WellNet

HEALTHCARE

Broker Guide

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WellNet

WellNet is a nationwide administrator of integrated health plans, population health management (wellness) and risk management programs…all powered by our proprietary technology. Leveraging real-time data, WellNet identifies the root of the problem and provides solutions for immediate cost reduction, sustainable savings and improvements in member health and outcomes.

WellNet Health offers employers with as few as 25 employees fully integrated, self-funded health plans that foster shared accountability between employer and member, delivers transparency of costs and provides the ability to proactively monitor, engage and influence member behavior.

The Control You Need

WellNet gives you access to all plan data and, more importantly, insightful analysis in real-time via our easy-to-use WellNet 4.0 management dashboard. Through intuitive dashboards leveraging real-time data, companies are empowered to manage their health plan's performance.

The Flexibility You Want

Customized plan designs, stop loss protection and funding options combined with fully integrated population health management programs enable us to structure the most appropriate health plan for your company's needs.

Know What You Pay For

Our program offers 100 percent visibility into every cost; enabling companies to budget their healthcare spend. Unlike other health plans, with WellNet, employers only pay for the healthcare their group consumes…no more lining insurance carrier pockets.

New Levels of Customization

WellNet offers a true alternative to the carrier market, providing affordable and innovative self-funded health plans to groups with as few as 10 employees. We provide access to premier national PPO networks, 65,000+ pharmacies, cost containment programs, population health management and white glove member and account services.

With PPO, EPO and HDHP plan designs, it's easy to find a plan that works for your company's specific needs.

Protection You Can Count On

All of WellNet's plans come with both specific and aggregate stop loss protection as well as immediate specific reimbursement and monthly aggregate accommodation. These features limit monthly costs fluctuations to changes in enrollment, not claims utilization. In addition, WellNet clients are provided with a fully integrated suite of technology and health management services delivered by our team of dedicated Account Managers and Registered Nurse Health Coaches.

Group Eligibility

Corporations, partnerships and sole proprietorships where there is a clear employee/employer relationship are eligible for WellNet Health.

Newly Established Companies

Companies that have been in business for three months or less must provide the following to be considered as eligible employer groups:

- Articles of Incorporation and/or Partnership and Proof of Establishment
- Financial Viability Letter from their Financial Institution

Special Consideration Groups/Industries

The following industries and groups may be required to submit additional information to be considered or may be considered ineligible:

Religious Organizations
Metal/Coal Mining
Oil and Gas Exploration/Extraction
Explosives
Asbestos Products
Long Haul Trucking
Tobacco Stores and Stands/Tobacco Products
Commercial Sports
Legal Services
Medical Services

The following industries and types of groups are ineligible:

Multiple Employer Trust (METs)
Multiple Employer Welfare Associations (MEWAs)
Associations
Employee Leasing Firms
Professional Employer Organizations (PEOs)
Human Resource Management Companies
Taft Hartley Trusts

Participation

Employers must meet the following participation requirements:

- At least 50 percent of all full-time employees (FTEs) must participate in the Plan
- At least 75 percent of all eligible employees should have credible coverage
- The employer is required to contribute a minimum of 50% of the employee only cost of the lowest cost plan offered.
- If the employer contributes 100 percent of the employee premium, 100 percent participation is required
- *Exceptions to the above provided upon request*

Employee Eligibility

All full-time employees (working at least 30 hours per week/48 weeks per year) are eligible. Owners, sole proprietors, partners, officers and directors are eligible only if they qualify as full-time employees.

Eligible dependents of an employee are a lawful spouse and/or unmarried children from birth to age 26. A child means a child by birth, legal adoption or legal guardianship or a stepchild. Employers may choose to include domestic partners as eligible dependents. This designation must be made at the beginning of the plan year.

Retirees can be eligible for medical benefits only if the group has 20 or more employees and has received underwriting approval.

Contract laborers and employees paid on commission are eligible for benefits on the employer plan if more than 50 percent of their income is derived from that employer. Tax information is required as proof of eligibility. A group cannot be solely comprised of 1099 employees.

Pre-existing Condition Limitation

NOTE – pre-existing condition limitations will NOT apply to Plans with effective dates of January 1, 2014 or later

A pre-existing condition is a condition, regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received during six months before the enrollment date under the group insurance plan. When a person enrolls on a timely* basis, coverage is provided for pre-existing conditions after the person has been covered by the group plan for 12 consecutive months. When a person does not enroll on a timely basis, other provisions apply. If the person has prior creditable coverage, the pre-existing time period may be shortened or waived as outlined in the Summary Plan Design (SPD).

