GUNDERSEN
HEALTH PLAN

# GROUP MASTER POLICY AGREEMENT

| | |
|---|---|
| GROUP: | |
| GROUP NUMBER: | |
| EFFECTIVE DATE: | |
| POLICY PERIOD FROM: | TO: **UNTIL CANCELLED** |

## PLAN DESIGN

Gundersen Health Plan, Inc., (hereinafter called plan) agrees to provide health care benefits in accordance with the terms and conditions of this agreement to members of the above-referenced group. This agreement is made in consideration of the group's application and payment of the required premium on behalf of the group's participating members covered in this agreement. This agreement shall take effect on the effective date stated above and shall begin and end at 12:01 am, Central Standard Time. For small groups, this agreement is guaranteed renewable except for the reasons stated herein.

This is a legal contract. The group may accept the contract by payment of premiums, enrollment of employees, or in any other reasonable manner. The contract includes the following:

PART A: General Provisions
PART B: Certificate of Coverage/ Schedule of Benefits
PART C: Employer Group Application
PART D: Employee Enrollment Form

2016 IOWA.GMA
Revised: 10/21/15
Effective Date: 1/1/2016
IID Approval Date: 10/27/15

# PART A. GENERAL PROVISIONS

Terms used herein are defined within the Certificate of Coverage. The term employer shall mean the group as indicated on this Group Master Policy Agreement.

## I. ELIGIBILITY AND ENROLLMENT

The definition of a small employer group means a person actively engaged in business that, on at least 50% of the employer's working days during the preceding year, employed not less than 2 and not more than 50 full-time eligible employees. If the employer was not in existence during the preceding calendar year, it will qualify as a small employer group if it reasonably expects to employ at least 2 but no more than 50 employees on at least 50% percent of the employer's working days during the preceding year.

The definition of a large employer group means a person actively engaged in business that, during at least 50% of the employer's working days during the preceding calendar year, employed 51 or more fulltime eligible employees.

Group size for plans obtained through the Federally Facilitated Exchange/Marketplace is determined by the Exchange.

A. ELIGIBILITY

The following individuals may qualify for coverage in accordance with the eligibility criteria set forth in the Certificate of Coverage:

1. Eligible employees and their dependents;
2. Early retirees and their dependents;
3. Medicare-eligible retirees and their dependents; and
4. COBRA or State of Iowa continuation eligible defined individuals.

The employer's eligibility requirements are subject to approval by the plan, and state and federal law. No change in the employer's eligibility requirements shall be permitted to affect eligibility or enrollment under this policy unless such change is agreed to by the plan.

The plan shall not establish rules for eligibility, including continued eligibility, of an individual to enroll under the terms of the coverage based on any of the following health status-related factors in relation to the individual, or a dependent of the individual:

1. Health status;
2. Medical conditions, including both physical and mental conditions;
3. Claims experience;
4. Receipt of health care;
5. Medical history;
6. Genetic information;
7. Evidence of insurability, including conditions arising out of acts of domestic violence; and
8. Disability.

If the employer has employees in more than one state, Iowa Code Chapter 513B and Insurance Division Chapter 191, shall apply to coverage issued to the employer if:

1. The majority of eligible employees are employed in Iowa; or
2. If no state contains a majority of the eligible employees, the primary business location of the employer is in Iowa.

The plan may limit employers that may apply for coverage to those with eligible individuals who live, work, or reside in the service area.

In determining whether the laws of Iowa or another state apply to coverage issued to an employer, the provisions shall be applied as of the date the coverage was issued to the employer for the period that the plan coverage remains in effect. The coverage provisions shall apply to all individuals covered under the plan, whether they reside in the state of Iowa or another state.

B. ENROLLMENT

The employer agrees to notify employees of their eligibility and to provide them with access to enrollment. Employers providing coverage through the Federally Facilitated Marketplace (FFM) will provide employees with electronic access to enroll via the FFM. Employees offering coverage outside of the FFM will provide employees with an enrollment application.

The Policyholder shall maintain all required documents, as well as all required signature(s) of any applicable Member, that are necessary to establish compliance with applicable law in the event that the Policyholder files a Member's application or enrollment form electronically through Insurer's internet portal or any other electronic media, and shall make such documents and signature(s) available to the Insurer upon its reasonable request.

Eligible employees and their dependents may enroll for coverage as stated in the Certificate of Coverage. Applications must be received in our office within the appropriate time frame as outlined in the Certificate of Coverage.

The eligibility date means the first day coverage.

