# Table of Contents

**Company** .................................................................................................................................... 1

**Appointment** ................................................................................................................................ 4

**Commissions** ............................................................................................................................ 10

**Fully Insured Plans** .................................................................................................................. 12

**Self-Funded Plans** .................................................................................................................... 31
Getting to Know Health Alliance

Our Mission
Our mission is to provide competitive insurance products that maximize value to shareholders, purchasers and members.

Our Vision
Health Alliance will be the leading provider-sponsored health insurer in the Midwest.

Our Values
Our values and Code of Conduct embrace the following core values of Health Alliance:

- Communicate openly and honestly and settle differences respectfully and through appropriate avenues.
- Show Compassion and caring for our members.
- Use Common sense in solving problems on behalf of our members.
- Show Consideration for fellow employees, management and colleagues.
- Cooperate in accommodating requests that are in the best interest of our members and our organization even though it may not always be in an individual employee’s best interest.

Through this Code of Conduct, we can assure that our Members’ Rights are adhered to and that the actions of Health Alliance employees and our participating providers protect these Members’ Rights. Our members have the right to:

- Be treated with respect and recognition of their dignity and right to privacy.
- Reasonable access to health care.
- Participate with practitioners in decision making regarding their care.
- A candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage.
- To receive information about Health Alliance, its services, its practitioners and providers, and members’ right and responsibilities.
- To voice complaints or appeals about Health Alliance or the care provided.
- To make recommendations regarding the Health Alliance Members’ Rights and Responsibilities policies.

Our Commitment to Ethical Practices
We are committed to an environment in which compliance with rules, regulations (state and federal) and sound business practices is woven into the corporate culture. We accept the responsibility to aggressively self-govern and monitor adherence to legal requirements and this Code of Conduct.

We must never sacrifice ethical and compliant behavior in pursuit of business and financial objectives. The mission, values and visions of Health Alliance are pursued with fairness, honesty and integrity.

Health Alliance History
Health Alliance is a provider-sponsored, for-profit health insurance company that offers a wide range of flexible benefit options to fully insured employer groups and individuals throughout Illinois and Iowa and self-funded employers throughout the United States. Health Alliance was founded in 1979 as CarleCare, a not-for-profit health maintenance organization formed by Carle Clinic Association in Urbana, Illinois.

CarleCare enrolled its first members in its only product, a fully insured HMO, in 1980. In February 1988, CarleCare converted to a for-profit corporation and in November 1989, was reorganized as a for-profit domestic stock insurance company owned by a single shareholder, Carle Clinic, and renamed Health Alliance. As such, Health Alliance was able to administer a full range of managed care plans on a fully insured or self-funded basis. Health Alliance began offering Third Party Administrative
(TPA) services later that year. To further diversify its product portfolio, Health Alliance launched a PPO product in 1990, a gated PPO product in 1994, and a POS product in 2000. In 2003, Health Alliance introduced a line of customizable health plans, now called My Health Alliance plans, created specifically for individuals who are not covered by health insurance through an employer plan.

In 1997, Health Alliance received approval from the Health Care Financing Administration (now the Centers for Medicare & Medicaid Services) to sell and administer a Medicare HMO. The first members were enrolled in October 1997. Five years later, Health Alliance unveiled a line of Medicare Supplement plans. Health Alliance launched a Medicare PPO plan in January 2005, and a Stand-Alone Prescription Drug Plan (PDP) in 2011.

Health Alliance implemented a growth strategy in 1994 built on relationships with other large health care provider groups and organizations. Our close ties with provider organizations allow Health Alliance to easily build broad, high-quality networks for our clients.

Today, Health Alliance is one of the largest health insurance organizations in downstate Illinois with a staff of more than 500. Now a part of The Carle Foundation, Health Alliance provides coverage to more than 310,000 people throughout the country and is a national leader in health plan quality and member satisfaction.

A Value-Driven Philosophy

Health Alliance is committed to ensuring that the care delivered to our members is of the highest value. We take our commitment to providing value to our customers very seriously. But saying we are committed to value is not the same as showing you our commitment. That’s why we seek accreditation from the National Committee for Quality Assurance (NCQA).

NCQA is a private, not-for-profit organization dedicated to improving health care quality. For an organization to receive NCQA accreditation, it must adhere to NCQA’s rigorous standards designed to evaluate the health plan in the areas of patient safety, confidentiality, consumer protection, access, service and continuous improvement.

Health Alliance first became NCQA accredited in 1995 and has maintained NCQA’s highest level of accreditation, Excellent, since then, proving year after year that we are deeply committed to providing value to our customers.

What does VALUE mean?
“Value” includes three components: quality, service and cost, in that order. Our NCQA accreditation helps us prove our commitment to quality and service.

Each spring, we visit the offices of Primary Care Physicians to audit the medical records of a randomly selected group of members. This audit is conducted as part of NCQA’s Healthcare Effectiveness Data and Information Set (HEDIS®) to evaluate how our QUALITY of care compares with other health plans nationwide. Our impressive HEDIS scores help us maintain our Excellent accreditation in years when NCQA does not conduct a full audit.

To measure SERVICE, Health Alliance participates in the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), developed by NCQA and the Agency for Healthcare Research and Quality. During this assessment, a random group of our members are asked to rate their ability to obtain information from Health Alliance, the timeliness of services and the speed and accuracy by which Health Alliance processes claims, among other measures. These results are an indication of how well Health Alliance meets our members’ expectations. In fact, in 2011, members gave Health Alliance one of our highest scores ever for “Rating of Health Plan” – 84.9 percent compared to the national average of 62.4 percent!
Our commitment to providing AFFORDABLE plans is exemplified in our initiatives that help contain plan costs by keeping our members healthy. For example, 77.4 percent of our female members received breast cancer screenings and 79.2 percent received cervical cancer screenings in 2011. These results are high because we send annual reminders to women who have not received these important tests in addition to covering the cost for these procedures.

Initiatives like these translate into real savings for the health plan and its customers. After all, the average mammogram only costs $100 and the average Pap test only costs $25–$60, while treating late-stage cancer can result in hundreds of thousands of dollars in treatment expenses.

**AM Best Rating**
Health Alliance annually requests and pays for the AM Best Company to review the company and issue a financial rating of the health plan. AM Best performs a detailed review of the financial condition of Health Alliance, which includes reviews of audited financial statements and statutory filings, along with interviews of key management personnel. Health Alliance believes ratings based upon actual interviews and evaluations are far more valuable than the ratings some firms publish using only statutory filings.

Health Alliance currently has a B++ rating. This rating reflects strong earnings growth, improved capitalization and a competitive expense ratio, which is expected to decrease further as technological improvements continue. Improved operating results are due to a low expense ratio and a decrease in the medical loss ratio, which is the result of disciplined underwriting as well as control over pharmacy and hospital costs.

As part of Carle Foundation, Health Alliance has been given a stable long-term rating of A+ from Standard & Poor’s Ratings Services.
Appointment

Consideration
It is our intent to be agent-friendly and to encourage good, sound business practices using Agents as the preferred distribution method for groups.

Commissions for small groups (50 or fewer eligible employees) will be calculated according to the Commission and Bonus Schedule and will not be negotiated.

For all cases, an in-force agent relationship will be honored if at all possible. If no Agent exists on a new case with fewer than 50 eligible lives, every effort will be made to assign that case to a Health Alliance-approved Agent.

- The agent is eligible to represent Health Alliance on the date a Health Alliance company official signs the Agency Agreement, providing the agent is appropriately and actively licensed in the appropriate state.
- An agent requesting to test for the Life, Accident and Health license will not be eligible to represent Health Alliance until actual notification of successful completion of the test is received.

Quote requests will not be processed nor any commissions paid until an agent has met the above criteria.

Agency Agreements
It is our practice to enter into business contracts with agencies. Any person who meets the Health Alliance criteria as an agent, and who will be representing Health Alliance products to prospective clients, must have met all requirements of the Agency Agreement, have an active license on file with Health Alliance and be listed on the Agency Agreement. The fact that Health Alliance pays commission to an agency does not automatically approve all agents within that agency to solicit on behalf of Health Alliance.