Prior credible coverage includes: other group health insurance plans, Medicare, Medicaid, TRICARE, or other military-sponsored health care, and similar types of plans.

A pregnancy is not subject to a pre-existing condition limitation. A newborn or adopted child is not subject to a pre-existing condition limitation if we receive an enrollment form for the child within 31 days from the date of birth, adoption or placement for adoption.

* *Timely enrollment occurs within 31 days, or as allowed under the Plan, from the date a person is eligible for coverage.*

Standard Stop Loss Provisions

- 12/18 contract on specific and aggregate stop loss insurance
  - Contract covers a 12-month plan year plus a six month run-out period
  - Specific stop loss deductibles of $15,000+ (*minimum varies by state)*
- Immediate specific reimbursement
- Monthly aggregate accommodation
- Groups with 50+ enrolled employees can fund to “Total Estimated Expected Cost” versus “Total Estimated Maximum Cost”
- Other options available upon request

Please submit all quote requests to quotes@wellnet.com.

Include all required information to ensure that your request is processed without delay.

Availability By State

WellNet Health Plans are available in all 50 states and the District of Columbia (DC) for plans with a minimum of 25 enrolled employees, though requirements vary by state and stop loss carrier:

A minimum of 101 + full-time equivalents (FTEs) is required for employer health plans in New York (NY)

A minimum of 51+ full-time equivalents (FTEs) is required for employer health plans in California (CA), North Dakota (ND).

A minimum of 25+ FTEs is required for group health plans in Delaware (DE).

Employer health plans with 50 or fewer FTEs in Alaska (AL), Arkansas (AK), Colorado (CO), Connecticut (CT), Florida (FL), Kansas (KS), Louisiana (LA), Maine (ME), Maryland (MD), Minnesota (MN), Nevada (NV), New Hampshire (NH), North Dakota (ND), Oklahoma (OK), Oregon (OR), Pennsylvania (PA), Tennessee (TN) and Vermont (VT) have additional specific deductible and/or aggregate attachment point restrictions.

All Quotes

Employer Information

- Company name
- SIC code
- Effective date
- Address for main office; zip codes for all other locations
- Current benefit summary or plan design
- Desired plan design(s)
- *Current and renewal rates (if available)*

Employee Information (census in .xls file format)

- Date of birth
- Gender
- Home zip code
- Work location *(if there is more than one)*
- Coverage tier (waived, employee, employee + spouse, etc.) for all employees including those on COBRA and in the waiting period

Plan Designs

WellNet offers standard PPO, EPO, and QHDHP plan designs. In addition, we have the ability to match in-force plan designs for existing self-funded clients or those clients with 100+ enrolled employees.

Fixed Costs

Specific & Aggregate Stop Loss

Insurance premiums for specific and aggregate stop loss insurance.

PPO Services

Fee for PPO network access.

TPA Fees

Fee for third party administration services. Includes access to PBM (CVS Caremark), large case management (LCM), utilization review (UR), COBRA administration and any implementation and/or run-out fees commiserate with the terms of the stop loss contract.

Program Expense

Comprised of broker's commission (6 percent of Estimated Maximum Cost unless adjustment is requested) and WellNet's revenue, which covers the cost of underwriting, a dedicated Account Manager, live member services representatives, WellNet 4.0 technology, Care Management (Registered Nurse Health Coaches), and other ancillary services.

Insurance regulation has traditionally been a state responsibility, which makes for tremendous variety among all 50 states. For example, all states require insurance carriers to offer or include coverage for specified healthcare services; these requirements are known as state benefit mandates. Even if multiple states have mandates concerning the same type of benefit, they may vary in scope or specificity. Fully insured plans are subject to these state mandates, Self-insured plans are not subject to state regulation, only federal regulation.

ERISA and HIPAA

Regardless of whether health plans are fully insured or self-funded, at a minimum they are subject to federal standards, fully insured plans are further regulated by state insurance regulations. Two federal laws, the Employee Retirement Income Security Act of 1974 (ERISA, P.L. 93-406) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191), have significant impact on how health coverage is provided.

ERISA outlines minimum federal standards for private-sector, employer-sponsored benefits, including health benefits. In general, ERISA requires that plan fiduciaries act prudently and in the best interest of beneficiaries, participants be informed of their rights and there be disclosure of a plan's financial activities.

While ERISA provides for general regulation of employee benefit plans, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) specifically regulates health benefits. HIPAA established federal requirements on private coverage and issuers of such coverage, including the availability and renewability of coverage for certain individuals under specified circumstances, limitations on the amount of time that coverage for pre-existing medical conditions may be excluded and prohibition of discrimination on the basis of health factors. HIPAA also includes provisions addressing the electronic transmission of health information and the privacy of personally identifiable medical information.

