOCAL CLIENT MANAGEMENT TEAM

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

# CHANGES TO AN EXISTING CONTRACT

## PLAN AND ELIGIBILITY REQUIREMENT CHANGES

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

## EMPLOYEE AND DEPENDENT CHANGES

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

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

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

## COBRA

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

### The qualifying COBRA events include:

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

## STATE CONTINUATION COVERAGE

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

### The qualifying events are:

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

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

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

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

## FORMS

[Eligibility Certification Form](#)

[Member Application and Change Form](#)

[EFT Enrollment and Change Form](#)

[Employer Group Application](#)

[HMO Group Plan Summaries](#)

[Express Scripts, Inc.,](#)

[Mobile Application Download](#)

[Preferred Drug List](#)

# MID-SIZE GROUPS

51-100 Total Employees on Quarterly Wage and Tax

## PRODUCTS

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

Please click on the link to view available plans: [Mid-size Plans](#)

## PRESCRIPTION DRUG COVERAGE

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

View Network Health's [Preferred Drug List](#).

## PRIOR CARRIER DEDUCTIBLE CREDIT

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

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

## OUT-OF-AREA COVERAGE SOLUTIONS

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

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

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

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

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

## ELIGIBILITY

### GROUP ELIGIBILITY

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

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

## 24-HOUR COVERAGE

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

## EMPLOYEE ELIGIBILITY

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

## DEPENDENT ELIGIBILITY

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

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

## EARLY RETIREE ELIGIBILITY

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

## WAITING PERIODS FOR NEW HIRES

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

## OPEN ENROLLMENT

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

## LATE ENROLLMENT

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

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

## SPECIAL ENROLLMENT

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

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

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

# HOW TO OBTAIN A QUOTE

## GUIDELINES FOR BASE RATE QUOTE SUBMISSION

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

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

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

## FINAL PROPOSALS WITH RAPID GRx UNDERWRITING

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

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

### 20-50 ENROLLED

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

### 51-100 ENROLLED

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

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

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

## FULLY UNDERWRITTEN MID-SIZED GROUP RATE REQUEST PROCESS

**To obtain a fully underwritten rate offer, submit the forms listed below to either**

**[largegroupquotes@networkhealth.com](mailto:largegroupquotes@networkhealth.com) or Network Health  
Attn: Quoting Specialist  
1570 Midway Place  
Menasha, WI 54952**

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

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



## REQUIRED FORMS NEEDED FOR FULLY UNDERWRITTEN RATES

- Completed nine page Wisconsin Small Employee Uniform App-OCI26-501 (rev6-2010) or the Network Health three-page application
- Applications must be completed and signed within 90 days of requested effective date
- Waiver forms for each eligible employee waiving coverage for themselves and/or their dependents including reason for waiving
- Three-page Network Health application for all full-time employees, including waivers (to include reason for waiving)
- Most recent quarterly Wage and Tax report (UCT-101 with employment status - FT, PT, Termed)
- Most recent carrier renewal
- Most recent carrier invoice

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

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

## 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
- First month's premium

Incomplete submissions may delay members receiving member materials.

## PAYMENT OF PREMIUMS

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

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

## PREMIUM WHEN ADDING OR TERMING COVERAGE MID MONTH

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

## NETWORK HEALTH TERMINATION OF A GROUP PLAN

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

# MEMBER MATERIALS

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

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

## RENEWALS

### MID-SIZE GROUP RENEWALS

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

### RENEWING CURRENT OR ALTERNATE PLAN(S)

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

### ELIGIBILITY REQUIREMENT CHANGES

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

### BUY DOWN IN BENEFITS OFF RENEWAL

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

### CHANGING RENEWAL DATE

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

## LOCAL CLIENT MANAGEMENT TEAM

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

## CHANGES TO AN EXISTING CONTRACT

### PLAN AND ELIGIBILITY REQUIREMENT CHANGES

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

### EMPLOYEE AND DEPENDENT CHANGES

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

- Secure email to [nhcommercialenrollment@networkhealth.com](mailto:nhcommercialenrollment@networkhealth.com)
- Using our [online employer portal](#)
- Fax forms to 920-720-1904

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

Visit Wisconsin Department of Health Services website at [www.dhs.wisconsin.gov](http://www.dhs.wisconsin.gov) for details on state continuation rights.

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

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

## FORMS

[Application for Employees 51-100](#)

[Eligibility Certification Form](#)

[Member Application and Change Form](#)

[EFT Enrollment and Change Form](#)

[Employer Group Application](#)

[Express Scripts, Inc., Mobile Application Download](#)

[Preferred Drug List](#)

[MDLIVE®](#)

# LARGE GROUPS

101+ Total Employees on Quarterly Wage and Tax

## PRODUCTS

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

[Large Group Plan information](#) is available on the [Agent Resources](#) page.

### FULLY INSURED

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

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

### PRESCRIPTION DRUG COVERAGE

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

View Network Health's [Preferred Drug List](#).

### PRIOR CARRIER DEDUCTIBLE CREDIT

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

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

### OUT OF AREA COVERAGE SOLUTIONS

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

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

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

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

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

# ELIGIBILITY

## GROUP ELIGIBILITY

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

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

## EMPLOYEE ELIGIBILITY

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

## DEPENDENT ELIGIBILITY

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

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

## EARLY RETIREE ELIGIBILITY

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

## WAITING PERIODS FOR NEW HIRES

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

## OPEN ENROLLMENT

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

## LATE ENROLLMENT

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

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

## SPECIAL ENROLLMENT

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

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

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

## HOW TO OBTAIN A QUOTE

### QUOTE REQUEST FOR GROUPS WITH 101+ EMPLOYEES

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

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

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

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

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

## APPLICATION/ENROLLMENT

### CASE SUBMISSION

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

- Completed employer group application
- First month's premium or ACH form

Incomplete submissions may delay members receiving member materials.

# CARRIER PLAN OFFERINGS

## EMPLOYEES' OPTIONS

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

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

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

## 12-MONTH RATE GUARANTEE

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

## PAYMENT OF PREMIUMS

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

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

## PREMIUM WHEN ADDING OR TERMING COVERAGE MID-MONTH

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

## NETWORK HEALTH TERMINATION OF A GROUP PLAN

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

## MEMBER MATERIALS

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

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

Additional information is available through the member portal at [login.networkhealth.com](https://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](mailto:nhcommercialenrollment@networkhealth.com)
- Using our **online employer portal**
- Fax forms to 920-720-1904
- Mail to:

**Network Health  
Enrollment Services  
1570 Midway Place  
Menasha, WI 54952**

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

## COBRA

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

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

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

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

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

## **FORMS**

[Eligibility Certification Form](#)

[Member Application and Change Form](#)

[EFT Enrollment and Change Form](#)

[Employer Group Application](#)

[Express Scripts, Inc. Mobile Application Download](#)

[Preferred Drug List](#)

[MDLIVE®](#)

