Benefit Administrator's Guide

Managing Your Health Alliance Plan

Fully Insured

Health Alliance™

Contents

Thank you for investing in the health and wellness of your employees by choosing a Health Alliance™ plan made for you. We've developed this Benefit Administrator's Guide to help you manage your organization's health plan. If you have any additional questions, please contact your client consultant or broker.

Enrollment and Eligibility Information

Log in to HealthAlliance.org to:

- Enroll employees.*
- Add dependents.
- Change or terminate member coverage.
- Update demographic details.
- Print temporary ID cards for employees or order new ones.
- Review plan materials.
- Look up participating providers.
- Look up employees' eligibility.
- Access forms and resources to assist with day-to-day functions.
- Access your monthly premium statements and pay your invoice.

The Group Enrollment Agreement (GEA) is part of your contract and includes:

- Exhibit A (policy book).
- Exhibit B (questionnaire).
- Exhibit C (plan rate sheet).
- Exhibit D (Summary of Benefits and Coverage).
- Exhibit E (Trading Partner Agreement).

Refer to your Exhibit B for info on:

- Eligibility for new hires.
- Eligibility for employees going from part time to full time.
- Coverage termination for employees who end their employment.

Refer to the Commercial Group SEP fliers for more details on the Special Enrollment Periods employees can enroll under as well.

Immediately report the following events to us:

- Employee retirement.
- Employee disability (including but not limited to end-stage renal disease).
- Dependent disability (including but not limited to end-stage renal disease).
- Employee returning to work from disability.
- Dependent no longer has a disability.

Dependent children attending school outside our service area can get in-network care through a national network for no additional cost with our Student Extended Network Program.

If you realize you made a mistake when submitting enrollment changes, call your client consultant as soon as possible.

**When you submit an online enrollment, you must keep a signed version of the application on file for the life of the policy plus 10 years. You may also submit applications or changes via fax to (217) 902-9755 or email to Membership@HealthAlliance.org. If submitting applications or changes online, you don't need to send us the original application.*

Dependent and Newborn Coverage

Illinois and Indiana

Dependents
Children are eligible for dependent coverage until the last day of the month they turn age 26. Regardless of marital or student status, a child age 26 or above is eligible if the child has a disability, is incapable of self-sustaining employment, and is dependent on a parent or other caregiver for lifetime care and supervision.

Dependent children who are Illinois veterans and received a release for anything but a dishonorable discharge can be covered up to age 30.

Newborns
If the employee member is the birth mother paying premiums for individual coverage (employee only), the newborn child is covered initially from birth, for a minimum of 48 to 96 hours or the length of time the child's birth mother is admitted for delivery, whichever is longer.

If the employee member is paying premiums for family coverage, a newborn is covered for the first 31 days of life.

If payment of an additional premium is required, coverage after 31 days is contingent upon the submission of a completed group employee application form and payment of the premium within 31 days following the birth. If no additional premium is due, a completed group employee application form must be submitted to Health Alliance within 31 days following the birth.

Iowa

Dependents
Children are eligible for dependent coverage until the last day of the month they turn age 26. Regardless of marital status, a child age 26 or above is eligible if the child has a disability, is incapable of self-sustaining employment, and is dependent on a parent or other caregiver for lifetime care and supervision.

In Iowa, unmarried dependents age 26 and older may remain covered if they maintain full-time student status.

Newborns
If the employee member is the birth mother paying premiums for individual coverage (employee only), the newborn child is covered initially from birth, for a minimum of 48 to 96 hours or the length of time the child's birth mother is admitted for delivery, whichever is longer.

If the employee member is paying premiums for family coverage, a newborn is covered for 60 days.

If payment of an additional premium is required, coverage after 60 days is contingent upon the submission of a completed group employee application form and payment of the premium within 60 days following the birth. If no additional premium is due, a completed group employee application form must be submitted to Health Alliance within 60 days following the birth.

Medicare Eligibility

The following are eligibility* rules for Medicare primary and Medicare group or groups, by size.**

Groups with 20 or More Total Employees:
- Members must be at least 65 years old.
- Members must have elected Medicare Parts A and B.
- Members can't be actively working.
- Group must offer retiree coverage.

Groups with 19 or Fewer Total Employees:
- Members must be at least 65 years old.
- Members must have elected Medicare Parts A and B.
- Members are eligible whether they're actively working or not.