Selection Criteria
Selection and/or qualification of an agent to solicit business for Health Alliance will be based on the following criteria:

- Actively licensed to solicit health products in the appropriate state
- Geographic location
- Market need
- Potential/projections for growth via this agent
- Community standing/reputation
- Other products marketed by the agent
- Percent of agent’s time spent on health insurance-related products
- Compliance with the Health Alliance Agent Contract and Commission Schedule
- Personal interview
- Ability to provide proof of current E&O coverage

Health Alliance reserves the right to refuse appointment of agents in accordance with selection criteria or other business decisions.
Retention Criteria and Cause for Termination
Barring any qualifying misconduct or circumstances, an agent handling existing business with Health Alliance will be **automatically renewed** into the following year, provided the represented groups renew their Health Alliance coverage.

**Agents of Health Alliance are expected to service the account by:**
- Maintaining communication between Health Alliance and the group
- Renewing all contracts and agreements on an annual basis with the group
- Delivering rate renewals when applicable, a minimum of 30 days before the anniversary of the group’s coverage
- Communicating policy and plan design changes
- Encouraging timely payment of premiums (Note: agent will not be paid on a group until currently due premium has been paid to Health Alliance)
- Continuing to solicit new business for Health Alliance

There should be one signed Agent Agreement in the files of Health Alliance. This agreement is sufficient for a period longer than one year, provided the information is still accurate and neither party has chosen to terminate the contract. It is the agent’s responsibility to update files of Health Alliance regarding his/her pertinent contract information.

Commissions are paid monthly for the prior month’s premium received.

Health Alliance considers the following sufficient cause to terminate its relationship with an agent:
- You or your agents violate any insurance law or regulation or state or federal criminal law
- You or your agents fail to notify the company of any change of employment or ownership
- You or your agents fail to promptly remit all premium monies due to Health Alliance
- Loss of the agent’s insurance license
- You or your agents, who employ or are a former Health Alliance employee, accept Agent of Record change status on an existing Health Alliance account or call on an existing Health Alliance account for any reason within a period of one year from the date of termination of employment from Health Alliance

**Protocol for quotes via an Agent**
Health Alliance Medical Plans will accept a quote request from any recognized agent.

Quotes will be subject to Underwriting Guidelines. The proper procedure for processing a quotation request, as outlined in this manual, should be followed.

All agents who are licensed but do not have any business with Health Alliance are strongly encouraged to have a Health Alliance sales representative with them at the presentation to the group.

**Regular Correspondence Between Health Alliance and Agents**
The more information agents have about Health Alliance, the better for all concerned. Health Alliance strives to:
- Routinely send out product updates and pertinent marketing materials to all active Agents of Health Alliance
- Provide Agent manuals and ongoing updates
- Conduct Agent seminars
- Email Agents for quick notification of time-sensitive issues and information
Agents and C.E.U.
It is not the responsibility of Health Alliance to see to, or control, whether an Agent is current with his/her continuing education units as demanded by the state.

Reference to Agent Agreement
Information in this section is meant to supplement the terms of the signed Agent Agreement (sample enclosed in this manual). All terms of the Agent Agreement are intended to be part of the Health Alliance Agent policy referenced in this section.

Agent of Record

Agent/Agency of Record Changes
Using their own letterhead, individuals or groups shall notify Health Alliance in writing of any Agent/Agency of Record change requests. Agent of Record changes will be accepted or denied at the discretion of Health Alliance. Health Alliance will give the current agent 10 business days to contact the individual or group. If the individual or group chooses to rescind the request, they must do so in writing to Health Alliance within the 10 days.

Health Alliance will transfer payment of commissions from the former Agency of Record to the new Agency of Record on the 1st of the month following the date of acceptance by Health Alliance. Retroactive Agent of Record letters will not be honored.

The company will pay commissions at the “schedule” set forth in Schedule “A” on all Agent of Record changes from established Health Alliance direct accounts the first policy year. Receipt by Health Alliance of a new “Agent of Record” designation on a direct account will take effect the first of the month following receipt of such notice and approval by Health Alliance.

If a group were to authorize Health Alliance to release their health information to another agent, they must do so in writing. Health Alliance will notify the group’s current Agent of Record and provide them with copies of all information sent.

Compliance Statement

Our Commitment to Ethical Practices
Health Alliance is committed to maintaining a reputation for excellence by establishing the highest ethical principles and professional standards and ensuring compliance with applicable state and federal laws. These principles and standards apply to our relationships with beneficiaries, providers, employer groups, vendors, consultants, regulatory agencies, brokers and employees.

In support of this commitment, and in conformance with the standards set forth in the U.S. Federal Sentencing Guidelines and the compliance program guidance for Medicare Advantage organizations published by the Office of Inspector General, U.S. Department of Health and Human Services, Health Alliance has established a corporate compliance program. It fosters an environment in which compliance with rules, regulations (state and federal) and sound business practices are woven into the corporate culture. The compliance program focuses on the detection and prevention of violations of federal and state law and promotes reporting of concerns about business practices. There is no retribution for asking questions, raising concerns or reporting possible violations in good faith.
Health Alliance accepts the responsibility to aggressively self-govern and monitor adherence to the requirements of law, the compliance program guide and policies and procedures. Your understanding of this commitment and your willingness to partner with us in adhering to these principles and standards are essential to the well-being of our members and to the success of the business partnership.

Guidelines for Brokers
The following guidelines will help you and your company conduct business in a mutually satisfactory manner and carry out workplace activities within appropriate ethical and legal boundaries.

Brokers are expected to:
- Act with integrity.
- Operate in compliance with all applicable laws and regulations.
- Protect the physical and intellectual property of Health Alliance and any assets entrusted to your care against loss, theft, destruction, misappropriation and misuse.
- Never offer or accept any bribes, kickbacks or inducements in connection with performing duties for Health Alliance.
- Never pursue a business opportunity or relationship that would compromise Health Alliance ethical standards or violate a law or regulation.
- Respect the rights and dignity of our employees and beneficiaries. Health Alliance does not tolerate any form of discrimination, abuse, harassment or intimidation in the workplace.
- Never use for personal gain any information obtained as a business partner of Health Alliance.
- Comply with all relevant government requirements regarding record, document and data retention, including the confidentiality of beneficiary information and other proprietary information.
- Report suspected violation of any law, regulation or policy to the Health Alliance Compliance Officer or through the Health Alliance Compliance Line, listed below. Retaliation against anyone who in good faith reports such violations will not be permitted.

Business Courtesies
The business partnership must be free of inappropriate conflicts of interest. Health Alliance brokers should not give gifts of more than nominal value. Generally, you should not give or accept gifts of more than nominal value (as a rule of thumb no more than $100). Excessive entertainment or other substantial favors should not be provided to current or potential clients. This excludes “door prizes” and other giveaway items received at trade association meetings and conferences.

In addition, Medicare’s marketing guidelines allow only nominal giveaways for prospective enrollees if the value is $15 or less. Gifts of money or cash equivalents are never permissible.

Anti-Kickback Laws
The federal anti-kickback laws prohibit persons or entities from knowingly offering, paying, soliciting or receiving remuneration of any kind to induce the referral of business under a federal program. In addition, most states have laws that prohibit kickbacks and rebates.

Compliance Hotline
Health Alliance has established a telephone hotline and an email address as mechanisms for employees, brokers and other business partners to report suspected violations and compliance issues. The Compliance Line phone number is (217) 383-8304. This method of reporting can be anonymous. The Compliance email address is complianceline@healthalliance.org. Health Alliance does not permit retaliation against anyone who in good faith reports suspected wrongdoing.
Conclusion
Awareness of the Health Alliance compliance program will allow you to maintain our commitment to the highest ethical principles and professional standards and ensure compliance with all applicable laws and regulations. If you have any questions about the Health Alliance compliance program or our guidelines for brokers, please call the Compliance Officer at (217) 337-3497.

