ILLINOIS 51+ EMPLOYEE EXHIBIT B

Employer Federal Tax ID Number (TIN):			
Group Number:			
Group Name:			
Group Contact:			
Email Address:			
Address:			
City:	State:	Zip Code:	
Phone Number:	Fax Number:		

SECTION 1: EXHIBIT B FOR GROUPS WITH 51+ EMPLOYEES

1. Plan year effective date: From: To:

2. Contract renewal date, if different than plan year: From: To: ❑ same as plan year

3. Benefit year type:
   ❑ Annual (January 1 to December 31, regardless of contract renewal month)
   ❑ Contract (12 months starting with the contract year date)

4. Enrollment *(please check Yes or No)*

Open Enrollment:

❑ Yes; Group shall conduct an open enrollment period each year the Agreement is in effect, during which time all eligible employees and their eligible Dependents who are not enrolled as Members of Health Alliance may enroll as Members. This open enrollment period shall only apply if all plans of coverage offered by the group agree to conduct an annual open enrollment whereby eligible employees and their eligible Dependents may enroll in any plan.

If yes, what is your open enrollment date? _____

❑ No; employees and any eligible Dependents enrolling after the eligible grace period* expires will be treated as a "Late Entrant."

*If you meet the requirements stated in the "policy holder" or "dependent" subsections and you also meet the group's eligibility requirements, you may enroll by submitting a completed group application form to your employer within 31 days of your eligibility date.

Dual Choice: ❑ Yes or ❑ No

Yes; Group shall conduct a dual choice period each year the Agreement is in effect, during which time all eligible employees and/or family Dependents who are currently enrolled as a Member in one of the Health Alliance Plans may switch to the other Health Alliance Plan. Dual choice is subject to underwriting guidelines.

If yes, what is your dual choice date? _____

Annual Election: ❑ Yes or ❑ No

Yes; Group shall conduct an annual election period each year the Agreement is in effect, during which time all eligible employees and/or family Dependents who are currently enrolled as Members in any group sponsored healthcare insurance plan may switch plans without pre-existing condition limitations. This annual election period shall only apply if all plans of coverage offered by the Group agree to conduct an annual election whereby eligible employees and/or family Dependents may enroll in any plan.

If yes, what is your annual election date? _____

5. Total number of employees including full-time, part-time, seasonal, owners, etc.? _____

To calculate FTE and FTE equivalents, use the following formula:

- FTE—Full-time employees are those that worked, on average, 30 hours or more a week for more than 120 days in a year.
- FTE equivalent—Take all part-time (PT) employees who worked fewer than 30 hours per week, but equal to or more than 120 days per year:
  – Calculate by taking all of the PT employees' hours per week, add the hours together and divide by 30; OR
  – Use the calculator at HealthCare.gov.
  If the total number of employees isn't a whole number, round down to the nearest whole number.
- Seasonal employees who work fewer than 120 days a year are not counted in the calculation.

Full-time Equivalent Total _____

6. Number of employees eligible for coverage?

7. How many hours per week must the employee work in order to be eligible for coverage? _____
   Please note: 30 hours per week or more = full time.

8. When are new hires eligible for coverage? You may not have a waiting period that exceeds 90 days.*
Choose one eligibility option:
- ❑ Employees are eligible for coverage the first of the month following 30 days.
- ❑ Employees are eligible for coverage the first of the month following 60 days.
- ❑ Date of Hire.

*February will be counted as 30 days.

9. Choose one termination option:
- ❑ The employee coverage terminates the end of the month the employee leaves employment.
- ❑ The employee coverage terminates the date the employee leaves employment.

10. Are there classes of employees not eligible for coverage? ❑ Yes ❑ No
If Yes, please list:

11. Are there classes of employees with different eligibility dates (i.e. management vs. non-management)? ❑ Yes ❑ No
If Yes, please describe:

12. Is retiree coverage offered (age 65 and older)? ❑ Yes ❑ No
To be eligible at retirement, retirees must receive at least a 25% contribution from their former group toward the cost of the single premium rate **or** the retiree must be "Primary Medicare Eligible" (not applicable to Illinois Municipal Retirement Fund (IMRF) participants). IMRF? ❑ Yes ❑ No

Are early retirees (prior to age 65) offered coverage? ❑ Yes ❑ No
If Yes, at what age? Years of service?
Other?

Would you like Health Alliance to send the Medicare Part D Creditable or Non-Creditable coverage certificates to Medicare-eligible or soon to be Medicare-eligible employees? ❑ Yes ❑ No

13. Are you allowing Late Entrants? ❑ Yes ❑ No
If yes, coverage is effective the first of the month after Health Alliance receives the Group Application/Change Form. (If an employee does not apply during their Initial enrollment period, 31 days from eligible effective date, employee will be considered a late entrant.)