# MEDICARE

## WHAT ARE A BENEFICIARY'S GUARANTEED RIGHTS?

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

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

## WHAT GRIEVANCES AND APPEAL RIGHTS DOES A BENEFICIARY HAVE?

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

## WHAT ARE MEDICARE STAR RATINGS?

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

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

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

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

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

# MEDICARE ELECTION PERIODS

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

#	POPULATION	QUALIFICATION	REFERENCE	TIME FRAME	EFFECTIVE DATE	CODING
<b>NEW TO MEDICARE</b>						
<b>1</b>	Newly Eligible (IEP for Part D/ ICEP)	Has both Medicare Parts A and B for the first time.  Either you are turning 65 or you are in month 25 of receiving Social Security or Rail Road Retirement Disability Benefits.	Copy of Medicare Card  Medicare Entitlement Letter  SSA Award Letter	<p>Begins three months immediately before entitlement to both Medicare Part A and Part B and ends on the later of the following.</p> <p>The last day of the month preceding entitlement to both Part A and B, or the last day of the individuals Initial Enrollment Period for Medicare Part B.</p> <p>Generally individuals will have an IEP for Part D that is the same period as the Initial Enrollment Period for Medicare Part B.</p> <p>When an individual enrolls in an MAPD plan during their IEP for Part B they have used both their ICEP and IEP for Part D.</p>	<p>Enrollment request made prior to month of eligibility, effective date is first day of the month of Medicare eligibility.</p> <p>Enrollment request made during or after first month of eligibility, effective date is first day of the month following the month of election.</p> <p>(An individual is considered to have attained age 65 on the day before the 65th anniversary of his or her birth.)</p>	<p>ICEP: MA Election IEP for Part D: MAPD Election</p> <p>MSA Eligible</p>
<b>2</b>	Opted out of Medicare Part B when first eligible and then later enrolled in Part B, Delays Part B enrollment beyond their IEP for Medicare Part B	<p>Entitled to Medicare Part A.</p> <p>Newly enrolled to Part B.</p>	<p>Copy of Medicare Card</p> <p>Medicare Entitlement Letter</p> <p>SSA Award Letter</p>	<p><b>Begins</b> three months before Part B effective date.</p> <p><b>Ends</b> last day of the month preceding entitlement to both Part A and Part B.</p>	<p>Application received in any of the three months prior to Part B effective date.</p> <p>Example: Part A has an effective date of 6-1-2015 Part B has an effective date of 8-1-2016. The plan effective date would be 8-1-2016.</p>	<p>ICEP</p> <p>MSA Eligible</p>
<b>3</b>	Enrolled into Part B during the Part B General Enrollment	<p>Entitled to Medicare Part A.</p> <p>Adding Part B during the General Enrollment Period Jan. 1 - Mar. 31.</p>	<p>Copy of Medicare Card</p> <p>Medicare Entitlement Letter</p> <p>SSA Award Letter</p>	<p><b>Begins</b> April 1 <b>Ends</b> June 30</p>	<p>Application received in April, May, or June plan effective July 1.</p>	<p>ICEP</p> <p>MSA Eligible</p>

#	POPULATION	QUALIFICATION	REFERENCE	TIME FRAME	EFFECTIVE DATE	CODING
4	Newly Eligible for Part D but not eligible to enroll in a Part D plan at any time during their Initial Enrollment Period for Medicare Part B  Initial Enrollment Period for Part D (IEP for Part D)	An individual is eligible to enroll in a Medicare Advantage Part D plan (MA-PD) when he or she is entitled to both Medicare Part A and B, and permanently resides in the service area of a Part D plan.	Ultimately CMS provides a Part D effective date and maintains it in the CMS systems, Medicare Advantage Prescription Drug (MARx).	If the Part D effective date is outside of the Initial Enrollment Period for Medicare Part B and an individual is not eligible to enroll in a Part D plan at any time during their Initial Enrollment Period for Medicare Part B then the IEP for Part D window is then a seven month period including the 3 months before becoming eligible for Part D, the month of eligibility, and the three months following eligibility for Part D.	First of the month following receipt of application, but not earlier than Part D effective date maintained in MARx.	IEP for Part D If outside of ICEP MSA Not Eligible
5	Eligible for Medicare prior to age 65, attaining age 65	Have Part A and B due to disability and are turning 65.	Individual's 65th Birthday	<b>Begins</b> three months before month of birthday Includes birthday month.  <b>Ends</b> last day of the third month after the month they attain age 65.	Enrollment request made prior to month of birthday, effective date is first day of the month of birthday.  Enrollment request made during or after birth month, effective date is first day of the month following the month of election.	IEP2 MAPD plan  MSA Not Eligible
<b>ANNUAL ELECTION PERIOD (AEP)</b>						
6	All Beneficiaries	Annual Election Period (AEP)		<b>Begins</b> October 15 <b>Ends</b> December 7	January 1	AEP MSA Eligible
<b>OPEN ENROLLMENT PERIOD (MA-OEP)</b>						
7	Enrolled in a Medicare Advantage plan (MA/MAPD)	Must be active in a Medicare Advantage plan.	MARx	Enrolled as of January 1 - <b>Begins</b> January 1; <b>Ends</b> March 31	First day of the month following receipt of the enrollment request.	MA-OEP MSA Not Eligible
8	New Medicare Advantage enrollees	New Medicare Advantage enrollees following IEP/ICEP Medicare entitlement.	MARx	New ICEP enrollees <b>Begins</b> Month of entitlement to A and B. <b>Ends</b> Last day of 3rd month of entitlement.	First of the month following receipt of application.	MA-OEP New MSA Not Eligible

#	POPULATION	QUALIFICATION	REFERENCE	TIME FRAME	EFFECTIVE DATE	CODING
<b>BENEFICIARIES WHO MOVE</b>						
<b>9</b>	Change in Permanent Residence	<p>Permanently moved inside plan's service area with new plan options available.</p> <p>Permanently moved outside plan's service area.</p>	Beneficiary's Attestation	<p><b>Before Move Begins</b> the month before month of permanent move. <b>Ends</b> two months after the move.</p> <p><b>After the Move Begins</b> month beneficiary notified plan of the move. <b>Ends</b> two months after notification of the move.</p>	First day of the month following the notification of the move, but not earlier than the move.	<p>MOV</p> <p>MSA Not Eligible</p>
<b>10</b>	Change in Residence	Returning to the U.S. after permanently living outside the U.S.	Beneficiary's Attestation	<p><b>Before Move Begins</b> the month before month of permanent move. <b>Ends</b> two months after the move.</p> <p><b>After Move Begins</b> month beneficiary notified plan of the move. <b>Ends</b> two months after notification of the move.</p>	First day of the month following the notification of the move, but not earlier than the move.	<p>RUS</p> <p>MSA Not Eligible</p>
<b>11</b>	Released from incarceration	Released from incarceration.	Beneficiary's Attestation	As early as month before release, lasts up to two months after release.	First of the month following receipt of enrollment request, but not earlier than release date.	<p>INC</p> <p>MSA Not Eligible</p>
<b>INSTITUTIONALIZED BENEFICIARIES</b>						
<b>12</b>	Institutionalized Beneficiaries	Resides in skilled nursing facility, intermediate care facility, psychiatric, rehab, long-term care, or swing-bed hospital.	<p>Beneficiary's Attestation</p> <p>Members address located in the facility</p>	<p><b>Begins</b> first day Institutionalized. <b>Ends</b> two months after discharge.</p> <p>This election is continuous for those that reside in these facilities.</p>	First of the month following receipt of the enrollment request.	<p>LTC</p> <p>MSA Not Eligible</p>
<b>LOW INCOME BENEFICIARIES</b>						
<b>13</b>	LIS (Non-Medicaid)	Have Part D subsidy.	<p>Beneficiary's Attestation</p> <p>LIS validated in CMS Portal MARx</p>	<p>Begins the month the individual qualifies for LIS. Can only be used once during each of the following time periods:</p> <ul style="list-style-type: none"> <li>• January – March,</li> <li>• April – June, and</li> <li>• July – September.</li> </ul> <p>It may not be used in the 4th quarter of the year (October – December).</p>	First of the month following receipt of the enrollment request.	<p>HLP</p> <p>MSA Not Eligible</p>