HIPAA Privacy

Health Alliance expects all contracted agents to abide by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule as outlined in the agency agreement. This document provides a brief summary of the Privacy requirements.

Protected Health Information (PHI) is defined as all individually identifiable health information transmitted or maintained by a covered entity, regardless of form.

Personal Representative
A Personal Representative is someone who has the authority to act on the behalf of an enrollee. Personal Representatives should be treated the same as an enrollee in relation to disclosing PHI and making requests on behalf of the enrollee. Examples of a Personal Representative:

- Parent of a minor under the age of 18
- Legal guardian or power of attorney
- Executor or administrator of an estate

Be sure to obtain a copy of the legal document declaring representation.

Verification of the Identity and Authority of an Individual Requesting Disclosure of PHI
The identity of an enrollee, as well as individual’s authority to receive the PHI, should be verified prior to disclosing PHI.

Minimum Necessary
Only the minimum necessary information to accomplish the purpose of the use, request or disclosure should be used or disclosed.

Authorization to Use and Disclose PHI
Brokers are permitted to receive an enrollee’s eligibility, enrollment or disenrollment information without first obtaining an authorization from the enrollee. Disclosure of information to outside individuals is only allowed per the agency agreement. Health Alliance requires a HIPAA compliant authorization form to be completed by an enrollee, prior to releasing an enrollee’s claims information to the agent. For additional information call 1-800-965-4022.

An enrollee has the right to revoke an authorization, in writing, at any time, unless Health Alliance has already taken action in regards to the authorization, or the authorization was obtained as a condition of obtaining insurance coverage.

Enrollees Rights:
An enrollee has the right to:

- Access his or her PHI contained in a designated record set
- Amend his or her PHI contained in a designated record set
- Request an accounting of disclosures
- Confidential communication
- Restrict the use or disclosure of his or her PHI
All requests should be forwarded to the Health Alliance Privacy Officer for review. Agreement to a request will be at the discretion of the Health Alliance Privacy Officer. A detailed explanation of member rights of appeal is included in the Privacy Officer letter to the members.

**Complaints**
A complaint from an enrollee regarding the privacy or confidentiality of his or her PHI should be forwarded to the Health Alliance Medicare Services Department.

Suspected breaches of privacy or confidentiality should be reported to the Health Alliance Privacy Officer at 1-800-851-3379, extension 3418.

**Safeguarding PHI**
Contracted agents are required to use reasonable efforts to maintain the security of PHI and to prevent unauthorized use and/or disclosure of such PHI. The following are examples of reasonable efforts to safeguard PHI.

**Paper documents**
- Place documents that contain PHI in lockable file cabinets, storage bins or desk drawers, or use other means to secure PHI during periods when the area is left unattended. Keep PHI out of sight if you do not have access to locked storage.

**Computers and personal digital assistants or similar devices**
- Use a password-protected screensaver.
- Turn off or lock computers when left unattended.
- Do not store any PHI on a hard drive (C: drive).
- Do not maintain an enrollee’s information on a PDA.

**Printers:**
- Do not leave documents containing PHI on a printer overnight.

**Conversations:**
- Conduct phone conversations concerning an enrollee’s claims information or other PHI where you cannot be overheard. For example, avoid discussing private information in public areas such as elevators or restaurants.
- When meeting an enrollee or an enrollee’s Personal Representative in person, meet in a location where you cannot be overheard. For example, do not hold a conversation with an enrollee regarding his or her PHI in the lobby of a building.

**Disposal of paper with PHI:**
- Shred documents that contain PHI prior to disposal or recycling.

**Information carried from one building to another or to a home office:**
- When transporting documents or electronic data storage devices that contain PHI, do not leave documents or storage devices unattended unless they are in a locked vehicle or a locked container (if possible).
Commissions

Schedule A - Standard Agent

Commission and Bonus Schedule Effective January 1, 2012

Note: Within this contract, reference to a “Subscriber” means the employee working for a client group. A “member” means a covered life, and may be an employee, or his/her dependent.

I. Commission Schedule on Group Business - Insured Commercial Group:

Small Groups:

<table>
<thead>
<tr>
<th># Of Subscribers Enrolled</th>
<th>Payment Per Enrolled Subscriber Per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 50</td>
<td>$33.75</td>
</tr>
</tbody>
</table>

Large Groups:

<table>
<thead>
<tr>
<th># Of Subscribers Enrolled</th>
<th>Payment Per Enrolled Subscriber Per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 50</td>
<td>$30.00</td>
</tr>
<tr>
<td>51 – 150</td>
<td>$20.00</td>
</tr>
<tr>
<td>151 – 250</td>
<td>$13.00</td>
</tr>
<tr>
<td>251+</td>
<td>As Negotiated</td>
</tr>
</tbody>
</table>

*Large Group commissions may be negotiated by the Agent with the group, but must be presented and will be paid as a Per Enrolled Subscriber Per Month

II. Commissions for Commercial Group Medicare Coverage:

- Medicare Supplement Plans
  - $15.00 per member per month per paid policy
- Medicare HMO and PPO Products
  - $15.00 per member per month per paid policy
- Stand-Alone Part D
  - $5.00 per member per month per paid policy

III. Commissions for Individual and Medicare Market Products (Insured):

- Individual Market Products
  - $18.00 per member per month per paid policy
- Medicare Supplement Plans
  - $20.50 per member per month per paid policy

IV. Self-Funded Product Commissions

Commissions payable on groups shall be calculated and payable monthly, based on revenue received and processed by Health Alliance on behalf of the stop-loss carrier for the groups’ policy year in accordance with the following schedule:

<table>
<thead>
<tr>
<th>Product Type</th>
<th>Commission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Products with stop loss coverage</td>
<td>Up to 10% of stop-loss premium</td>
</tr>
<tr>
<td>ASO contracts</td>
<td>negotiable</td>
</tr>
</tbody>
</table>
V. Self-Funded Product Retention Bonus Program

Qualifications and Guidelines

1. To qualify for this bonus program, an Agent must have at least three cases and $100,000 in revenue (administrative fees, reinsurance commissions retained by Health Alliance, and any other case-related revenue) as of the starting point of the year (12/31 of the previous Calendar Year). Additionally, the Agent must maintain an equal or greater case count and at least 90% of “beginning” revenue.

2. Individual case revenue is capped at $1,000,000.

3. The bonus program runs from December 31 to December 31.
   a. “Beginning” revenue is calculated by annualizing revenue as of 12/31 of the previous year.
   b. “Ending” revenue is calculated by annualizing revenue as of 12/31 of the current year.

4. The bonus payable is based on achieving both revenue and case count levels:
   a. If revenue is met, but case count level is not, then bonus (if minimum thresholds have been met) is based on the lower case count. **Example**: Agent renews five cases and $100,000 in annualized revenue; a bonus of $3,000 would apply.
   b. If case count level is met, but revenue level is not, then bonus is based on lower revenue level. **Example**: Agent renews 16 cases and $250,000 in annualized revenue; a bonus of $7,500 would apply.

<table>
<thead>
<tr>
<th>Bonus Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Cases</strong></td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>10</td>
</tr>
<tr>
<td>15</td>
</tr>
<tr>
<td>20</td>
</tr>
<tr>
<td>25</td>
</tr>
<tr>
<td>30+</td>
</tr>
</tbody>
</table>

Schedule A

Commission Schedule for Individual and Senior Market Products (Insured)
Effective January 1, 2012

- Individual Market Products
  - $18.00 per member per month per paid policy
- Medicare Supplement Plans
  - $20.50 per member per month per paid policy
Fully Insured Plans

Illinois groups are defined as small (2-50 employees) or large (51+ employees) based on the total number of employees (including part-time employees).

Iowa groups are defined as small (2-50 eligible employees) or large (51+ eligible employees) based on the number of eligible employees.