1. As a new eligible employee.
2. Annual open enrollment period coinciding with the groups renewal; or
3. A special enrollment period as defined in the Certificate of Coverage.

C. EFFECTIVE DATE

The effective date is defined as the date each enrollee and their eligible dependents, if any, become enrolled and entitled to benefits specified in your Summary of Benefits and Coverage. Unless otherwise stated in the Certificate of Coverage, the effective date of coverage is always the 1st of the month.

D. TERMINATIONS

Large Employer Groups

Employers must notify the plan of terminations within 31 days from the event. If the employer fails to notify the plan within this 31 day time period, the plan will

reimburse the employer up to a maximum of two months for premium received on a terminated employee. For other losses of eligibility, the plan will reimburse the employer for premium dating back to the first day of the month following loss of eligibility. In no case will the plan refund more than 12 months of premium received following the loss of eligibility for reasons other than employee termination.

Small Employer Groups
Coverage will end the last day of the month in which the event occurred; or the last day of the month in which notification is received, whichever is later, unless otherwise stated in the Certificate of Coverage.

E. CONDITIONS OF COVERAGE

Except for reasons relating to a health status factor, if an employee is not in active status on his or her effective date, coverage will not become effective until return to active status. The employee is considered to be in active status if they are actively working, or not actively working, but meet all of the following conditions:

1. The employee retains employment rights in the industry;
2. The employee has not had their employment terminated by the employer, if the employer provides the coverage, or has not had their membership in an organization (such as an association or union) terminated, if the organization provides the coverage;
3. The employee is not receiving disability payments from an employer for more than 6 months;
4. The employee is not receiving Social Security disability benefits; and
5. The employee has employment based group health plan coverage that is not COBRA continuation coverage.

If the effective date falls on a day of regular, paid vacation, or a regular non-working holiday for the employee, coverage is effective on the effective date only if the employee was in active status on his or her last working day.

## II. PREMIUMS

A. PREMIUM RATE

The premium rates are renewed annually and are subject to change effective on the employer's annual renewal date.

Premium rates will be based on the following factors:

1. Single or family coverage;
2. The age of each covered member/dependent; and
3. The geographic rating area.

The premium rate for the policy may be changed if the nature or the extent of the risk under this policy is changed by amendment, or by reason of any provisions of law or any government regulation.

The plan shall not require an individual, as a condition of enrollment or continued enrollment under the coverage, to pay a premium or contribution which is greater than a premium or contribution for a similarly situated individual enrolled in the

coverage on the basis of a health status-related factor in relation to the individual or to a dependent of an individual enrolled under the coverage.

The plan shall not modify coverage with respect to an employer or any eligible employee or dependent through riders, endorsements, or other means, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered.

B. PREMIUM PAYMENT

The premium is payable monthly in advance by the employer, to the plan or to the Federally Facilitated Marketplace. The first month's premium is due before the effective date of this policy. Subsequent premium payments are due before the first day of the month for that month's coverage. The employer will arrange to collect any necessary member contributions toward the premium and pay the total monthly premium due the plan on behalf of those members.

- Non-Marketplace Groups - There is a 31 day grace period after the premium due date for premium payment. If the monthly premium is not received during the grace period, all rights of the members under this policy may terminate. Acceptance of a later payment of monthly premium by the plan on one or more occasions shall not constitute a waiver by the plan of its right to receive timely payment of monthly premiums, or in any way change the due date of the payment of the monthly premium.

- Marketplace Groups – There is a 31 day grace period after the premium due date for premium payment. Employers are required to pay the total invoiced amount or total account balance. If the monthly premium is not received during the grace period, all rights of the members under this policy may terminate and coverage will be terminated retroactively to the last day of the month when payment was received in full.

C. PREMIUM AND ADJUSTMENTS

The employer may dispute any billed charges in writing. The written notice must be received by the plan within 60 days of the premium bill in question. The employer waives any premium adjustment or refund if the notice is not received by the plan within 60 days. Any adjustments made as a result of a dispute will be reflected on the next monthly premium bill.

Small Groups

Premiums will be prorated if an effective date is within the month. Refer to the Certificate of Coverage for Special Election Period effective dates.

## III. POLICY TERMINATION

A. DURATION OF POLICY

This policy shall continue in effect on a monthly basis, and shall renew on the employer's annual renewal date. This policy is subject to nonrenewal and termination as described in this section. Notice of termination must be received from

the employer before the 15th of a month for it to be effective on the last day of that month. Notification of termination received after the 15th of a month, will result in a termination date on the last day of the following month.