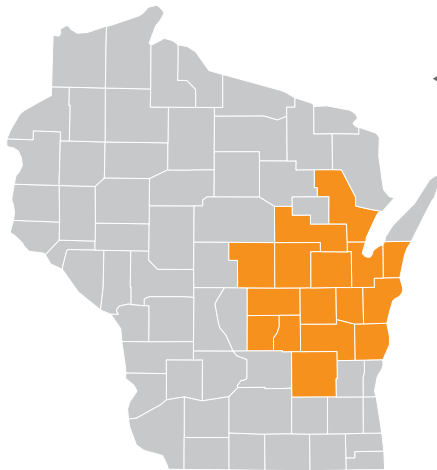
#	POPULATION	QUALIFICATION	REFERENCE	TIME FRAME	EFFECTIVE DATE	CODING
14	LIS (gain, lose, or have a change in Status)	Have gain, lose or change of Low Income Subsidy (LIS).	Beneficiary's Attestation  Gain, lose, or change validated in CMS Portal MARx	<b>Begins</b> within three months of change, or notification of such a change, whichever is later. Use of this SEP does not count towards the once per calendar quarter limitation.  <b>Ends</b> three months after the change or notification of change, whichever is later.	First of the month following receipt of the enrollment request.	NLS  MSA Not Eligible
15	Dual Eligible	Have Medicaid.	Medicaid validated using the ForwardHealth Portal.	<b>Begins</b> the month the individual qualifies for Medicaid.  Can only be used once during each of the following time periods: • January - March, • April - June, and • July - September. It may not be used in the 4th quarter of the year (October - December).	First of the month following receipt of the enrollment request.	MDE  MSA Not Eligible
16	Dual Eligible (gain, lose, or have a change in Status)  *Consider Member Most Likely Has LIS	Have gain, lose or change of Medicaid benefits.	Gain, lose, or change of Medicaid validated using the ForwardHealth Portal.	<b>Begins</b> within three months of change, or notification of such a change, whichever is later. Use of this SEP does not count towards the once per calendar quarter limitation.  <b>Ends</b> three months after the change or notification of change, whichever is later.	First of the month following receipt of the enrollment request.	MCD  MSA Not Eligible
<b>CREDITABLE COVERAGE AND EMPLOYER GROUP PLANS</b>						
17	Current Employer/Union Group Coverage	Have creditable group coverage including COBRA.	Beneficiaries' Attestation	Anytime while enrolled in group coverage.	Can choose a future effective date up to three months after the month of application, but effective date cannot be earlier than the first of the month following month in which the request is made.	EGHP  MSA Not Eligible
18	Loss of Employer Group Coverage	Voluntary or involuntary termination of group coverage.	Beneficiary's Attestation	<b>Begins</b> month group allows or disenrollment or date COBRA ends. <b>Ends</b> two months after group coverage ends.	Can choose a future effective date up to three months after the month of application, but effective date cannot be earlier than the first of the month following month in which the request is made.	LEC  MSA Not Eligible

#	POPULATION	QUALIFICATION	REFERENCE	TIME FRAME	EFFECTIVE DATE	CODING
19	Involuntary Loss of Creditable Prescription Drug Coverage	<p>Involuntary loss of coverage. Coverage is no longer creditable.</p> <p>This does not include loss of coverage due to nonpayment of premium.</p> <p>*Enrollment into MAPD.</p>	<p>Beneficiaries' Attestation</p> <p>Letter stating loss of creditable coverage</p>	<p><b>Begins</b> either month of notice or month the loss or reduction of coverage occurs, whichever is later.</p> <p><b>Ends</b> two months later.</p>	First of the month following receipt of the enrollment request, permits enrollment in a MAPD/PDP only.	<p>LCC</p> <p>MSA Not Eligible</p>
<b>TERMINATION OF PLAN CONTRACT</b>						
20	Termination of plan contract with Medicare with mutual consent	Contract with Medicare is ending with mutual consent.	<p>Beneficiaries' Attestation</p> <p>Letter of Notification</p> <p>Medicare Advantage Plan must notify Beneficiary by October 1 if it won't offer health coverage next year, and it must continue to provide coverage through the end of the current calendar year.</p>	Lasts from December 8 of that year through the last day of February of the next year. (This SEP is in addition to the Fall Open Enrollment period from October 15 through December 7, can switch Medicare health coverage and enroll or disenroll from Part D drug coverage.	<p>Enrollments made from October 15 through December 31 are effective January 1.</p> <p>Enrollments made during January are effective February 1.</p> <p>Enrollments made in February are effective March 1.</p>	<p>NON</p> <p>MSA Not Eligible</p>
21	Mid-year plan closes or changes it's contract (forced disenrollment) Mutual termination of contract with CMS or CMS terminates the plan's contract(s)	Contract with Medicare is ending with or without mutual consent.	<p>Member Attestation</p> <p>Notice of Termination</p> <p>Medicare Advantage Plan must notify 60 days before the proposed date of termination or modification.</p>	<p><b>Begins</b> two months before termination.</p> <p><b>Ends</b> one month after effective termination.</p>	Can request new Medicare Advantage Plan coverage start the month after notice and up to two months after old Medicare Advantage Plan or Part D plan coverage ends.	<p>OTH</p> <p>MSA Not Eligible</p>
22	CMS terminates Medicare Advantage Plan's contract because of misconduct or other problems.	Contract with Medicare is ending without mutual consent.	Member Attestation Termination Letter (plan must give 30 days notice before the termination date).	Begins one month before the termination occurs and lasts for two months afterward.	Can choose to have new Medicare Advantage Plan coverage begin up to three months after the month your old coverage ended.	<p>OTH</p> <p>MSA Not Eligible</p>

#	POPULATION	QUALIFICATION	REFERENCE	TIME FRAME	EFFECTIVE DATE	CODING
<b>STATE PHARMACEUTICAL ASSISTANCE PROGRAMS</b>						
<b>23</b>	Belongs to a State Pharmaceutical Assistance Program (SPAP) Wisconsin Senior Care	Wisconsin Senior Care at any level. Senior Care ending. (Loss of Senior Care due to failure to pay premium is not considered involuntary.)	Wisconsin Senior Care award letter  State of Wisconsin ForwardHealth Portal  Member/Applicant Attestation	<b>Begins</b> Immediately. <b>For Loss:</b> begins either the month of loss eligibility or notification of the loss, whichever is earlier, and ends two months after either the month of the loss of eligibility or notification of the loss, whichever is later. This election can only be used once per year.	First of the month following receipt of the enrollment request. This SEP is only to enroll into an MAPD or to switch from MA to MAPD.	PAP      MSA Not Eligible
<b>5-STAR PLAN</b>						
<b>24</b>	Enroll into 5- Star Plan	Beneficiary may enroll into a plan with a 5-Star Rating during the year the plan has an overall 5-Star.	Plan Performance Star Rating	Continuous when the plan holds the 5-Star Rating.	First of the month following receipt of the enrollment request.	5ST   MSA Not Eligible
<b>DISENROLLMENT ELECTIONS</b>						
<b>25</b>	Gain or maintain other creditable coverage	Gain or enroll in coverage such as Tri-Care, Wisconsin Senior Care or Veterans Affairs (VA).	Validation of Wisconsin Senior Care  Letter indicating gain of creditable coverage	<b>Begins</b> immediately. <b>Ends</b> date elect disenrollment.	First of the month following receipt of the <b>written disenrollment request</b> . This election is for disenrollment from a MAPD plan It can also be used to change from MAPD to MA.	OCC   MSA Not Eligible
<b>26</b>	Trial Period	Individuals who terminated a Medicare Supplement (Medigap) plan when they enrolled in an MA/MAPD for the first time, and who are still in the "Trial Period."	Must receive written request to disenroll and be in first 12 months of an MA/MAOD plan.  *Members who were previously enrolled in a supplement and who are enrolling for the first time into a Medicare Advantage plan have a valid SEP to disenroll during their first 12 months. They may go back to original Medicare and have a guaranteed issue to return to the Medicare Supplement (same Supplement and same company).	<b>Begins</b> upon enrollment in the MA plan. <b>Ends</b> after 12 months of enrollment or when the beneficiary disenrolls from the MA plan, whichever is earlier.	First of the month following receipt of the <b>written disenrollment request</b> .	12G      MSA Eligible (If meets requirements noted under *)

#	POPULATION	QUALIFICATION	REFERENCE	TIME FRAME	EFFECTIVE DATE	CODING
27	Enrolled in a MA/MAPD during the IEP/ICEP at 65th birthday and dropping it within 1st 12 months (other than an MSA plan)	MA eligible individuals who elect an MA plan (other than an MSA plan) during the initial enrollment period (IEP) for Part B surrounding their 65th birthday (Individuals entitled to Medicare prior to age 65 are NOT eligible for this SEP).	Elected a MA/MAPD plan during IEP/ICEP surrounding 65th birthday.  CMS MARx	Anytime during the 12 month period that begins on the effective date of coverage in the MA/MAPD plan.	Termination date is first day of the month following the month of written notice.	12J       MSA Not Eligible
<b>CANCELLING APPLICATIONS</b>						
28	First time MSA enrollees (during AEP)	First time MSA application.	Return to original Medicare	After December 7 and up to December 15.	Verbal or written request.	
29	New applications to Network Health	Prior to plan effective date.	Return to prior plan or original Medicare	Prior to plan effective date.	Verbal or written request.	