Group Eligibility Requirements

1. Must submit a copy of the most recent Quarterly Wage & Tax Statement (QWTS) including the following information for all employees of the group:
   a. Names
   b. Employee Status (i.e. full time, part time, seasonal, termed, etc.)
   c. If no QWTS available, submit one from A and one from B:

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>IRS 1040 – Schedule C or F</td>
<td>Articles of Incorporation</td>
</tr>
<tr>
<td>IRS 1065 – Partnership Income</td>
<td>Partnership Agreement</td>
</tr>
<tr>
<td>IRS 2106 – Employer Business Expenses</td>
<td>Current Business, State or Occupation License</td>
</tr>
<tr>
<td>IRS 1120 – Group Income Statement</td>
<td>Affidavits from customers or suppliers</td>
</tr>
<tr>
<td>IRS 941 – Not for profit employer statement</td>
<td>Records of receipts, expenditures, invoices suitable for audit</td>
</tr>
<tr>
<td>IRS 990 – Return of Organization exempt from tax</td>
<td>Leases and other contracts</td>
</tr>
</tbody>
</table>

2. An employer/employee relationship must always exist. One criterion used to confirm this relationship is that the employer withholds Federal and Social Security taxes from the employee’s paycheck.

3. The business must be organized as a sole proprietorship, partnership or corporation. Facilities may include the home office and branch offices if requested.

4. The group must be licensed to operate as a business.

5. The group must be an active ongoing business entity. The operation must be located and transacting business in the same place for at least three months.

6. The business must continually consist of two or more active employees.

Combined/Separate groups – Single employer groups with multiple Tax ID numbers are considered to be one group if:

a. One owner controls at least 51 percent of each separate business
b. Copy of current 1120 S (K-1 form) is provided
c. Copy of QWTS/Payroll records provided

Family Businesses

Special consideration must be given if one family, related by blood or marriage and living in the same household that compensation from the prospective employer is the employee’s main source of earned household, comprises 50 percent or more of a prospective group. The employer also will need to confirm income. Payroll records maintained by the employer should be made available for inspection.
If related employees are living in separate households, the family members may constitute 100 percent of the prospective insured group. Proof may be obtained through copies of the employees’ driver’s licenses or other bona fide means.

The following questions should be asked when screening potential family businesses for coverage:
1. How many employees are related?
2. What are the relationships between the family members?
3. Do they all live in the same household?
4. Is the employer’s compensation their main source of income or do they have other jobs?
5. Do the family members work at least 30 hours per week, 48 weeks per year?

Family members who work fewer than 30 hours per week or who have another primary source of earned income will be declined. Family members who are not shown on the quarterly tax statement should be investigated and may be subject to declination.

Groups comprised solely of husband and wife, with no other employees, are not eligible for coverage unless both husband and wife can demonstrate employment.

**Employee Requirements**

1. All of the following requirements must be met for employees to be considered eligible:
   a. Actively at work in their normal work location on a full-time basis at least 30 hours per week, 48 weeks per year, and who is compensated on a salaried or hourly basis.
   b. Must have completed the established waiting period under the employer’s plan of coverage.
   c. Must be included on the employer’s payroll for Social Security and Federal Income Tax Withholding.

2. Ineligible Employees include:
   a. People such as directors, stockholders, partners, advisors or consultants who are not working as described in the previous section.
   b. Temporary or seasonal employees.
   c. Part-time employees who work less than 30 hours per week.
   d. Individuals who do not live within daily commuting distance from their normal place of business.
   e. Individuals without a verifiable W-2 employer/employee relationship whose sole income is based on commissions.

3. Husband and Wife Employees:
   a. If a husband and wife both qualify as eligible employees, one spouse may elect to take Dependent Coverage or to be covered separately. If covered separately, the children may be considered the dependents of either employee. A two-life group consisting solely of husband and wife is not eligible for coverage unless husband and wife are both employees.

**Dependent Requirements**

1. Eligible dependents include any of the following as defined by the employer:
   a. An insured’s legally married spouse or domestic partner who is not legally separated from the employee.
      i. Common Law Spouse: If the State that the employee lives in considers the common law spouse to be a legal dependent, then they are eligible to apply for coverage.
   b. Any child (natural-born or legally adopted).
   c. A child for whom the employee is the court-appointed legal guardian.
   d. A stepchild who lives with the employee at least 50 percent of the year and is dependent on the employee for support.
e. A child placed for adoption for whom the employee assumes total or partial support in anticipation of an adoption.

f. Each unmarried child age 26 or older who is incapable of sustaining employment because of mental retardation or permanent and total physical handicap. The dependent must be primarily dependent upon the covered employee for support and maintenance. The dependent must have been incapacitated before his or her 26th birthday while covered under the plan and has been continuously incapacitated since his or her 26th birthday.

**June 1, 2009 and after:** A dependent who is an Illinois Veteran who received a release or discharge other than dishonorable is eligible for coverage until age 30.

2. Ineligible dependents are any of the following:
   a. A legally separated spouse or unless otherwise ordered by the court
   b. A parent or grandparent of the employee or employee’s spouse
   c. A member of the active armed forces
   d. A grandchild of the employee
   e. A cousin, niece or nephew of the employee or employee’s spouse
   f. A foster child

**Evaluating the Employer Unit for Eligibility**

1. **Industry Classification**

   Standard Industrial Classification (SIC) Codes are codes used to differentiate levels of risk inherent in businesses with certain characteristics. In 1997, the North American Industry Classification System (NAICS) officially replaced the U.S. Standard Industrial Classification (SIC) System.

   To link to a table correlating SIC code numbers to NAICS codes, go to: www.census.gov/epcd/www/naicstab.htm

   Businesses with characteristics as listed below may be ineligible to apply for coverage:
   - Seasonal in nature
   - In operation less than three months
   - Composed solely of husband and wife unless both husband and wife are employees
   - Fewer than two full-time employees
   - Whose work is done primarily in the home

   Activities of some industries create special hazards or are seasonal in nature and cannot be included in the underwriting of group coverage under this Plan. Certain industries require additional premium to cover the risk.

2. **Census Characteristics**
   a. List name, age/date of birth, gender, dependent status, residence zip for all employees (including COBRA)
   b. If 50 percent or more of the employees within a proposed group are related by blood or marriage, the employer must certify that the family members are employees of the business
Ineligible Groups
• Businesses that are in operation less than three months.
• Businesses operated out of the home. (This requirement may be waived under special circumstances.)
• A two-life group comprised solely of a husband and wife with no other employees unless both husband and wife are employees, and can be demonstrated through documentation.
• Any business that is undergoing bankruptcy or under a Chapter XI reorganization.
• Any business that has been established as an association, co-op, union, fraternal organization, volunteer organization or where there is not an employer/employee relationship or is formed solely for the purpose of getting insurance.
• Businesses that have more than 50 percent of their subscribers residing outside of the Health Alliance service area.

Health Alliance as option to another carrier – 51 + over
• All eligible employees must either enroll with Health Alliance, an alternate carrier or waive coverage.
• Minimum participation of 10 subscribers or 25 percent.
• Health Alliance rating tiers and employer contribution must match the rating tiers and employer contribution strategy for all other options offered to the group.
• Health Alliance premium rates should be within +/- 25 percent of all alternate carriers offered to the group.
• Benefit designs, including limitations, exclusions and prescription drug coverage, should be substantially similar across all carriers. The Health Alliance Underwriting Department will review plan designs to determine if this criteria is met.
• Health Alliance reserves the right to non-renew or terminate based upon the following criteria: 1) Membership retention falls below 75 percent of pre-renewal enrollment. 2) Employee contribution exceeds 15 percent.