B. TERMINATION, NONRENEWAL, OR DISCONTINUANCE

This policy may be terminated or nonrenewed by the employer at any time by giving advance written notice. Notice of termination must be received from the employer before the 15th of a month for it to be effective on the last day of that month. Notification of termination received after the 15th of a month, will result in a termination date on the last day of the following month.

The plan may terminate or nonrenew the policy with at least 10 days advance written notice only for the following reasons:

1. Failure to pay premium when due;
2. Fraud or misrepresentation by the employer;
3. Failure to meet enrollment participation or premium contribution (non-marketplace only) requirements;
4. Employer is no longer eligible to participate in the Health Insurance Marketplace if coverage was obtained through the Health Insurance Marketplace;
5. The Plan ceases to offer coverage in the market in which the Group Master Policy Agreement is included;
6. The Plan ceases to be designated as a Qualified Health Plan in the Health Insurance Marketplace, if coverage was obtained through the Health Insurance Marketplace;
7. There is no longer a member who resides or works in the service area; or
8. The Group Master Policy Agreement is issued to a bona fide association and the employer ceases to be a member.

The plan may choose to discontinue offering this policy if the plan provides a 90 day notice of the cancellation to each employer and to each member who has coverage under this policy, and offers to each employer the option to purchase plan's other plans that it offers in the service area.

The plan may choose to discontinue offering this policy and all of its other policies in the State of Iowa if the plan ceases to offer in Iowa all health benefit policies in the large group market or in the small group market, or in both group markets. The plan must provide notice to all affected employers and to the Commissioner in each state in which an affected member resides not later than 180 days before termination of coverage. The plan may not establish a new class of business earlier than five years after the nonrenewal of the policies.

C. PARTICIPATION REQUIREMENTS

Small employer group participation requirements do not apply if the employer group's effective date or annual open enrollment period is between November 15th and December 15th of each year.

For small employer groups, the following participation requirements must be met:

| Number of Eligible Employees* | Number Enrolled |
|---|---|
| 2-4 | 2 |
| 5-6 | 3 |
| 7 | 4 |
| 8-9 | 5 |
| 10 | 6 |
| 11 or more | 70% |

** Rounded up to the nearest whole number.

The FFM calculates the participation rates for Marketplace groups.

For large employer groups with 51 or more employees, 75% of the eligible employees must participate. This does not include persons with continuation coverage as a former member of an employer group or other creditable coverage unless such coverage is sponsored by the employer. In dual choice situations, the minimum participation in the Gundersen Health Plan must be at least 30% of all eligible employees.

If the plan terminates this policy for failure to meet participation requirements, the plan will provide at least 20 days advance written notice of termination. The employer may continue coverage under this policy for an additional 60 days after the termination date, if the employer notifies us prior to the termination date that they are requesting the additional 60 days of coverage. If the employer meets the participation requirements at any time during the 60-day period, the plan shall continue this policy in force as though the employer's eligibility had been continuous.

D. NOTICE OF TERMINATION
When this policy is terminated under Section III, the plan will provide the employer with written notice in advance of the termination date along with a sufficient number of copies of termination notices that the employer must distribute to members.

## IV. RENEWAL

This policy will be renewed on the employer's annual renewal date. The plan will notify the employer at least 60 days before the annual renewal date. If the plan notifies the employer less than 60 days before the annual renewal date, the terms will not take effect until 60 days after notice is provided.

Coverage is renewable with respect to all employees or their dependents at the option of the employer, except for one or more of the following reasons:

1. The employer fails to pay or to make timely payments of premiums or contributions pursuant to the terms of the plan;
2. The employer performs an act or practice constituting fraud or makes an intentional misrepresentation of a material fact under the terms of the coverage;
3. Noncompliance with the plan's minimum participation requirements or employer contribution requirements;
4. No enrollees connected to the plan live, reside, or work in the service area;
5. The membership of an employer group in a bona fide association, which is the basis for the coverage which is provided through such association, ceases, but only if the termination of coverage, occurs uniformly without regard to any health status-related factor relating to any covered individual.
6. The Commissioner of Insurance finds that the continuation of the coverage is not in the best interests of the employer group, or enrollees, or would impair the plan's ability to meet its contractual obligations;

The plan may choose to discontinue offering, and cease to renew a particular type of health insurance coverage in the large group market, if the plan does all of the following:

