# IOWA GROUP SIZE 51+ 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 GROUP SIZE 51+

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."

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 eligible employees including full-time, part-time, seasonal, owners, etc.?

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.
   - ❑ Other ___________________________________________________

   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.

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

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

11. 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 a single premium rate **or** the retiree must be "Primary Medicare Eligible" (not applicable to IMRF participants).

Do you have employees eligible for IMRF benefits? ❑ Yes ❑ No

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

Medicare Part D Creditable vs Non-Creditable. Send notices? ❑ Yes ❑ No

12. 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.

13. 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.

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

15. *Please note:* Common Law and Legally Married Spouses are eligible in Iowa 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
Do you have a Health Reimbursement Account (HRA)? ❑ Yes ❑ No

17. When someone returns from Leave of Absence, when are they eligible for coverage?
❑ Standard (effective immediately upon return) ❑ Other ______________________________

18. When is a rehire eligible for coverage?
❑ Standard (treat as New Hire) ❑ Other ______________________________

19. What is the effective date of coverage for an employee who moves from ineligible to eligible *(i.e. part-time to full-time status)*?
❑ Standard (treat as New Hire) ❑ Other ______________________________

20. When is a transfer eligible for coverage?
❑ Standard (effective first of the month following the date of transfer) ❑ Other ______________________________

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

A. **Applications:** Must be submitted within 31 days from the eligibility date or a special enrollment period.

B. **Effective Date of Dependent Coverage Termination:** Coverage may continue through the last day of the month the dependent turns age 26. 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.

An unmarried dependent 26 years of age or older may remain covered under the plan only if the child is enrolled as a full-time student at an educational institution. Coverage for the unmarried full-time student will terminate the last day of the plan year of graduation or cessation of studies whichever is earlier.

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. **Job Status Change:** Non-benefit eligible to benefit eligible treated as a new hire.

E. **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.

F. **Leave of Absence Policy:** Health Alliance will allow employees on leaves of absence 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 leaves of absence (medical, disability, education or personal leave) authorized by the Group will be allowed to pay 100% of their own premium for a maximum of six months. There must be a documented bona fide reason to believe that the employee will return to work upon conclusion of the leave of absence.

G. **Return from Leave of Absence Policy:** Coverage is effective immediately upon return from leave of absence.

H. **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.

I. **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.

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

K. **Rehire Policy:** Treat as a new hire.

L. **Transfer Policy:** Coverage is effective the first of the month following the date of transfer.

## SECTION 3: AGREEMENT

Approved by:

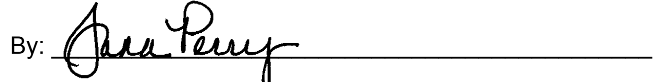
Name of Company: ________________________________

By: ________________________________

Its: ________________________________

Date: ________________________________

Health Alliance Medical Plans, Inc.

By: 

Its: Vice President of Sales and Retention

Date: ________________________________

**OR**

❑ By clicking this checkbox, you acknowledge that you are authorized to sign for ________________________________, 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: ________________________________