## NETWORK HEALTH MEDICARE ADVANTAGE SERVICE AREA

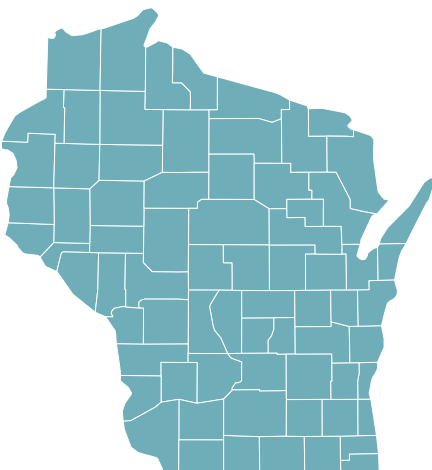
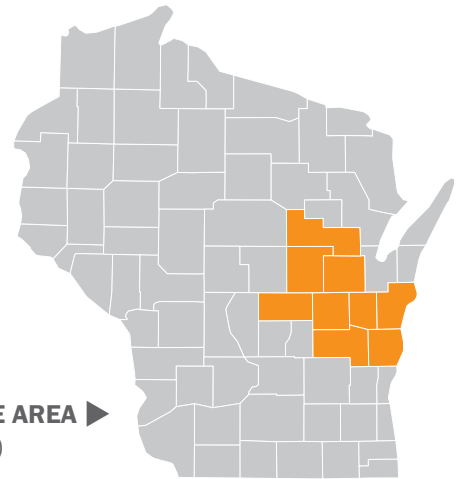


### ◀ NORTHEAST PPO SERVICE AREA

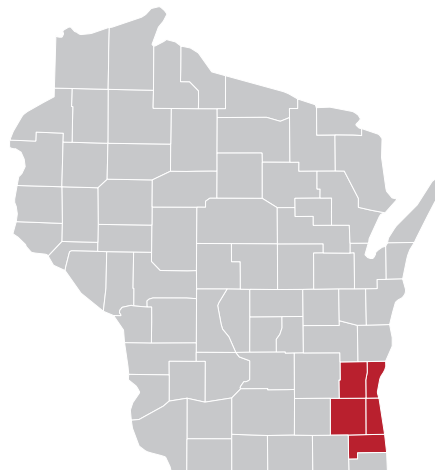
Network PlatinumSelect (PPO)  
 Network PlatinumChoice (PPO)  
 Network PlatinumPlus (PPO)  
 Network PlatinumPlus Pharmacy (PPO)  
 Network PlatinumPremier (PPO)  
 Network PlatinumPremier Pharmacy (PPO)  
 NetworkCares (PPO SNP)

### NORTHEAST PPO SERVICE AREA ▶

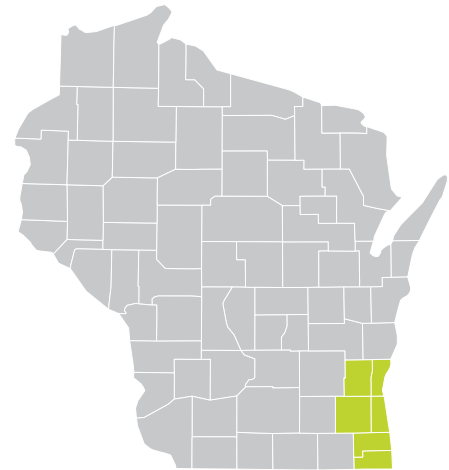
Network PlatinumZero(PPO)



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



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



**SOUTHEAST HMO SERVICE AREA**  
 Medicare Explore (HMO)

# What Are the Different Medicare Coverage Options Offered by Network Health?

Network Health offers a variety of Medicare plan options.

## Preferred Provider Organization – PPO\*

- Includes a network of providers
- Members can go out-of-network
- Plans may include prescription drug coverage

[Learn more about our PPO plans.](#)

## Health Maintenance Organization – HMO\*

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

[Learn more about our HMO plans.](#)

## Special Needs Plan – SNP\*

Networks Health only offers a D-SNP.

- The member is eligible for both Medicare and Medicaid

[Learn more about our SNP plans.](#)

## Medical Savings Account – MSA

Combines a high deductible Medicare Advantage plan and a medical savings account

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

[Learn more about our MSA plan.](#)

*\*Available in specific counties. See previous page for service areas.*

# Top EIGHT Things to Know About an MSA BenefitWallet Account

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

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

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

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

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

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

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

- ▶ Soft transfer the call to BenefitWallet.

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

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

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

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

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

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

# Scope of Appointment Form

Personal/individual marketing appointments typically take place in the beneficiary's home, but these appointments can occur in other venues such as a library or coffee shop. All one-on-one appointments with beneficiaries are considered sales/marketing events.

- A scope of appointment form must be completed by the beneficiary prior to discussing any topics agreed upon in the scope of appointment.
- Representatives can only discuss topics that were agreed upon within the scope of appointment.
- Representative may not market non-health care related products (such as annuities or life insurance).

## **Please Note**

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


Scope of Appointment Documents should be retained for 10 years by the agent.



# Application Verification Email


When writing new business or submitting short enrollment forms for existing business, agents will receive a verification email within 24-48 business hours. If agents do not receive that email, please call Network Health's agent advisors at 920-720-1260 to validate if the application was received.

## Sample Verification email




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

To Gehrke, Kimberly

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

Tracker



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

	Member Last Name	Member First Name	Member M.I.	Plan Code	Date Received	Agent - E-mail for Applications
<a href="#">Report</a>	[REDACTED]	REGGIE	A	NPP20000	04-26-2016	<a href="mailto:pekoehle@networkhealth.com">pekoehle@networkhealth.com</a>
<a href="#">Report</a>	[REDACTED]	JANICE		NPP80000	04-29-2016	<a href="mailto:pekoehle@networkhealth.com">pekoehle@networkhealth.com</a>
<a href="#">Report</a>	[REDACTED]	CYNTHIA	J	NHPMSA1A	04-19-2016	<a href="mailto:pekoehle@networkhealth.com">pekoehle@networkhealth.com</a>

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

# Individual Enrollment Request Agent Agreement

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

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

## FORMS

To find the most up to date forms visit [networkhealth.com/agent-resources/index](http://networkhealth.com/agent-resources/index).

# 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](https://www.cms.gov) for a full overview of the marketing guidelines.

Agents are prohibited in engaging activities 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.

# MEDICARE AGENT ORDERING SITE

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



The screenshot shows the Network Health login page. At the top is the Network Health logo. Below it, a message states: "You must login to use the Network Health online ordering system". There are two input fields: "Email Address:" and "Password:". Below the password field is a "Continue ->" button. A horizontal line separates this from the bottom section, which contains the text: "If you do not know your username or password, enter your email address below and it will be emailed to you." Below this is another "Email Address:" input field and a "Submit" button.

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



This screenshot is identical to the one above, but with the "Continue ->" button circled in orange to indicate it should be clicked after entering the login information.