Rating Tiers
I. Groups with 2-50 employees (Small Groups)
• Groups of 2-20 enrollees (age/gender rates)
  1. Age-band rated with risk pool tiering.
  2. List-billed for each enrollee depending on employee age at start of group contract.
• Groups of 21 + enrollees (tiered rates)
  1. Age-band or four-tier rated with risk pool tiering (Employee, Employee/Spouse, Employee/Children, Family).
  2. Group/broker may request two-tier, three-tier, or four-tier rates to match current carrier.
  3. Billed a fixed rate for the entire contract year.
• Group will be determined as either list-billed or fixed-rate billed at time of initial enrollment. Group will continue to be list-billed until having 21 or more subscribers at renewal. Group will continue to be fixed-rate billed until having 15 or fewer subscribers at renewal.

Rating Methodology
• Groups with 2-50 employees: Community rated by class using age, gender, family composition and service area. Rating for both new groups and renewals includes application of risk pool tier factors based on health questionnaires and prior claims experience.
II. Groups with 51 or more employees (Large Groups)

• Group may be rated on a two-tier, three-tier or four-tier structure.
• If offered as an option, the Health Alliance rate structure must match all other carriers.

Rating Methodology
• Groups with 51 or more employees: Community rated by class using age, gender, family composition and service area. Rating for both new groups and renewals may include adjustments for prior claims experience. Health Alliance has the option of declining to quote a group in the 51 + market.

Note: Illinois groups are defined as small or large based on the total number of employees (including part-time, seasonal and excluded class employees.)

Iowa groups are defined as small or large based on the number of eligible employees.

See page 13 for a definition of eligible employees.
Employer Application

**General Information on the Form**
A completed Employer Application represents a formal request made by an employer to participate in the proposed plan. Contained within the body of the Application are the specific coverages requested by the employer. Therefore, it is very important that all the following areas be properly completed and signed in the proper places.

All changes or additions to the Employer Application must be initialed and dated by the employer. The Employer Application must be signed and dated by the owner or an officer of the business.

**Requested Effective Date**
The requested effective date should be the first day of a month. Exceptions for small groups for 15th of the month effective date may be made with prior approval of Health Alliance. The initial premium will be prorated with subsequent billing statements generated on the regular billing cycle.

All application material must be signed and received before the requested effective date.

**Business Name and Address**
1. Groups whose business address is the same as the owner’s residence address may be suspect. Health Alliance will request documentation that shows a legitimate business exists. A combination of the following documents may be used to support eligibility:
   a. Form 1040 with attached W2 and all applicable schedules
   b. Form 1065 (U.S. Income Tax Return for partnerships)
   c. Form 1099 (U.S. Income Tax Form for miscellaneous income)
   d. Form 1120 (U.S. Income Tax Return for corporations)
   e. Form 112S (U.S. Income Tax Return for Sub Chapter S Corporation)
   f. Corporate quarterly tax statements
   g. Forms reporting unemployment compensation tax paid to the state
   h. Payroll records
   i. Agreement of sale
   j. Articles of Incorporation or business License
2. Acronyms are not an acceptable form of the employer’s name.
3. A post office box number is not an acceptable business address for the employer.

**Year Business Started**
To be eligible, a firm must have been operational for at least three months.

**Number of Full-Time Employees**
The total number of full-time employees, whether or not they are in an eligible classification, should be entered on the Employer Application.

**Number of Part-Time Employees**
The total number of part-time employees should be entered on the Employer Application.

**Classes Not Eligible**
1. The exclusion of certain classes of people, such as union employees, is permissible. The important factor is that exclusion be accomplished in a non-discriminatory manner not a “carve-out” (i.e., loyal employees vs. all salary or all hourly employees) manner. Certain classes of people that are normally considered eligible cannot be excluded.
2. The number of employees in each excluded class should be entered on the Employer Application with a description of the excluded class.
   a. Note: The number of eligible employees should be the difference between the number of full-time employees on the payroll and the number of employees within the ineligible classes. Either an Evidence of Insurability form or Waiver of Insurance form should be received for each eligible employee.

**Employer Contribution**
The employer must pay a required minimum percentage of the total premium to be eligible for coverage. The percentage paid by the employer is necessary to determine whether the plan is contributory or non-contributory for participation requirements. Refer to the “Contribution Requirements” section on page 19.

**Waiting Period**
1. Current Employees
   a. The employer may select a waiting period from zero to six months for current employees who are actively employed at the time the coverage takes effect. All current employees must have the same waiting period.
2. Future Employees
   a. The employer may select a waiting period from one to six months for all future employees. All future employees must have the same waiting period.

Waiting periods for future employees may be changed upon receipt of a written request from the employer at renewal time period. The new waiting period will be effective at the renewal month. The new waiting period will apply only to employees hired after the date of the change.

**Prior Carrier Coverage**
The employer must provide a copy of the prior plan’s billing statement.

Review of the prior plan’s final billing statement should determine if all eligible employees listed on the prior plan’s billing have submitted an Evidence of Insurability form or a Waiver of Insurance form.

**Deductible Credit and Deductible Carryover**

**Deductible Credit** is the total amount of deductible paid by the member under the former carrier’s coverage that is credited toward satisfaction of the deductible under the new coverage.

Health Alliance will allow the following regarding deductible credit:
- Contract year to contract year with no change in effective date. No rate change since no credit will be allowed.
- Contract year to contract year with a change in effective date. Rates will change based on how many months of credit occur.
- Calendar year to calendar year with no rate change.
- Contract year to calendar year or calendar year to contract year. Rates may change based on how many months of credit occur.
**Deductible Carryover** is the amount paid by a member toward satisfaction of a deductible during the last three consecutive months of a calendar year that is applied toward satisfying the deductible for the following calendar year. Deductible carryover is only applied at the group’s renewal.

Health Alliance will allow deductible carryover on either a calendar year or a contract year basis.

Note: New groups who would like deductible credit must request it prior to receiving final rates.

Health Alliance’s standard practice is to include deductible carryover upon renewal of all plans, with the exception of HSA/HRA compatible plans. If a group elects an HSA/HRA compatible plan, Health Alliance will allow deductible credit and/or deductible carryover if requested prior to receiving final rates; however, it will be the responsibility of the group to ensure that the maximum amount of credit or carryover would not potentially disqualify their plan from participation in these savings arrangements.

**Contribution Requirements (All Groups, Regardless of Size)**

**Employer/Employee Contributions and Effect on Participation Levels**
The employer must contribute a minimum of 50 percent of the employee-only premium. An employer’s willingness to contribute a significant amount shows the employer’s true interest in establishing a long-term medical coverage program for its employees.

**Waivers**
Eligible employees who must pay part of the cost of their coverage have the option of waiving coverage. The group is still required to comply with participation requirements. Individual coverage does not count as a valid waiver. See [page 20](#) for valid reasons for waiving coverage.
Participation Requirements

Contributory Plans
If the employer pays part, but not all, of the premium for employees, the plan is considered contributory. Contributory plans that are sole source require the satisfaction of both the 50% rule and the 75% rule below. If not sole source (51+ employees), then the 25% rule must be applied. If the participation requirements for a contributory plan are not satisfied, the entire case will be declined.

50% Rule – Sole Source
50% of eligible employees (see page 13) are required to take coverage.

75% Rule – Sole Source (If you’ve satisfied the 50% rule)
75% of eligible employees, less valid waivers (see below) must take coverage.

Special 75% rule circumstances:

<table>
<thead>
<tr>
<th>Eligible Employees</th>
<th>Required Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-3</td>
<td>all</td>
</tr>
<tr>
<td>4-5</td>
<td>all less 1 valid waiver</td>
</tr>
<tr>
<td>6+</td>
<td>75% (eligibles minus valid waivers)</td>
</tr>
</tbody>
</table>

25% Rule – Dual Carrier
25% of eligible employees (see page 13) are required to take coverage.

Valid Reasons for Waiving Coverage:
- The employee is covered under his/her spouse’s group insurance plan sponsored by another employer.
- The employee is covered under CHAMPUS or CHAMPVA, Military, Medicare/Medicaid or Association Coverage (doctors/lawyers covered under an association that covers employees.)

The fully completed Group Application/Change form with reason for waiving marked must be submitted for all employees or for dependents whose coverage is waived.