FOR ADDITIONAL INFORMATION ON ERISA & HIPAA please visit: http://www.dol.gov/ebsa/compliance_assistance.html

Stop Loss Insurance

Although self-funded health plans are not subject to state regulations, stop loss insurance policies are subject to state insurance regulators. Depending on the state the corporation is domiciled in, there may be certain restrictions on group size, specific and aggregate deductible levels or other limitations. If you are unsure about the restrictions for a particular state, please contact us for more information

WellNet works with several stop loss carriers. All of our stop loss carrier partners are A- rated or better and offer stop loss contract terms in-line with the Standard Stop Loss Provisions described under "Quote Requirements" above. WellNet underwrites one of two ways:

Individual Health Questionnaires

All eligible employees, including COBRA participants and new employees in the waiting period, must complete individual health questionnaires. Eligible employees who are waiving coverage are not required to provide medical information. Individual health questionnaires must be signed by employees within sixty (60) days of the Plan's proposed effective date.

WellNet accepts individual health questionnaires via:

- Paper/.pdf applications – available from WellNet upon request
- On-line through WellNet 4.0
    - WellNet supplies a secure link and instructions at no additional charge
    - Questionnaires are collected by WellNet and then distributed back to broker when complete
    - Groups can use paper/.pdf applications alongside
- FormFire or EasyAppsOnline – broker paid services

Paid Claims

WellNet will accept any historic paid claims data to assist in underwriting. Our preference, when underwriting based on paid claims, is to review the following within sixty (60) days of the Plan's proposed effective date:

- Monthly paid claims and corresponding enrollment for 24 consecutive months
- Large claims reports for 24 consecutive months, preferably including diagnosis and prognosis
- Benefit summary or plan design for current and prior year
- *Specific and aggregate stop loss premiums (self-funded groups on)*

Employer Requirements

All Employers must submit the following documents in order to complete underwriting:

- Employer application*
- Employer certification*
- Employer disclosure *
- Electronic eligibility file (.xls file format)*
- Most recent quarterly wage & tax reports
- Most recent invoice from current carrier
- The final rate sheet for each plan that the employer would like to offer must be signed and dated.

Broker Requirements

Brokers who are not appointed with the stop loss carrier must submit an Agent Data Sheet* along with copies of their insurance license and Errors & Omissions (E&O) insurance policy. This form only needs to be completed once. WellNet will pay any appointment fees.

Rate Changes

Rates cannot change during the plan year unless:

- Enrollment changes by more than 20 percent

Subsequent information becomes known which, if known prior to the effective date, would have affected the rates, deductibles, terms or conditions for coverage.

** Call or email us at 888-947-9478 or quotes@wellnet.com to request a copy.*

Required Employer/Broker Materials

The following items are required to begin the implementation process.

- All of the Employer and Broker Requirements described in "Underwriting Guidelines"
- A binder check made out to *WellNet Healthcare Administrators Inc.* in the amount of the monthly Estimated Maximum Cost (or Estimated Expected Cost if approved by WellNet) indicated on the rate sheet.

  If mailing the check by UPS or FedEx send to:

  WellNet Healthcare Administrators Inc.
  Attn: Rose Hughes, Finance Department
  57 Street Road
  Southampton, PA 18966

  If mailing the check by USPS send to:

  WellNet Healthcare Administrators Inc.
  Attn: Finance Department
  PO Box 354
  Southampton, PA 18966

  Email a digital copy of the binder check to **quotes@wellnet.com**

Onboarding Materials

Employers will receive onboarding materials including the following. These documents are also available online via WellNet 4.0.

- Welcome Letter
- Summary of Benefits and Coverage (SBC)
- Contact List
- Temporary ID Card
- Instructions on How to Locate a Network Provider
- Instructions on How to Log Into 4.0 Web Portal

Plan Documents

Employers must review and sign the following documents. WellNet provides countersigned copies of these documents. Employers should retain copies of all signed documents for their records.

- Administrative Services Agreement – allows WellNet to administer the health plan on behalf of the employer.
- Plan Document and Summary Plan Description – governs the administration of the health plan; includes a benefit summary, lists of covered, excluded and limited services, etc.
- Stop Loss Application – initiates the specific and aggregate stop loss insurance policies.
- New York Goods Pool – must be on file in the event that a member requires services in New York.
- Network/Utilization Review Agreement (if applicable) – agreement with the network or utilization review provider