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



**network health**

**Confirm Your Address and Contact Information**

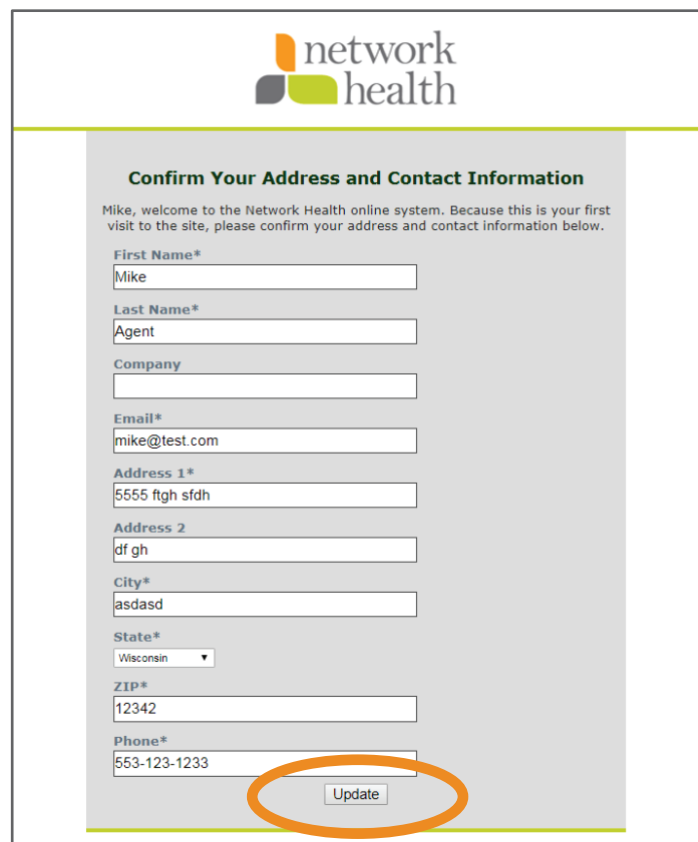
Mike, welcome to the Network Health online system. Because this is your first visit to the site, please confirm your address and contact information below.

Name: **Mike Agent**  
Address: **5555 ftgh sdfh df gh**  
City, State, ZIP: **asdasd, WI 12342**  
Email: **mike@test.com**  
Phone Number: **553-123-1233**

☒ The above information is correct and current.

[I need to edit my contact information](#)

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



**network health**

**Confirm Your Address and Contact Information**

Mike, welcome to the Network Health online system. Because this is your first visit to the site, please confirm your address and contact information below.

First Name\*

Last Name\*

Company

Email\*

Address 1\*

Address 2

City\*

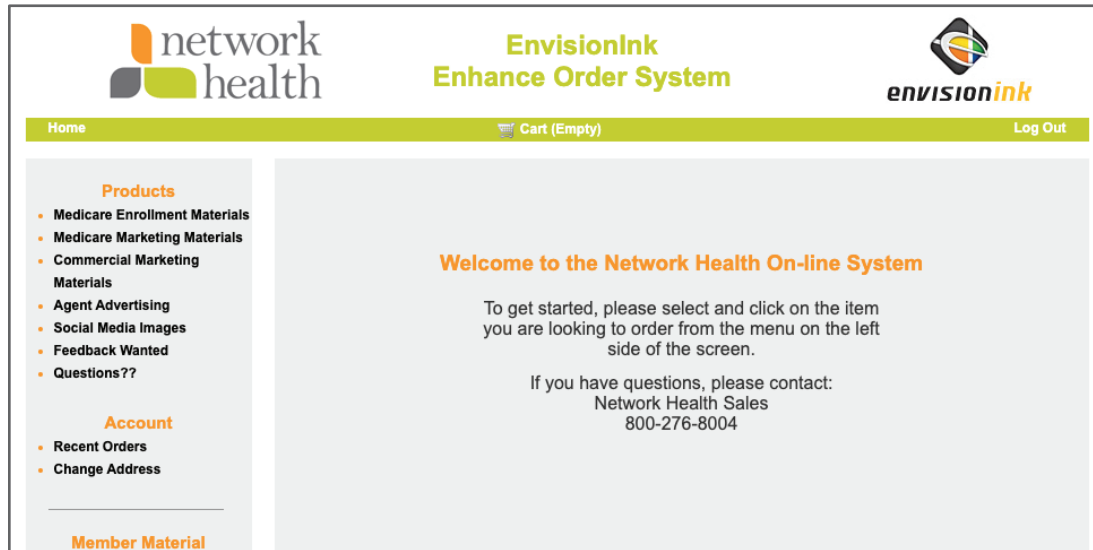
State\*

ZIP\*

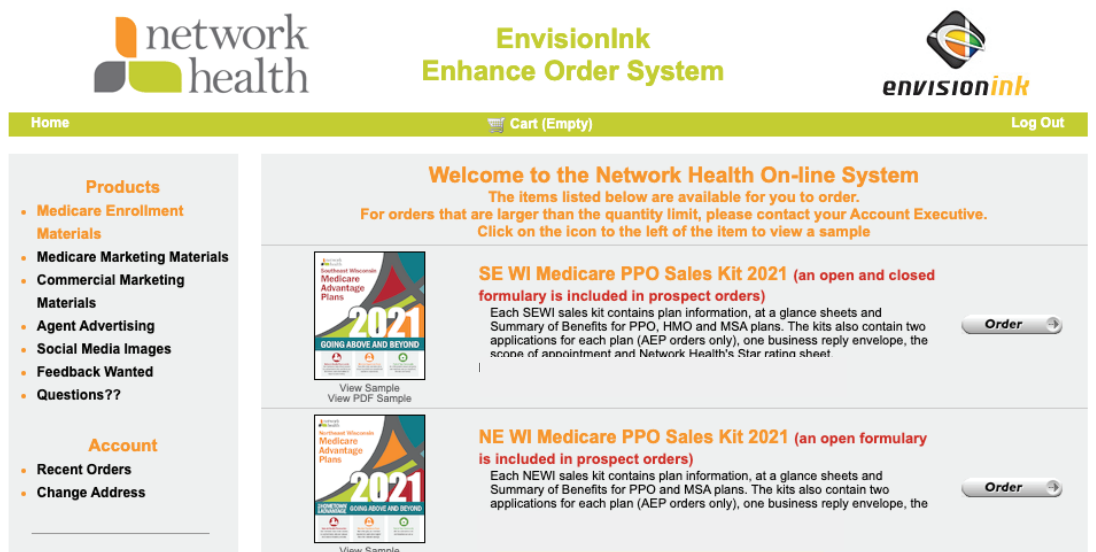
Phone\*

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

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



To begin an order for enrollment materials, click the **2021** link on the left of the screen under **Products/Medicare Enrollment Materials**. On the enrollment materials screen you will see all the Network Health sales kits available to order, as well as extra enrollment forms. (*Scroll down the page to display.*)



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

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

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

The screenshot shows the 'EnvisionInk Enhance Order System' interface. At the top, there are logos for 'network health' and 'envisionink'. Below the logos, there's a navigation bar with 'Home', 'Cart (Empty)', and 'Log Out'. The main content area displays the product 'SE WI Medicare PPO Sales Kit 2021'. It includes a description of the kit and a section for 'Order Type\*' with two radio buttons: 'Agent Order' (selected) and 'Prospective Member Order'. Below this is a 'Quantity' selector with a dropdown menu showing numbers from 1 to 55. An 'Add to Cart' button is located to the right of the quantity selector, highlighted with an orange circle.

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

The screenshot shows the 'Your Cart' page in the 'EnvisionInk Enhance Order System'. The top navigation bar now shows 'Cart (1 Item)'. On the left, there's a sidebar with 'Products' and 'Account' sections. The 'Products' section lists various categories, including 'Medicare Enrollment Materials'. The main content area shows the item 'SE WI Medicare PPO Sales Kit 2021' with its description, quantity (1), and date added (July 7, 2021). A 'Checkout' button is highlighted with an orange circle.

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

**network health** **EnvisionInk Enhance Order System** **envisionink**

Home Cart (1 Item) Log Out

**Products**

- Medicare Enrollment Materials
- Medicare Marketing Materials
- Commercial Marketing Materials
- Agent Advertising
- Social Media Images
- Feedback Wanted
- Questions??

**Account**

- Recent Orders
- Change Address

**Checkout**  
Items In This Order

**Agent No Cost Items**

**SE WI Medicare PPO Sales Kit 2021**  
Quantity: 1  
Date Added: July 7, 2021  
Remove

**Shipping Information for Items Shipped to Agent**

First Name\* Agent  
Last Name\* Smith  
Company Network Health  
Address\* 1570 Midway Pl  
Address 1570 Midway Pl  
City\* Menasha  
State\* Wisconsin  
ZIP\* 54952  
Email For Confirmation\*  
**Place Order**

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

**network health** **EnvisionInk Enhance Order System** **envisionink**

Home Cart (Empty) Log Out

**Products**

- Medicare Enrollment Materials
- Medicare Marketing Materials
- Commercial Marketing Materials
- Agent Advertising
- Social Media Images

**Your order has been successfully placed.**

Your order number is: **NHA58849**

An email confirming this order has been sent to: jgreshay@networkhealth.com



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

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

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

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

network health

EnvisionInk Enhance Order System

envisionink

Home Cart (1 Item) Log Out

**Products**

- Medicare Enrollment Materials
- Medicare Marketing Materials
- Commercial Marketing Materials
- Agent Advertising
- Social Media Images
- Feedback Wanted
- Questions??