**In general, eligibility is determined by the Centers for Medicare & Medicaid Services.*

***Size is based on total employees (full time, part time, seasonal, etc.).*

Notice of Creditable Coverage

Employers sponsoring a group health plan with prescription drug benefits are required to notify their Medicare-eligible plan participants as to whether the drug coverage provided under the plan is "creditable" or "noncreditable." Creditable coverage is defined as health insurance or prescription drug coverage that meets or exceeds coverage provided by Medicare.

1. The first disclosure requirement is to provide a written disclosure notice to all Medicare-eligible individuals annually who are covered under its prescription drug plan, prior to October 15th each year and at various times as stated in the regulations, including to a Medicare-eligible individual when they join the plan. This disclosure must be provided to Medicare-eligible active working individuals, Medicare-eligible COBRA individuals, Medicare-eligible individuals with disabilities and any retirees.

    a. Model creditable coverage notice.

    b. Model noncreditable coverage notice.

    c. If you're unsure whether the plan(s) your group offers is creditable, please contact your client consultant. Your employee will need the information contained within the notice if they decide to join a Medicare Part D plan later.

2. The second disclosure requirement is for entities to complete the Online Disclosure to CMS Form to report the creditable coverage status of their prescription drug plan. The Disclosure should be completed annually no later than 60 days from the beginning of a plan year (contract year, renewal year), within 30 days after termination of a prescription drug plan or within 30 days after any change in creditable coverage status. This requirement does not pertain to the Medicare beneficiaries for whom entities are receiving the Retiree Drug Subsidy (RDS).

It's important to understand what creditable coverage means – your employees may wind up paying lifelong penalties for keeping your group plan if it is noncreditable. The Medicare Modernization Act imposes a late-enrollment penalty on individuals who do not maintain creditable coverage for a period of 63 days or longer following their initial enrollment period for the Medicare prescription drug benefit. Accordingly, this information is crucial to an individual's decision whether to enroll in a Medicare Part D prescription drug plan.

Reporting Requirements

CMS Section 111 MSP Mandatory Reporting Requirements

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173) adds mandatory reporting requirements with respect to Medicare beneficiaries who have coverage under group health plan (GHP) arrangements effective January 1, 2009.

Health Alliance handles this reporting for your plan. Therefore, it's important that you report all changes to your members' eligibility data in a timely manner. To report correctly, Health Alliance is required to maintain Social Security numbers for all members.

Some details about the law:
The purpose of the Section 111 GHP reporting requirements is to enable CMS to correctly pay for the health insurance benefits of Active Covered Individuals by determining primary versus secondary payor responsibilities. Section 111 requires CMS and GHP Responsible Reporting Entities (RREs), like Health Alliance, to electronically exchange health insurance benefit information on a quarterly basis.

RREs are defined as any entity serving as an insurer or third-party administrator for a GHP, and in the case of a GHP that is self-insured and self-administered, a plan administrator or fiduciary.

Reporting must consider the following:

- All individuals covered in a GHP age 45 through 64 who have coverage based on their own or a family member's current employment status.
- All individuals covered in a GHP age 65 and older who have coverage based on their own or a family member's current employment status.
- All individuals covered in a GHP who've been receiving kidney dialysis or who have received a kidney transplant, regardless of their own or a family member's current employment status.
- All individuals covered in a GHP who are under age 45, are known to be entitled to Medicare and have coverage in the plan based on their own or a family member's current employment status. When reporting these under-age-45 individuals, you must submit their Medicare Health Insurance Claim Number (HICN/MBI).

Other Details

When Medicare entitlement is due to end-stage renal disease (ESRD), the group health plan will be primary (regardless of group size or working status) for the first 30-month coordination period.

The Medicare Secondary Payer (MSP) provisions for people with disabilities apply to all employers in a multiemployer GHP if one or more of the employers has 100 or more full- and/or part-time employees. The Employer Tax ID Number and the Social Security number for each Active Covered Individual, as defined above, is required to be submitted to CMS as part of the RRE data submission.

Other Key Information

Provider Search

To find an in-network provider, go to HealthAlliance.org and choose Find Care.

Simplify your premium bill processing.