Dependent Participation
The employee must be covered under the plan of coverage selected by his or her employer to elect coverage for his or her eligible dependents.

Eligibility Dates

Employee Eligibility Dates
Employees shall become eligible for coverage according to the following guidelines:
1. Current Employees
   a. Each employee, actively employed on or before the group’s original effective date, will be eligible for coverage on the group’s effective date. If the employer elects a waiting period for current employees, the employee will become eligible for coverage after satisfaction of the waiting period.
2. New Employees
   a. New employees must complete an application if they wish to apply for coverage under the plan. New employees are eligible to apply for coverage effective on the first day of the month following completion of the established waiting period. This date is considered the eligibility date. Coverage is always subject to approval as stated below.

3. If an employee is not actively at work on the date the coverage would have otherwise become effective, coverage will not become effective until the day that he or she returns to active, full-time work.

**Dependent Eligibility Dates**

Dependents are eligible for coverage according to the following guidelines:

1. Original Dependents
   a. On the date the current employee or newly hired employee becomes eligible for coverage, any existing dependents of the employee also will become eligible. If the employee initially waives coverage for dependents and wishes to add the spouse and/or child at a later date, the dependent is considered a late applicant and will be deferred to the next plan anniversary unless they experience a special enrollment opportunity.

2. Newly Acquired Dependents (other than newborns)
   a. When adding an eligible dependent (spouse and/or child other than a newborn child) to existing coverage, only the demographic portion of the medical application needs to be completed, in addition to a Notice of Termination or Change form. These forms must be received within 31 days from the date of dependent acquisition (i.e., date of marriage or legal adoption). If approved, coverage will become effective on the date of acquisition of the dependent.
   b. If these forms are received after 31 days, the dependent is considered a late applicant and will be deferred to the next plan anniversary month.

3. Newborn Children
   a. If you are paying premiums for individual coverage, your newborn is covered only if you submit an application form to Health Alliance within 31 days of the birth. If you are paying premiums for Family coverage, your newborn child is automatically covered for the first 31 days after birth. If payment of an additional premium is required, coverage after 31 days is contingent upon the submission of a completed application form within 31 days following the birth. For a newborn child to continue to be covered, only the demographic portion of the medical application needs to be completed in addition to a Change form. These forms must be completed and received within 31 days from the date of birth. If completed within the 31-day period after birth, the child will automatically be approved for coverage.
   b. If coverage is applied for after 31 days from the date of birth, the newborn is considered a late applicant and will be deferred to the next plan anniversary month.

**Open Enrollment**

- Groups with 2-50 employees: may be conducted annually at renewal.
- Groups with 51 or more employees: conducted annually as determined by the group (usually at renewal)
Employee Application

**General Information**
Health Alliance requires information pertaining to eligibility, benefits, and health to be obtained directly from the applicant.

a. The application forms must be completed by the applicant in their entirety. The applicant must sign and date all applicable sections.

b. Employee Applications must be completed in ink (preferably black). If completed in pencil, request new forms to be completed in ink.

c. Late applicants are employees who fail to apply for coverage for themselves and/or their eligible dependents within the thirty-one day period immediately following their eligibility date. A pre-existing condition limitation period may apply.

**Medical Questions**
All medical questions must be answered for all new small and large group accounts, as mandated by Health Alliance Underwriting. This is the most crucial part of the underwriting process. It is imperative that all questions answered “yes” be explained fully and understood by the underwriter. The diagnosis or nature of illness provided by the applicant should be specific enough for the underwriter to calculate debits accurately. The applicant must always provide the onset date, treatment provided, and degree of recovery.

Specific details of treatment are required, including actual names of medications, (e.g., a response of “antibiotic” is not sufficient). The degree of recovery must also be specific, such as 100 percent or complete. An answer of “normal” is not sufficient. “Normal” is a subjective term and must be clarified by the applicant. If high blood pressure is indicated, three blood pressure readings must be given—two within the last year and one within the last month.

If the Employee Application does not provide enough information to evaluate the risk, additional medical information should be requested from the employee.

**Appeals**
The broker or employer may appeal the underwriting decision. Any request for reconsideration must be made in writing and should include additional medical facts to support the appeal. An Attending Physician’s Statement (APS) may be submitted at the expense of the employer or employee. However, receipt of an APS does not guarantee acceptance. All pertinent information should be forwarded to the underwriter for review.

**Withdrawal of Application**
An employer may change his or her mind and request that the application for coverage be withdrawn. This request can come in writing or via the phone from the employer or the agent.

**Waiver of Group Coverage**
If the group can satisfy all participation requirements, the employee or dependent can waive health coverage for valid reasons. If health coverage is waived, a valid reason for declining coverage is always required. See page 20 for valid reasons to waive coverage.

Signing and dating the Waiver of Group Coverage section of the Group Application/Change Form documents that the coverage was offered to the applicant. Completion of this section may eliminate any future questions and protect the employer, the administrator and the carrier from possible liability.
Conversion of Coverage
Health Alliance HMO Conversion Plan – HMO & POS Members
A member may be eligible for the Health Alliance HMO Individual Conversion Plan if one of the following qualifying events occur:
• Cancellation of eligibility for coverage under the group policy
• Cancellation of the Group Enrollment Agreement
• Non-renewal of the Group Enrollment Agreement

To convert coverage, the member must submit a completed group application form and applicable premium payment to Health Alliance within 31 days after the date coverage under this Certificate is terminated.

Coverage under Health Alliance HMO Conversion Plan will not be available if one or more of the following occur:
• Cancellation of coverage under Group plan for failure to make timely premium payments; for fraud or material misrepresentation in enrollment or in the use of services or facilities; or for material violation of the terms of this Certificate.
• The member has not been continuously covered under this Certificate during the three months prior to the termination date.
• The member is covered by any other insured or uninsured plan, which provides hospital, surgical or medical coverage.
• The member is covered by or entitled to Medicare.
• The member has moved outside of the Service Area.
• The Group Enrollment Agreement has been terminated in its entirety, and there is a succeeding carrier providing coverage to the Group in its entirety.

Benefits under the Conversion plan will be terminated upon any of the following:
• You fail to make timely payments.
• You become eligible under another health plan or become entitled to Medicare.
• You move outside the Service Area.

Comprehensive Health Insurance Plan – HMO, POS & PPO Members
A member who is losing coverage under this Certificate may be eligible to convert coverage to the CHIP-HIPAA Plan, which is a comprehensive medical benefit plan offered under Section 15 of the Illinois Comprehensive Health Insurance Plan (CHIP) Act. This plan is available only to federally eligible individuals who qualify. For more information on the CHIP-HIPAA Plan, call 1-800-962-8384. If a member enrolls in a Health Alliance individual plan, he or she will lose eligibility to enroll under the CHIP-HIPAA plan.
Retirees may be covered in one of the following ways:

- Retired employees and their spouses who are 65 or older or disabled 65 or older who are eligible for Medicare may be covered on an employer-sponsored group health plan. Medicare is primary and the group health plan coverage pays secondary to Medicare.
- A Medicare supplement policy can be purchased from Health Alliance, which will pay secondary to Medicare up to the limits of the supplement policy. Health Alliance offers group Plans A, F and N. Employer groups may not modify the Medicare Supplement benefits.
- Retirees may enroll in a Medicare Advantage group plan. These plans are available with and without the Medicare Part D benefit. Applicants must be enrolled in Medicare Parts A & B (and Part D if applicable). Employer groups may modify the standard benefits for retirees and the premium rate will then be adjusted accordingly.