**Your Cart**

The items listed below have been saved in your shopping cart

**Checkout**

**SE WI Medicare PPO Sales Kit 2021**

Each SEWI sales kit contains plan information, at a glance sheets and Summary of Benefits for PPO, HMO and MSA plans. The kits also contain two applications for each plan (AEP orders only), one business reply envelope, the scope of appointment and Network Health's Star rating sheet.

Order Type: Prospective Member  
Quantity: 1  
Date Added: July 7, 2021

**Prospective Member Address:**  
J Greshay  
1570 Midway Pl  
Menasha, WI 54952

Remove

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

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

network health

EnvisionInk Enhance Order System

envisionink

Home Cart (1 Item) Log Out

**Checkout**

Items In This Order

**Prospective Member Items**

**SE WI Medicare PPO Sales Kit 2021**

Order Type: Prospective Member  
Quantity: 1  
Date Added: July 7, 2021

**Prospective Member Address:**  
J Greshay  
1570 Midway Pl  
Menasha, WI 54952

Remove

Email For Confirmation\* jgreshay@networkhealth.com

Place Order

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

**network health** **EnvisionInk Enhance Order System** **envisionink**

Home Cart (2 Items) Log Out

**Products**

- Medicare Enrollment Materials
- Medicare Marketing Materials
- Commercial Marketing Materials
- Agent Advertising
- Social Media Images
- Feedback Wanted
- Questions??

**Account**

- Recent Orders
- Change Address

**Checkout**  
Items In This Order

**Agent No Cost Items**

**Cares WI Medicare SNP Sales Kit 2021**  
Quantity: 1  
Date Added: July 7, 2021  
Remove

**Prospective Member Items**

**SE WI Medicare PPO Sales Kit 2021**  
Order Type: Prospective Member  
Quantity: 1  
Date Added: July 7, 2021  
Remove

**Prospective Member Address:**  
J Greshay  
1570 Midway Pl  
Menasha, WI 54952

**Shipping Information for Items Shipped to Agent**

First Name\*   
Last Name\*   
Company   
Address\*   
Address   
City\*   
State\*   
ZIP\*   
Email For Confirmation\*   
**Place Order**

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

**network health** **EnvisionInk Enhance Order System** **envisionink**

Home Cart (Empty) Log Out


**Your order has been successfully placed.**

Your order number is: **NHA10065**


An email confirming this order has been sent to: mike@test.com

[Return to Main Menu](#)

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



**EnvisionInk**  
 Enhance Order System



[Home](#)
[Cart \(2 Items\)](#)
[Log Out](#)

**Products**

- Medicare Enrollment Materials
- Medicare Marketing Materials
- Commercial Marketing Materials
- Agent Advertising
- Social Media Images
- Feedback Wanted
- Questions??

**Account**

- Recent Orders**
- Change Address

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**Manager Area**

- Login as Agent
- Manage Users
- Import/Export Users
- Inventory Reports
- Usage Reports
- Testing Only

### Member Material Request Orders

Search For Orders:

Order No	Order Date	Ship To	Status	Ship Date	Tracking
NHA58870	Jul 7, 2021	ROGER BUTZ	Order Placed		
1 - Pick Your Perks - Frequently Asked Questions 2 - Pick your Perks Reimbursement Form					
NHA58850	Jul 7, 2021	PEARL ADAMS KYLE	Order Placed		
1 - Pick Your Perks - Frequently Asked Questions 2 - Pick your Perks Reimbursement Form 1 - Pick Your Perks Reimbursement Instructions					
NHA58848	Jul 7, 2021	DIANE SCHMITT	Order Placed		
1 - EOC Go (009)					
NHA58847	Jul 7, 2021	SCOTT LEFEVRE	Order Placed		
1 - PHI Form and Instruction Sheet w/BRE					
NHA58846	Jul 7, 2021	ANTHONY KATCHEVER	Order Placed		
2 - Pick your Perks Reimbursement Form 1 - Pick Your Perks Reimbursement Instructions					
NHA58845	Jul 7, 2021	THOMAS WILLETT	Order Placed		
1 - Pick your Perks Reimbursement Form 1 - Pick Your Perks Reimbursement Instructions					
NHA58844	Jul 7, 2021	SCOTT LEFEVRE	Order Placed		
1 - PHI Form and Instruction Sheet w/BRE					
NHA58843	Jul 7, 2021	DONNA MARTZAHN	Order Placed		
1 - Pick Your Perks - Frequently Asked Questions					
NHA58842	Jul 7, 2021	VERNON BERTZYK	Shipped	Jul 7, 2021	00040899563742092854
2 - Pick your Perks Reimbursement Form					

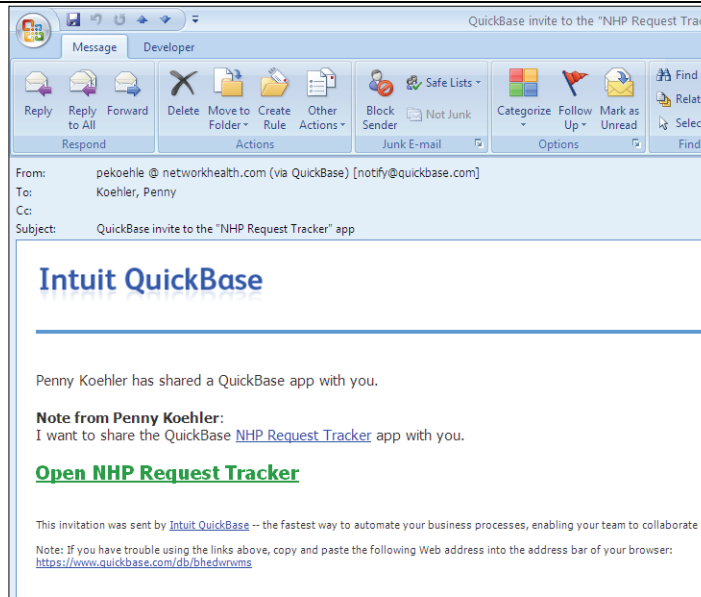
Agent kits will have tracking information added once the order has shipped. Individual kits shipped to prospects will not have tracking numbers, but you can see when it shipped.

# NETWORK HEALTH QUICKBASE

Register to Use Quickbase

<https://nhpexternalrealm.quickbase.com>

You will be sent an email invitation to the QuickBase application. Click on the Open NHP Request Tracker link contained in the email.



To register, click the **Create a log-in** link at the bottom of the page.

A screenshot of the QuickBase login page. It features a form with fields for 'Email Address' and 'Password'. Below the password field is a link 'I forgot my password' and a green 'Sign in' button. There is a checkbox for 'Keep me signed in on this computer'. At the bottom of the form, it says 'Not a QuickBase user? Create a log-in.' The 'Create a log-in.' link is circled in red. Below the form, the text 'Customizable business software.' is visible.

### Registration Page

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

### Intuit QuickBase

#### Sign Up for QuickBase

Already a QuickBase user? [Sign in.](#)

All fields marked with an asterisk (\*) are required.

First name \*

Last name \*

Email address \*

A verification email will be sent to this address.

Choose a password \*

Retype password \*

Password strength:

✓ Must be at least 8 characters

✓ Must include both numbers and letters

Please set up a security question in case you ever need to reset your password.

Question: \*

Done

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

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

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

Enter your password to display the My Apps page.