NEW: You will no longer receive monthly payment invoices via mail/print. All invoices will only be delivered electronically.

- Once you've created an account on HealthAlliance.org, you'll be able to log into that site and choose Pay Bill/View Invoices from below your group name on your dashboard to go to our online bill-pay tool, Revo.
- You can easily set up automatic payments, if preferred. Your first bill as a new or renewing group: arrives during the middle of the month coverage starts. You should get your other bills around the 15th of the month before it's due.
- Your premium payment is due on the first of the month, with a 31-day grace period. If we don't receive your payment by the eighth of the month in which it's due, your next invoice might not show that you've paid. Call Customer Service if you have any billing questions.
- Refer to the rate sheet in your Exhibit C to see how much you should charge for a new employee or dependent joining the plan.
- Each month, we'll send you a notice through the portal once your invoice is available.

Plan Design and Benefits

- To see whether your group's benefits are administered on an annual or contract year, refer to the plan-year type listed on your Exhibit B. Annual (or calendar-year) plans run January 1 to December 31. A contract-year plan may begin on the first day of any month.
- Visit the Forms and Resources section on Group.HealthAlliance.org for more information about your plan's benefits.
- Our members have access to programs that support them through every step of care:
  - Health coaching for help making healthy lifestyle choices.
  - Care coordination when they're receiving acute medical care or have a complex condition.
  - Care transition intervention for a smooth adjustment from hospital to home.
  - Medication management to help take meds safely.

Members can learn more about these programs by calling our Medical Management department at (800) 851-3379.

Annual Mailings

- Health Alliance will send the Medicare Part D Creditable or Non-Creditable Coverage certificates to Medicare-eligible employees. You may select this option on the Exhibit B.

Forms Provided by Request Only

- We can provide fully insured groups with a Schedule A Form 5500 upon request. This form is for employer groups that offer an employee welfare benefit plan, including health insurance. Please note that the insurance contract year may or may not correspond with your group's plan year.
- We can provide a Schedule C to self-funded groups upon request.

Large Group Plans

Large groups can choose a two-, three- or four-tier rate structure.

- **Two-tier** consists of single and family coverage.
- **Three-tier** consists of single, single plus one and family coverage.
- **Four-tier** consists of single, employee plus spouse, employee plus child(ren) and family coverage.

Large groups can also request table rates, where the cost is based on the member's age.

Employee Premiums

Groups on Transition Plans

For most small groups on transition plans, employee premium rates are based on age and sex. Some groups have composite rates.

Single

Find the employee's age in the male or female rate chart. Total monthly premium = cost per employee.

One Dependent

Married:
Find employee's age in the appropriate rate chart. Total monthly premium = cost per employee + cost for spouse.

Single with One Child:
Find employee's age in the appropriate rate chart. Total monthly premium = cost per employee + cost for one child.

Two or More Dependents

Married with One Child:
Find employee's age in the appropriate rate chart. Total monthly premium = cost per employee + cost for spouse + cost for one child.

Married with Two or More Children:
Find employee's age in the appropriate rate chart. Total monthly premium = cost per employee + cost for spouse + cost for two or more children.

Single with Two or More Children:
Find employee's age in the appropriate rate chart. Total monthly premium = cost per employee + cost for two or more children.

Important Age and Rate Information

Please note, for groups with 19 or fewer employees, the member's rate may change if they elect Medicare.

When a member's coverage is terminated between the first and 15th of the month, the member's full premium amount will be credited to the group's account and reflected on the next month's invoice.

However, when a member's coverage is terminated between the 16th and the end of the month, the full premium amount is charged.

ACA-Compatible Plans

For ACA small group plans, employee premium rates are based only on age. Large groups, with 51 or more total employees, can have either age rating or composite rating depending on your size.

Find each member's age in the appropriate chart and total all premiums.

Please check with your broker or your client consultant for more information.

Note: For small groups, the fourth and beyond dependent children under the age of 21 are covered on a subscriber's plan at no additional cost to the employer or employee.

All large group plans are ACA compliant.

- Health Alliance provides the 1095-B to all fully insured members.
- If you need a Schedule A Form 5500, contact Client Support or your client consultant.
- Health Alliance sends notification to fully insured members who qualify for notification for Medicare Part D, if you select this option on your Exhibit B.