14. Are you offering an Employee Only or Employee Child(ren) Only plan? ❑ Yes ❑ No
If yes, please note dependent information in this exhibit may not be applicable.

15. *Please note:* Civil Unions and Legally Married Spouses are eligible in Illinois regardless of Domestic Partner Coverage.
Would you like to offer Domestic Partner Coverage? ❑ Yes ❑ No
Domestic Partner is defined as:
- They are over age 18
- They must share a common permanent residence with the employee
- The employee and their domestic partner agree to be jointly responsible for each other's basic living expenses during the domestic partnership
- Neither the employee or their domestic partner is legally married, legally separated or a member of another domestic partnership
- Both the employee and domestic partner are capable of consenting to the domestic partnership
- The employee and the domestic partner are not related by blood closer than permitted by state law for marriage.

16. Do you have a Health Savings Account (HSA)? ❑ Yes ❑ No If Yes, vendor name: _____
Do you have a Health Reimbursement Account (HRA)? ❑ Yes ❑ No

17. When is a rehire eligible for coverage?
❑ Treat as new hire ❑ Other _____

18. What is the effective date of coverage for an employee who moves from ineligible to eligible *(i.e. part-time to full-time status)*?
❑ Treat as new hire ❑ Other _____

Job Status Change/Transfer Policy: Non-benefit eligible to benefit eligible treated as a new hire.

19. When is a transfer eligible for coverage?
❑ Effective first of the month following the date of transfer ❑ Other _____

20. What is the employer's percentage of contribution toward the employees premium?
(a minimum of 50% is required) % or Other:

SECTION 2: HEALTH ALLIANCE MEDICAL PLANS STANDARDS FOR ELIGIBILITY AND ENROLLMENT

A. **Applications:** Applications must be submitted to the employer no later than 31 days after the eligible effective date.

B. **Effective Date of Dependent Coverage Termination:** *For Illinois Groups*, coverage may continue through the last day of the month the dependent turns age 26. For former military personnel, coverage may continue through age 30 with proof of honorable discharge. Dependents with an apparent handicapped condition that does not allow him or her to stay employed and is totally dependent on his or her parents or other caregivers for lifetime care and supervision may stay on the plan after age 26. Physician documentation may be required.

C. **Effective Date of Employee Coverage Termination:** The group shall not be entitled to receive a refund of any portion of a premium paid to Health Alliance as a result of the Group's failure to accurately notify Health Alliance in writing within 31 days of the employee's effective date of termination. Premiums for the month of termination are payable according to the 15th of the month rule. See "Remittance of Premiums," Section 3.6 of the Group Enrollment Agreement.

D. **Medicare-Eligible Policy:** This policy applies to certain active employees age 65 and older, retirees age 65 and older and disabled persons eligible for Medicare primary coverage. If a "Medicare-Eligible" Member does not elect Part B coverage when they are first eligible then Health Alliance shall determine payment as if the Member had elected Part B coverage. This is required for Groups.

E. **Continuation Coverage:** For those plans eligible for COBRA (20 or more employees), please note that dependents may not be qualified beneficiaries if they don't meet the IRS rules or guidelines as a tax dependent.

Dependents that are eligible for this plan can be qualified beneficiaries for state continuation, spousal continuation and dependent continuation. Refer to your policy for more information.

F. **Layoff Policy:** Health Alliance will allow employees on temporary layoffs longer than six months to remain on the Plan if the Group resumes monthly contributions for these employees that meet or exceed the "Minimum Group Contribution" after the initial six-month period. Employees on temporary layoff authorized by the Group will be allowed to pay 100% of their own premium for a maximum of six months.

Return from Layoff Policy: Coverage is effective immediately upon return from layoff.

SECTION 3: AGREEMENT

Approved by:

[Name of Company]

By: _____

Its: _____

Date: _____

Health Alliance Medical Plans, Inc.

By: _____

Its: _____

Date: _____

OR

❑ By clicking this checkbox, you acknowledge that you are authorized to sign for [Name of Company], understand that an electronic signature is taking place, and hereby Electronically Acknowledge Execution of this Exhibit on the date so acknowledged and such Acknowledgement shall be treated as a valid signature for all purposes of the Agreement.

[Name of Company]

OR

SECTION 3: AGREEMENT

I agree that the information provided in Section 1 to be accurate to the best of my knowledge and that attempting to edit any content in Section 2 will nullify this document.

[Name of Company]

Signature: _____

Date: _____

Title: _____

Health Alliance Medical Plans, Inc.

Signature: _____

Date: _____

Title: _____