## Register to Use Quickbase

<https://nhpexternalrealm.quickbase.com>

### Sign In to QuickBase

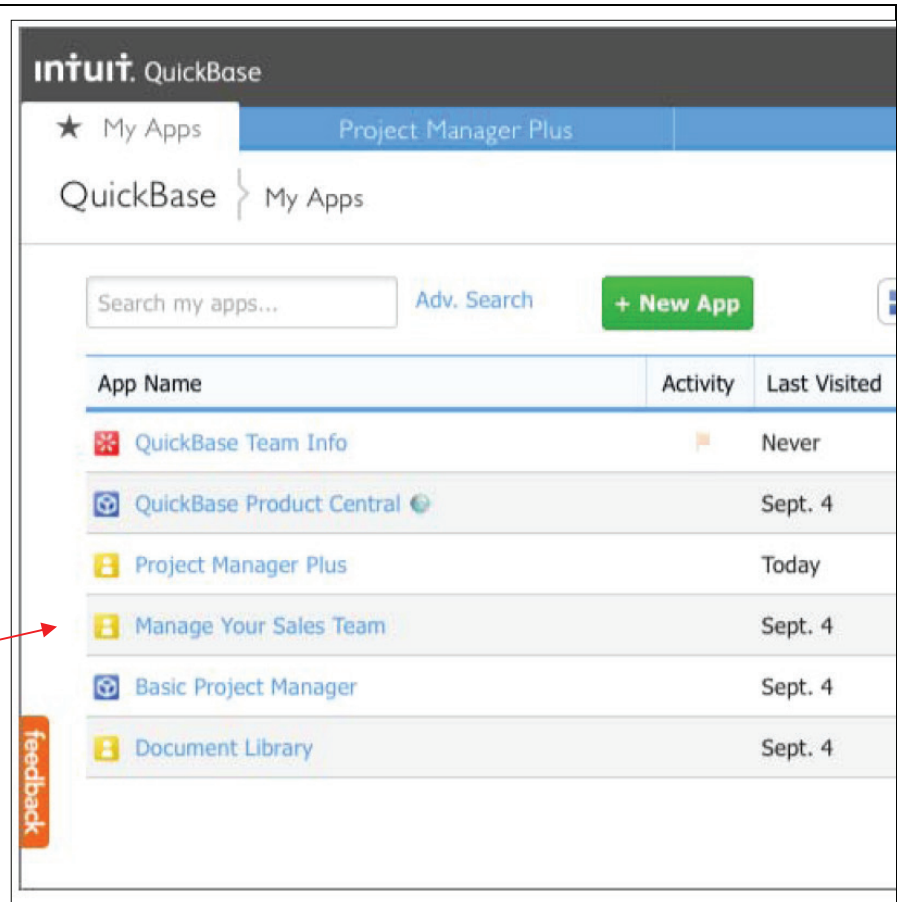
On the QuickBase home page [www.networkhealth.quickbase.com](http://www.networkhealth.quickbase.com), click Sign In at the top of the page.

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

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

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

The My Apps page displays.



## Network Health Request Tracker + Customer Service

Welcome screen from  
[nhpexternalrealm.quickbase.com](https://nhpexternalrealm.quickbase.com)

NH Request Tracker Home page  
<https://nhpexternalrealm.quickbase.com>

Click **New Agent Request**.

Determine request type from the following options.

**Enrollment**  
 Application or short enrollment forms.

**Sales Team**  
 LIS checks, Medicaid inquiry.

**Commissions**  
 Questions or issues with commission statements.



## Network Health Request Tracker + Customer Service

### Agent Request

Enter subject, title or request.

### Member Name

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

### Details

Enter specific information on what questions or concerns you have.

### Attachment

Attach a file like an application or supporting document.

### Agent Requests > Add Agent Request

Reports & Charts

#### Agent request

Please enter your agent request below.  
A confirmation will be emailed to the email address on record.

Agent request Type \*

Enrollment - Applications and Changes

Agent request

Member Name

Date of Birth

OR

Member ID Number

Details

Attachment

Choose File

No file chosen

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

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

**Customer Service can help with the following.**

Claims questions, billing questions, ID card reorder.

## Network Health Request Tracker + Customer Service

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



Mon 5/2/2016 2:03 PM

pekoehle @ networkhealth.com (via QuickBase) <notify@quickbase.com>

Update on 14760

o Gehrke, Kimberly

Tracker



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

Thank you,

Network Health

You can access your agent request at the link below.

<https://networkhealth.quickbase.com/db/bhedwnws6?a=dr&r=gpi>

## Network Health Request Tracker + Customer Service

### Agent Request

Enter subject or title or request.

### Member Name

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

### Correspondence

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

### Attachment

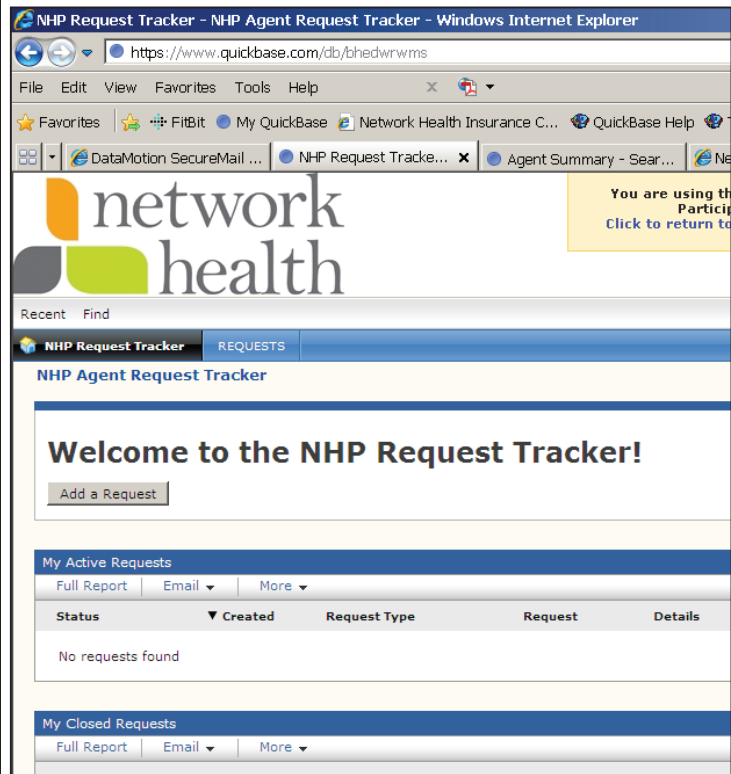
Attach up to three files (such as copies of the EOC or provider bills).

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

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

## Submitting an Application via Network Health Request Tracker

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



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

A screenshot of the "Add Request" form in the NHP Request Tracker. The form is titled "Add Request" and has a "REQUESTS" tab selected. Below the title is a "Request" section with a "Request Type" dropdown menu. A red arrow points to the "Request Type" dropdown, which is open, showing a list of options: "Commissions Question", "Customer Service", "Enrollment - Applications and Changes", and "Sales Team". The "Enrollment - Applications and Changes" option is highlighted. Below the dropdown are fields for "Request", "Member Name", "Date of Birth", "Details", and "Member ID Number". There is also a "New App" button in the top right corner.

## Submitting an Application via Network Health Request Tracker

### Request Field

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

### Member Name

Enter name.

### Date of Birth

Enter date of birth.