HealthAlliance.org

Helping You and Your Employees Make the Most of Your Coverage

Plan Materials
Members and employer groups can view most medical, pharmacy, vision and dental benefits (if applicable) and other plan materials in one place for easy access.

ID Cards
Members and employer groups can request new ID cards and print temporary ones.

Employer

Manage information.
You can manage your group and team member information – such as viewing and paying your group premium invoices online – from one easy location. You have access to all the employee features, plus you can view your Summary of Benefits and Coverage (SBC) and other plan documents.

Forms and Resources
You can visit the Forms and Resources tab of your account to connect with employer group forms and resources, including important fliers and tools, applications, Medicare group information, and much more.

Go to Group.HealthAlliance.org to log in or click Register as Group Admin to create an account.

Members log in at hally.com or through Hally® on the MyChart app to access plan materials, ID cards and more:

Provider Search
Members can see which doctors, hospitals and pharmacies are in their network. They can search by provider name, type, specialty or location.

Claims and Authorizations
Members can see the status of current claims and authorizations and a history of how their benefits were applied to past claims and authorizations.

Deductible and Out-of-Pocket Spending
Members can quickly see their deductible and out-of-pocket spending maximums in and out of network, and how close they are to reaching them.

Treatment Cost Calculator*
This powerful, personalized tool helps members choose the right treatments, facilities, doctors and costs for their needs.

**Not available to your employees who are Medicare members*

Paperless Member Materials
We provide many materials, like Explanations of Benefits, electronically – helping members go green.

Wellness Resources

We have tools – built into your plan – to help your employees be their healthiest.

Hally Health

With Hally health, your health plan gives your employees resources and support to help them live their healthiest lives. They simply visit hally.com or access Hally health through the MyChart app to log in to their account.

Health Coaching

Your employees can receive encouragement and support in making healthy lifestyle changes or learning to live with a new chronic illness, like diabetes.

Case Management

We help your employees get connected to the right doctors and services when they have a complex or serious medical condition.

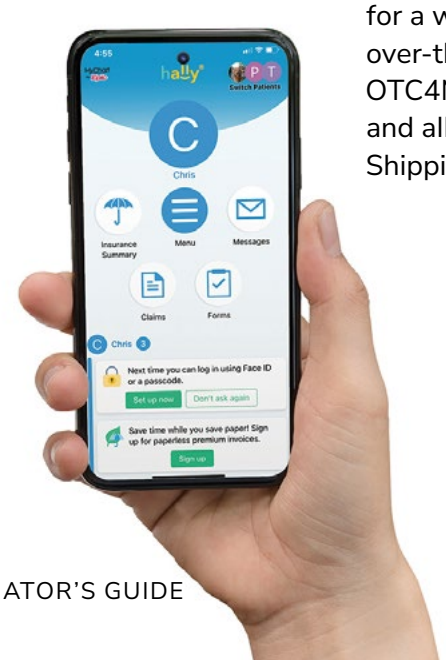
Nurse Advice Line

Your employees can get 24/7 answers to their health questions, like whether they need to set up an appointment or see a doctor right away.

Treatment Cost Calculator*

Your employees can compare prices and doctors for various services, based on real data and specific health plan usage.

**Not available to your employees who are Medicare members.*



More Perks, Rewards and Services

Fitness and Pharmacy Discounts

Your employees can save money on things they already do – like going to the gym and filling prescriptions.

Active&Fit Direct™

Your employees can join one of 10,000+ fitness centers nationwide for just $28 a month (plus a one-time $28 enrollment fee and applicable taxes). For more info, go to HealthAlliance.org/Active-Fit-Direct.

Preventive Services

We provide your employees with 100% covered preventive vaccines, annual wellness exams, mammograms, cancer screenings and more.

Quit For Life®

We can help your employees quit using tobacco with this guided program.

OTC4Me

Your employees get a 10% discount code for a wide variety of competitively priced over-the-counter (OTC) products with OTC4Me. They can order online or by phone, and all orders are shipped directly to them. Shipping is free on orders over $25.