Non-certified Medicare agents must involve a certified Health Alliance account executive or client consultant during sale, renewal and implementation of a Medicare group.
Requesting a Quote for Fully Insured Plans (Information Needed)

Small Groups (submit via email to quotes@healthalliance.org):

1. Initial Rates
   a. Group name
   b. Broker’s name and agency name. If a name is not given or the name given is not commercially preferred with Health Alliance Medical Plans, the group will be assigned to a Health Alliance sales representative. If only an agency name is given, the group will be assigned to the main contact for the agency.
   c. Effective date. If a date is not given, the effective date will be assigned based on the coordinator’s discretion. Effective dates move into the next month on the 20th of the month (e.g. from July 20 until the last day of July, quotes are given for September 1).
   d. Group’s city, state and zip code. If the quote is for a carve-out, the city, state and zip code of the location applying for health insurance is needed. Please note that there must be an employee with the authority to legally bind the company at that facility.
   e. Age or date of birth, gender, dependent status and residential zip code for all employees applying for coverage. This includes Medicare, COBRA, disability and spousal continuation status coverage.

2. Preliminary Rates
   a. Quote request including medical history data. This can be a quick note written on the quote request, an email or it can be based on a Health Alliance or a competitor’s application.

3. Final Rates
   a. Health Alliance employee applications completed and signed by all eligible employees for both employee and dependent coverage or waiver forms where necessary. (Applications are valid for 60 days from the date originally signed by the applicant.)
   b. Completed Employer Application including the Exhibit B.
   c. Copy of the most recent Quarterly Tax and Wage Statement including employee names and status.

Large Groups (submit to your Client Consultant):

1. Initial Rates
   a. Group name
   b. Broker’s name and agency name. If a name is not given or the name given is not commercially preferred with Health Alliance Medical Plans, the group will be assigned to a Health Alliance sales representative. If only an agency name is given, the group will be assigned to the main contact for the agency.
   c. Effective date. If a date is not given, the effective date will be assigned based on the coordinator’s discretion. Effective dates move into the next month on the 20th of the month (e.g. from July 20 until the last day of July, quotes are given for September 1).
   d. Group’s city, state and zip code. If the quote is for a carve-out, the city, state and zip code of the location applying for health insurance is needed. Please note that there must be an employee with the authority to legally bind the company at that facility.
   e. Age or date of birth, gender, dependent status and residential zip code for all employees applying for coverage. This includes Medicare, COBRA, disability and spousal continuation status coverage.
2. Final Rates (submit one of these forms of information):
   a. Claims Experience – two years of paid claims (including claims over $25,000 with diagnosis and prognosis) and covered lives, along with covered benefits for reported period. If employer wants current rate structure and relationship, also need current and preferably renewal rates.
   b. Health Applications – completed individual health applications for every eligible employee and their dependents using our small group application forms.
   c. Risk Appraisal Questionnaire (RAQ) – completed RAQ, which includes current and renewal benefits and rates, along with general health information to be completed by the employee benefit manager or responsible member of management for large groups.

Additional information needed for a quote request:
1. Current/historical funding mechanism
2. Known ongoing medical conditions
3. Carrier history

Underwriting has the option to accept the case, revise the rates (up or down) or decide to pull the quote based on information disclosed. Under Health Care Reform regulations, Health Alliance reserves the right to rescind a policy based on fraud or misrepresentation.

Quote Guidelines

Sharing of Information
No information or strategy received from one agent will be used for a quote prepared for another agent unless specifically requested by a prospective client in writing. (Exception: Health information that increases the assessed risk of a case will be required of all agents prior to the release of a quote.)

Expiration of Quotes
• A quote is valid through the quoted date.
• Groups that are “pre-screened” are done so as an estimate only, unless Health Alliance applications are used and all employees complete and sign the applications.

Statute of Limitations of Quotes
Information sent to Health Alliance will become Health Alliance property and can be used as Health Alliance deems fitting. Information used after one year does not have to be credited to the original source. However, if possible to reward the original source, all attempts to do so will be made.

Benefit Choice
For fully insured groups, Health Alliance will allow the employer to select two benefit plan designs. Dependents must be on the same plan. The premium rate difference on the two plans selected must not exceed 25 percent. For HDHP and HSA-compatible plans, the premium rate differential can be no more than 50 percent. Health Alliance must be sole source and renewals will be based on blended experience.
Illinois
The Small Employer Health Insurance Rating Act

Background
The Small Employer Health Insurance Rating Act (215 ILCS 93) was signed into law in 1999 to improve the “efficiency and fairness of the small group health insurance marketplace” by reducing the magnitude of increases charged to small employer groups when one or more of their members develop a costly medical condition. Costly medical conditions can cause small employers to increase the employees’ share of the premium costs, reduce health insurance coverage or drop health insurance coverage altogether. Reducing the magnitude of such premium increases benefits both the small employer and the employees (and their dependents).

To help control costs, the Act restricts the range of rates, which can be charged to groups that have similar policy coverages and demographic, geographic, or other objective group characteristics. It also restricts the amount by which small group carriers can increase rates for a particular group due to its claims experience. Although there are no specific numerical caps on premium rates or premium increases, the overall effect of the Act is to compress the range of rates and rate increases that can be charged for all small employer groups of a particular class.

Applicability
1. The Act applies only to health benefit plans for small employers. A small employer is defined as one that employs an average of 2 to 50 employees during the preceding calendar year. The exact definition is found in the Illinois Health Insurance Portability and Accountability Act (215 ILCS 97/5). The Act does not cover individual health insurance policies or groups of one.

2. This Act applies to all benefit plans provided to Illinois employers regardless of the state in which the contract is issued. This interpretation is based on a recent Department of Insurance review of public policy considerations and case law as applied to the rating of out-of-state health insurance contracts.

3. The Act applies to each plan that is delivered, issued for delivery, renewed, or continued in Illinois after July 1, 2000.

Rating Provision Examples
The rating provisions revolve around several key terms: Class, Index Rate, and Rating Period. The provisions: restrict the amount by which premiums for similar groups with similar coverages can differ; compress the range of rates for all groups in all classes; and limit the period to period change in rates. Rating provisions do not establish any specific caps on the rates or rate increases. The provisions are summarized below.

1. The Act allows an insurer to categorize its small employer groups according to expected substantial differences in administrative costs or claims experience, if these differences are due to: a) multiple marketing systems; b) the groups being acquired from another insurer; or c) the insurer having marketing arrangements with multiple association groups. Each one of these categories constitutes a class. The Act allows a maximum of four classes. The Director has the authority to allow an insurer to set up more classes under certain circumstances.
In general, companies will use one rate manual for each class of business in order to comply with the Act. Once established, small employer groups cannot be involuntarily shifted from one class to another.

2. The Act uses the Index Rate as the key mechanism for compressing the range of rates. For small employer groups in a particular class which have similar demographic, geographic, or other objective characteristics and similar coverages in their health benefit plans, the index rate is the arithmetic average of the lowest rate which is charged (or could be charged according to the rate manual) and the corresponding highest rate which is charged or could be charged. (The number of index rates for a particular class depends upon how it defines “similar” in the two contexts in which it is used.)

For each cluster of groups for which an index rate is calculated, the Act establishes that (A) the rates for any particular group cannot be more than 25% above or below the index rate. This is the **intra-class restriction** on rates.

When all index rates from all classes are considered, the Act requires that (B) any index rate cannot vary from any other index rate by more than 20%. This is the **inter-class restriction** on premium rates.

**HIPAA Requirements**

The Illinois Health Insurance Portability and Accountability Act (HIPAA)(215 ILCS 97) establishes underwriting and portability requirements for policies issued to small employers. The Act requires insurers to guarantee the issuance of any policy sold in the small employer market to any small employer group in the state (i.e. each health insurance carrier that offers health insurance coverage in the small group market must accept every small employer in the state that applies for such coverage). Exceptions to this guarantee apply if you do not meet the definition of a small employer as defined by the Act, or if you do not meet the minimum participation requirements as established by the insurer or HMO. **Therefore, insurers and HMOs who market to small employers may not refuse you coverage and are limited by the parameters of the Small Employer Health Insurance Rating Act in establishing premiums.**

**Sold Group Implementation**

**Agent/Consultant Responsibilities**

**Securing Coverage**

Applications for all employees must be completely filled out. The Employer Application must be completed prior to the requested effective date. For small groups, a copy of the group’s tax and wage report and a check in the amount of the first month’s premium must be included.