1. Provides advance notice of its decision to discontinue the plan to the Commissioner of Insurance a minimum of three days prior to the notice for affected employers, participants, and beneficiaries;
2. Provides notice of its decision not to renew a plan to all affected employers, participants, and beneficiaries no less than 90 days prior to nonrenewal of a plan; and
3. Offers to each employer group the option to purchase any other coverage currently offered by the plan without regard to the claims experience of the employer group under the discontinued coverage, or to a health status-related factor relating to any participants or beneficiaries covered, or new participants or beneficiaries who may become eligible for the coverage;

A decision by the plan to discontinue offering or renewing all of its health insurance delivered, or issued for delivery, to employers in this state shall do all of the following:

1. Provide advance notice to the Commissioner of Insurance no later than three days prior to the notice provided to affected employers, participants, and beneficiaries;
2. Provide nonrenewal notice to all affected employers, participants, and beneficiaries no less than 180 days prior to the nonrenewal of the coverage; and
3. Discontinue all health insurance coverage issued or delivered for issuance to employers in this state and cease renewal of such coverage.

## V. CONTRIBUTION REQUIREMENTS

Large groups only: a minimum of a 50% employer premium contribution must be met.

The contribution requirements for group plans obtained through the Federally Facilitated Marketplace are determined by the Marketplace.

## VI. MISCELLANEOUS PROVISIONS

A. NO MUTUAL INDEMNIFICATION

The parties to this policy agree that each party is and shall be solely responsible for any claim or damage resulting from its own negligence, acts or omissions. This policy shall not be construed to require either party to indemnify the other party from its negligence, acts or omissions.

B. DISCLOSURE

The employer agrees to make available to the plan upon reasonable notice and at a reasonable time, for examination and reproduction, such books, records of account, and other financial and accounting information concerning the administration of this policy as may be necessary for verification or audit purposes.

C. NON-EXCLUSIVE PARTICIPATION

The plan and the employer each reserve the right, without limitation, to enter into policies for and to participate in health care services and benefit programs other than those provided for in this policy.

D. ADVERTISING AND PROMOTION CONTROL

The plan reserves the right to control the use of its name and all symbols, trademarks, service marks and copyright presently existing, or hereinafter established with respect to it. The employer agrees that it will not use such name, symbols, trademarks, service marks or copyright in advertising or promotional materials or otherwise without the prior written consent of the plan and will cease any and all usage immediately upon request of the plan or upon termination of this policy.

E. NOTICES

Any notice required or permitted under this policy between the plan and the employer shall be in writing and shall be deemed to have been given when delivered in person and when sent by registered or certified United States mail, return receipt requested, properly prepaid, and properly addressed to the party's regular office address. Notices to any member shall be sufficient if given to the member or to the employer. The employer is, at all times, acting as an agent for members for notices hereunder and otherwise. The employer shall transmit notices received from members to the plan and shall transmit notices received from the plan to members as appropriate.

F. RIGHT OF MEMBERS

Each member is declared to be a third party beneficiary of this policy. The right of each person to receive coverage for health care services from the plan shall be limited by the Certificate of Coverage to this policy which is in effect when such services are rendered, subject to all conditions, exclusions and limitations then in effect. Nothing contained herein shall limit the right of the plan and the employer, which right is hereby expressly reserved, to amend or terminate this policy, or to modify any appendices hereto on a prospective basis from time to time. Plan may provide, but is not required to provide, notice of termination or amendment to members unless otherwise required by law. Member's reimbursement right for

otherwise valid claim is limited to claims submitted within 15 months of the date of service.

G. ASSIGNMENTS

Neither party shall have the right to assign or otherwise transfer its rights nor obligations under this policy except with the consent of the other; provided, however, that a successor in interest by reason of merger, operation of law, assignment, purchase or otherwise of the entire business of a party hereto shall acquire all the interest of such party hereunder.

H. GOVERNING LAW AND LEGAL ACTIONS

Per Iowa Code 514A.3.k, no legal action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three (3) years from the event upon which any such cause of action is based, or in the case of claims, three (3) years from the time written proof of loss is required to be furnished. This policy is delivered in the State of Iowa and is to be governed and construed pursuant to its laws.

I. NONWAIVER AND SEVERABILITY

No delay or failure by the plan to exercise any remedy or right accruing to it hereunder shall impair any such remedy or right or be construed to be a waiver of any such remedy or right, nor shall it affect any subsequent remedy or rights the plan may have hereunder, whether or not the circumstances are the same.