Health Alliance Medical Plans
3310 Fields South Dr.
Champaign, IL 61822

Premium Invoice

Sent 08/08/23

Account ID: XXXXX

Mail to:

BUSINESS NAME
1234 N FAUX RD
CHAMPAIGN, IL 61822

Invoice Information

INVOICE NUMBER: XXXXX

Current Month Premium:	$1,690.03
Retro-Active Transactions:	$0.00
Previous Balance:	$1,690.03
Previous Payments Received:	**-$1,690.03**
Account Credits Applied:	**$0.00**
Current Balance Due:	**$1,690.03**

Payment due by 9/1/2023

See following pages for statement details →

Questions?

If you would like to speak to a customer service representative, please call (866) 247-3296.

To review and pay online:

www.healthalliance.org

Pay by check:

Make checks payable to Health Alliance Medical Plans

Important Information

Please do not send messages to Health Alliance with your payment. Payments are processed electronically, and your message will not be received. Instead, please call the number on the back on your ID card or send your message to Health Alliance, 3310 Fields South Dr, Champaign, IL 61822.

Note: Depending on how you pay your premium, you may be asked to reenter your payment information. If you are currently enrolled in Autopay, no further action is needed.

Detach this portion and return with your payment

AMOUNT ENCLOSED
(Acct XXXXX) Invoice Date: 8/8/2023
INVOICE NUMBER: XXXXX

$

Payment Due
$1,690.03

Payment due by 9/1/2023

Check #

Mail To
Health Alliance Medical Plans
9865 Reliable Pkwy
Chicago, IL 60686

Current Month Summary
For period: 09/01/2023

Group: XXXXXX

Plan/Rider	Tier	Subscribers	Members	Amount
PREMIUM PLAN	TIER LEVEL	#	#	1,129.22
PREMIUM PLAN	TIER LEVEL	#	#	560.81

Total: 1,690.03

SAMPLE EOB

Health Alliance Medical Plans
Attn: Eligibility
3310 Fields South Drive
Champaign, IL 61822

Electronic Service Requested

<barcode>
<your name, address here>

Health Alliance™

Explanation of Benefits

THIS IS NOT A BILL

Date: 08/09/23
Claim #: 12345689
Processed: 8/3/23
Subscriber: XXXXX
For Patient: 007
Member ID: 0123456789
Group: XXXXX

Have questions?
☎**1-800-322-7451**
Hally.com

This EOB shows what we will pay for the services listed and what you may owe to the provider. Your provider will send you a separate bill with the amount you owe. Keep this EOB so you can compare it to the bill from your provider.

We applied benefits to a claim from Dr. Doctor

Service from Date	Procedure /DRG	Service	Billed	Discount/ Disallowed	Paid Amount	Primary Insurance	Deductible	Copay	Co-Insurance	Not Covered	Reason Code
8/3/23	99243 CPT(R)	OFFICE CONSULTATION NEW/ESTAB PATIENT 40 MIN	$375.00	$262.50	$72.50	$0.00	$0.00	$40.00	$0.00	$0.00	3, 45
		Claim Totals:	**$375.00**	**$262.50**	**$72.50**	**$0.00**	**$0.00**	**$40.00**	**$0.00**	**$0.00**	

What you owe providers after we negotiated savings and applied plan benefits. A negative amount indicates an adjustment to the claim.

YOUR RESPONSIBILITY:

$40.00

Code Summary
3 - Co-payment Amount
45 - Chgs excd fee sch/max allowable

If any portion of your claim was not paid in full, you may exercise your rights to appeal. Information about the appeal process is provided with this Explanation of Benefits. Call 1-800-322-7451 *or visit* HealthAlliance.org/Appeal.

Benefit Year Information - *Some services may not apply to your deductible or out-of-pocket maximum.*

Name	Family Limit	Family Used	Family Left	Patient Limit	Patient Used	Patient Left
In-Network Deductible	3,000.00	38.09	2,961.91	1,000.00	0.00	1,000.00
Out-of-Network Deductible	6,000.00	0.00	6,000.00	2,000.00	0.00	2,000.00
In-Network Out-of-Pocket Maximum	12,000.00	688.09	11,311.91	4,000.00	410.00	3,590.00
Out-of-Network Out-of-Pocket Maximum	75,000.00	0.00	75,000.00	25,000.00	0.00	25,000.00

You may receive additional EOBs for services performed by another provider, ie. Reading of xrays or lab work.

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-322-7451.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-322-7451.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-322-7451.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-322-7451.

Claim 123456789 FOR YOUR RECORDS

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