**Plan Design**

The acceptance letter will indicate the plan design and must be signed. The rate sheet must have the rates circled and initialed and be attached to the acceptance letter.

**Employee Meetings**

The broker and account executive should develop a schedule of employee meetings prior to the effective date.
Items Needed by Health Alliance
The following must be completed, signed and returned to Health Alliance:
• Group-appropriate Health Alliance Employer application (2-50 employees or 51+ employees)
• Health Alliance employee application (2-50 employees or 51+ employees) must be signed and dated not more than 60 days prior to the group’s effective date
• Premium rate sheet with appropriate effective date and acceptance letter indicating plan design
• COBRA Service Contract (if applicable)
• Binder check (Small Group only)

Management of Your In-Force Group

Group Name Change or Ownership Change Checklist
Submit all required documentation to your Client Consultant.

Group Ownership Change (with Tax ID change)
• Employer group application
• Group eligibility requirements
• New employee applications (will not need if their membership is not changing)
• Tax & wage form (if changing owners then list of all employees from new owners, indicating which are full-time or part-time.
• W-9

Group Name Change
• W-9

Mid-Year Plan Changes
To establish guidelines for mid-year plan changes in conjunction with the Illinois mandated law, ILLINOIS ADMINISTRATIVE CODE TITLE INSURANCE Chapter 1 Department of Financial and Professional Regulation Subchapter z ACCIDENT AND HEALTH INSURANCE part 2025 Health Insurance Portability and Accountability Standards 50 Ill. Adm. Code 2025.50.

Health Alliance will not allow groups to make mid-year benefit changes per the above referenced regulation, this includes description of coverage plan summary changes. All benefit changes must occur within 30 days of the group renewal date or sale effective date, with the exception of rate changes and eligibility changes. Health Alliance has made a business decision that this will also apply to Iowa groups.

If the group insists on a change to their description of coverage plan summary than the group will be re-written as a new group, with a new group number, and would have a new renewal month effective when the changes occurred. Members would receive all new materials (policy, amendments, riders, id card, etc.) and the group would be required to sign a new GEA, Exhibit C and Exhibit B. Please note that if a group is currently on a grandfathered plan and they elect to make this change they will lose their grandfathered status.

Rate changes mid-year are allowed for small and large groups.

Eligibility changes mid-year are allowed for large groups. As a general rule we do not allow small group eligibility changes mid-year, however we will be flexible and make exceptions with approval as needed. Any eligibility changes occurring mid-year must apply to the entire group.
Under specific circumstances changes would be allowed with approval from the Marketing Director or Marketing Manager of Client Development.

**Terminating the Group Plan**

A group contract can be terminated for the following reasons:

- Minimum enrollment requirements not maintained. Conversion policies will be offered to employees. Groups with one subscriber will be sent a termination letter and will be terminated if participation is not met.
- Non-payment of premium. A group that fails to remit the premium prior to the expiration of the applicable grace period will be terminated. Conversion policies will not be offered to employees.
- Employer goes out of business. A group whose originating organization goes out of business will have its group arrangements terminated as of the paid-to-date, provided Health Alliance was promptly notified. Conversion policies will be offered to employees.
- Employer requests termination. A group must request termination in writing. Failure to notify Health Alliance in writing in accordance with the contract will result in the group being liable for premiums covering the grace period. Conversion policies will be offered to employees if other group coverage is not made available.

**Re-enrollment of Groups**

- Group initiated cancellation: six-month waiting period for re-enrollment.
- Health Alliance initiated cancellation: 12-month waiting period for re-enrollment.
Self-Funded Plans

Administrative Services Organization/Third Party Administrator
We are able to provide claims, pharmacy and medical management administration under one roof, eliminating the need for multiple vendors. All data are accessible for the appropriate staff, which includes eligibility, claim detail, customer service documentation, medical management documentation and pharmacy programs.

We offer an array of programs to reduce costs without compromising quality or service. These programs include case management, preauthorization for select procedures, a value-driven formulary, select drug preauthorization, Be Well (our collection of wellness programs) and innovative pharmacy programs. All of this is done in a transparent environment with extensive communication to reinforce value to plan participants.

Self-Funded Request For Proposal (RFP)
Please submit to your Account Executive.

Pre-Submission RFP Questions
To provide a competitive proposal, Health Alliance/HCH needs the history of the potential group and their goals, including the following items:
• How long have they been with their current TPA or carrier?
• When was the last time the group obtained TPA bids?
• If they were out to bid last year, did they move to a new TPA or carrier? Why are they seeking bids again this year?
• Who is the current broker/consultant?
• What is your relationship with the prospective group?
• What services are they looking for that they are not currently receiving?
• What are their primary areas of concern? This could include service, turnaround, medical management programs, reporting, etc.
Submission of RFP
All requests for proposals should be faxed, mailed or emailed to the appropriate account executive with timeline expectations and response instructions. All submissions should include the following information:

- Complete name, address and phone number of group
- SIC code or type of industry
- Proposed effective date
- Complete current census which should include the following information (prefer in Excel format if possible)
  - Employee’s date of birth or age
  - Gender
  - Coverage elected (single, employee+spouse, employee+child(ren), family, etc.)
  - Zip codes (based on employee’s home address)
  - Identification if active, retired, COBRA, disabled
  - If multiple plans offered, indicator of which plan employee is under
- Complete claims experience for the past two years and for the current year which should include the following:
  - Total paid claims by month split between medical, dental and vision, if applicable
  - Total number of covered employees by month (if possible, split between employee only and family)
  - Large Claim report (claimants with claims exceeding $10,000 paid in plan year), including the following information:
    - Gender
    - Relationship – employee, spouse, child
    - Patient’s date of birth
    - Diagnosis
    - Prognosis
    - Last date of hospitalization
    - Status, such as active, retiree, COBRA or disabled
  - Listing of any potential large claimants, such as transplants, scheduled surgeries or hospital admissions
- Copy of current plan design
- Indication of any expected plan design changes
- Current network in place, including the cost associated with the network
- Stoploss/reinsurance information:
  - Current premium rates and renewal (if available)
  - Current specific deductible and proposed deductible amounts
  - Coverage type; specific only or specific and aggregate; aggregating specific; etc.
  - Expenses to be covered under specific and/or aggregate – medical only, medical and pharmacy
  - Contract type: 15/12, 12/12, 12/15, etc.
  - Any current lasers (amount of deductible and which large claimant it applies to)
Finalize Stoploss Quotes

Contingencies
The majority of stoploss quotes will be released with a list of contingencies. This list must be carefully reviewed with the potential client to make them aware of what could impact the rates. Any outstanding information must be provided to the stoploss carrier to finalize the quotes. Most carriers will require current paid claims information within two months of the proposed effective date. They may also require large case management notes on specific individuals that will provide detailed information on the diagnoses, proposed treatment plan and prognosis of the patient. This information should be obtained from the group’s current administrator.

Binder Check
Once the stoploss carrier obtains the final information, the employer must complete and sign a disclosure statement. In addition, the stoploss carrier will require a “binder check” equal to the first month’s premium. Health Alliance or HCH will assist with this calculation. The stoploss carrier will apply the credit to the first month’s premium and balance bill for any additional premium due, or they will credit the following month’s premium.

Final Rates
Once the carrier has reviewed the disclosure statement and any additional claims information, they will offer final rates. This process varies from carrier to carrier; however, most will require a signature from the employer as acceptance for the final rates. Your Account Executive will work with you through this process. It is critical that the final phases be completed as quickly as possible to avoid any unforeseen catastrophic claims impacting their rates. Our recommendation is to have the rates bound 30 days out.

Commissions
Stoploss quotes can be generated with a commission of 0–15 percent and split 50/50 with the agent/broker. If a different compensation is required, such as net commission, etc., it must be disclosed at the time the group is submitted to Health Alliance or HCH.