### Member ID Number

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

### Details

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

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

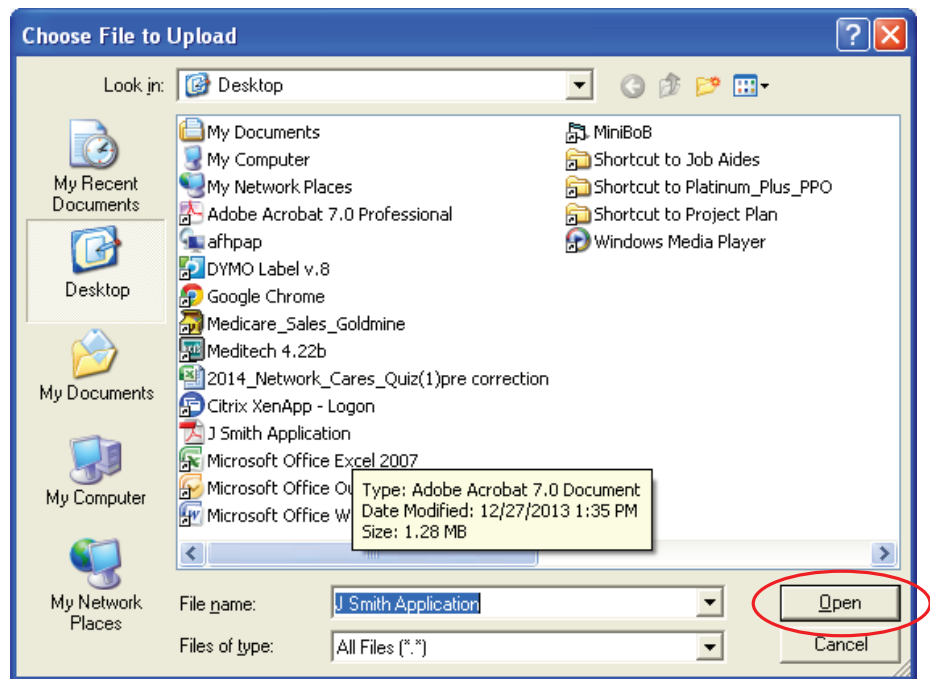
The screenshot shows the 'Add Request' form in the Network Health Request Tracker. The form is titled 'Request' and has a 'Save' button and a 'Cancel' button. The form fields are as follows:

- Request Type:** A dropdown menu with 'Enrollment - Applications and Changes' selected.
- Request:** A text field containing 'Application for James R Smith'.
- Member Name:** A text field containing 'James R Smith'.
- Date of Birth:** A text field containing '1/1/1945'.
- OR:** A label between the Date of Birth and Member ID Number fields.
- Member ID Number:** A text field.
- Details:** A large text area for additional information.
- Attachment:** A text field with a 'Browse...' button next to it.

This is a close-up screenshot of the 'Add Request' form, focusing on the Member Name, Date of Birth, Details, and Attachment fields. The 'Member Name' field contains 'James R Smith'. The 'Date of Birth' field contains '1/1/1945'. The 'Details' field is a large text area. The 'Attachment' field is a text field with a 'Browse...' button next to it, which is circled in red.

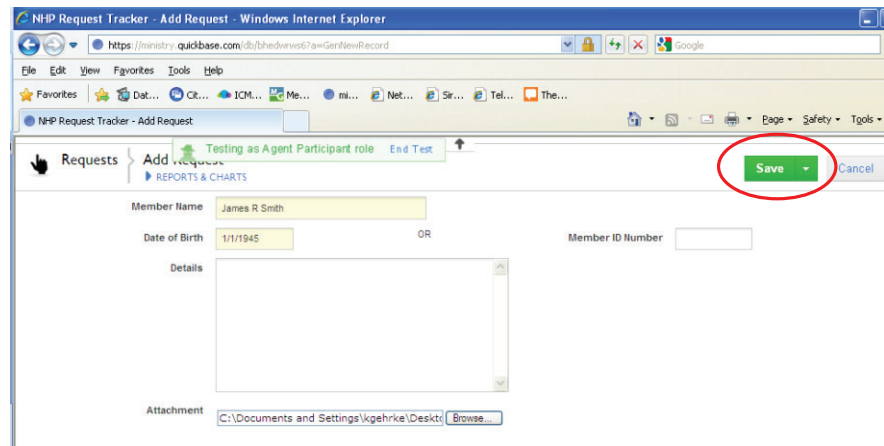
## Submitting an Application via Network Health Request Tracker

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



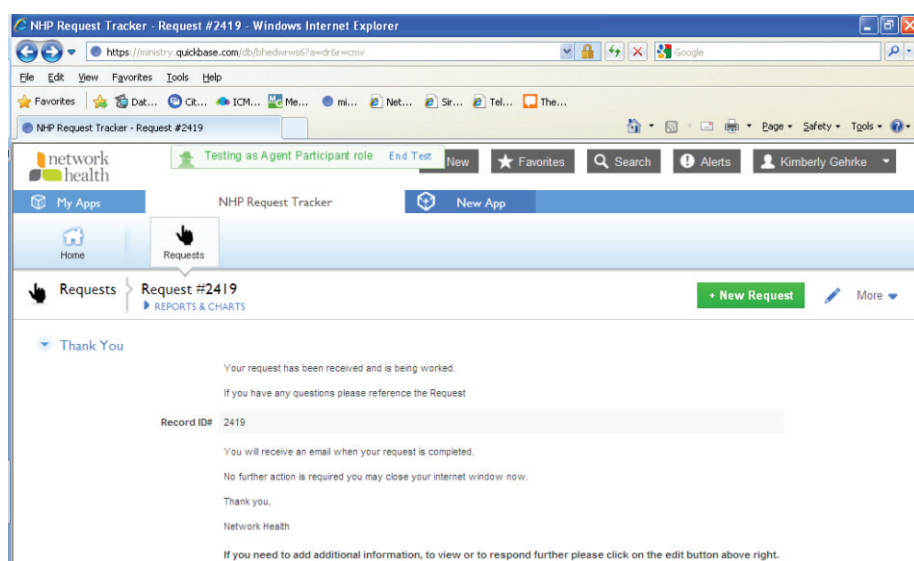
Click the **Save** button to save the request.

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



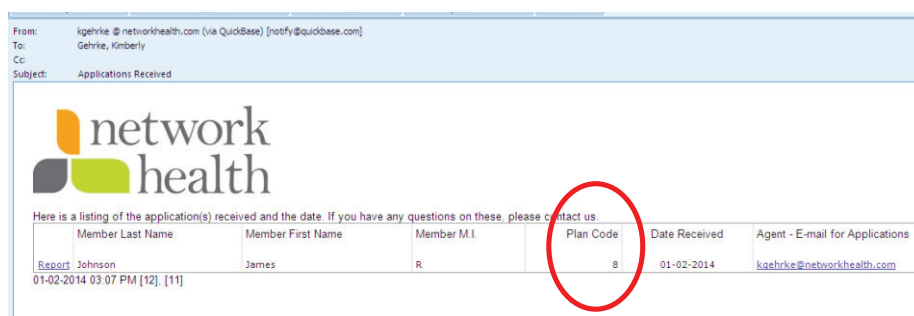
## Submitting an Application via NHP Request Tracker

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



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

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



## Submitting an Application via NHP Request Tracker

### Plan Verification Codes

Plan Contract	Plan Name	New Plan Benefit Package
H5215	Network PlatinumPlus (PPO)	001
H5215	Network PlatinumPlus with Pharmacy (PPO)	002
H5215	Network PlatinumPremier with Pharmacy (PPO)	005
H5215	Network PlatinumPremier (PPO)	006
H5215	NetworkCares (PPO SNP)	007
H5215	Network PlatinumSelect (PPO)	008
H5215	Network Health Medicare Go (PPO)	009
H5215	Network Health Medicare Anywhere (PPO)	010
H5215	Network PlatinumChoice (PPO)	011
H5215	Network PlatinumZero (PPO)	012
H1181	NetworkPrime (MSA)	001
H5644	Network Health Medicare Explore (HMO)	002

### Application Tips

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

(APR 12 / 2017 / 11:11)

Permanent Residence Street Address (P.O. Box is not allowed):

1234 JJ 4321 Any Street.

City: Any Town County: Winnebago State: WI



## Submitting an Application via NHP Request Tracker

### NHP Request Tracker Tips

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

#### Commission Questions

- Question on Commissions
- Needing your log in information

#### Customer Service

- Member's balance questions
- Questions on explanation of benefits
- Request new member ID Cards
- Information about other creditable drug coverage
- Request health care concierge to call a member
- Questions on prescription drug coverage

#### Enrollment Application and Changes

- Applications
- Changes

#### Sales Team

- Confirm NetworkCares eligibility
- More sales kits and other supplies
- Request a copy of application
- Request for marketing pieces

## ADDITIONAL INFORMATION

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

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

[illegible]

# NOTES

[illegible]