The unenforceability or invalidity of any provision or provisions of this policy as to any person or circumstances shall not render the provision unenforceable or invalid as to any other person or circumstance, and the unenforceability or invalidity of any provision shall not render the remainder of this policy invalid or unenforceable.

J. CLERICAL ERROR

A clerical error shall not deprive any person of coverage under the plan, provided that the error is corrected as soon as practical.

K. WORKER'S COMPENSATION

The coverage provided under this policy is not in lieu of and does not affect any requirements for coverage under Worker's Compensation Insurance or under any occupational disease act or law.

L. ENTIRE POLICY

This policy, including the Certificate of Coverage, the Employer Group Application, and the member's Enrollment Forms shall constitute the entire policy between the parties.

M. REPRESENTATIONS

All statements made by the employer or by a member shall be deemed representations and not warranties. No such statement shall void or reduce

coverage under this policy or be used in defense to a claim unless in writing, signed by the employer and/or a member.

N. AMENDMENT

No amendment of the policy and no waiver of any of its provisions shall be valid unless evidenced by an endorsement of an amendment attached to this policy. No agent has authority to change this policy or to waive any of its provisions.

O. FORMS

The employer shall keep on file copies of all documents, forms, and descriptive literature provided by Plan for distribution to members such as, but not limited to, the Certificate of Coverage, Enrollment Form, and Change of Status Form. All forms shall be made available to employees during the employer's regular business hours.

P. RECORDS

The employer shall furnish plan with all information and proofs that plan may reasonably require with regard to any matters pertaining to this policy. All documents furnished by the employer and any other records that may have a bearing on the coverage under this policy shall be open for inspection by plan at any reasonable time.

Q. COVERED EXPENSES

In no event shall any member be responsible to pay for health care expenses covered by this policy, except as otherwise provided in this policy.

R. CERTIFICATES OF COVERAGE

Plan will issue to the employee a Certificate of Coverage describing the health care services to which he/she is entitled and summarizing those provisions affecting each member.

S. CONFORMITY WITH STATUTES

Any provision of this policy that on its effective date is in conflict with the statutes of the state in which this policy is issued, on such date, is hereby amended to conform to the minimum requirements of such statutes. At the time of coverage renewal, the plan may modify the health insurance coverage if such modification is consistent with the laws of this state, and is effective on a uniform basis.

T. RESERVATIONS AND ALTERNATIVES

Plan reserves the right to contract with other corporations, associations, partnerships, or individuals for the furnishing and rendering of any of the services or benefits herein described on behalf of any member.

U. NOTICE OF PRIVACY PRACTICES

The Health Plan provides members with a written Notice of Privacy Practices explaining the uses and disclosures of protected health information. This notice must describe 1) the uses and disclosures of protected health information (PHI) that may be made by the Health Plan, 2) the member's rights, and 3) the Health Plan's legal duties, with respect to PHI. Members will receive the notice at the time of

enrollment. Members will be notified of any revisions to the notice within sixty-days. At least once in every three years, the Health Plan will notify members covered by the plan of the availability of the privacy notice and how to obtain a copy.

## PART B. MEMBER MATERIALS INCLUDING CERTIFICATE OF COVERAGE/SUMMARY OF BENEFITS AND COVERAGE

The Certificate of Coverage, including the Summary of Benefits and Coverage, is made a part of this policy. Any amendments revising the Certificate of Coverage are also made a part of this policy.

All Member Materials including the Certificate of Coverage and Summary of Benefits and Coverage are available via our website, www.gundersenhealthplan.org/member. Paper copies of the member materials are also available upon request. Contact our customer service number at (608)775-8007 or (800)897-1923 to request printed copies of the Member Materials.

A. Employers/Group Contacts can log into this site using their group number with a preceding "d". They will have access to all active divisions of the group, current enrollment application/waiver forms and Managed Care Notices (HMO and POS).
B. Employees can log into this site using their member number from their ID card. They will have access to documents specific to the benefit plan they are enrolled in.
C. Employers are required to post a notice in a visible location stating where Member Materials can be found. The notice should state that employees can log into our website, www.gundersenhealthplan.org/member using their member number from their ID card, Or they can call our customer service number at (608)775-8007 or (800)897-1923 to request printed copies of the Member Materials.

## PART C. EMPLOYER GROUP APPLICATION

The Employer Group Application is made a part of this policy.

## PART D. EMPLOYEE ENROLLMENT FORM

The Employee Enrollment Form is made a part of this policy.

A. It is the employer's responsibility to provide each employee a copy of their completed application/waiver of coverage.