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Association Health Plan Participation Requirements

Effective Plan Years Beginning On or After January 1, 2021

These Association Health Plan Participation Requirements (Requirements) apply to both Hometown Health Plan, Inc. and Hometown Health Providers Insurance Company, Inc. (collectively referred to as Hometown Health). These Requirements apply to employers who wish to purchase Hometown Health Association Health Plan coverage.

Hometown Health's participation requirements for Association Health Plan coverage adhere to the laws and regulations set forth under the Affordable Care Act, 29 CFR Part 2510, Title 57 of Nevada Revised Statutes and other applicable laws and regulations. In the event there is a conflict between these Requirements and Hometown Health's Evidence of Coverage (EOC), the EOC will prevail. In the event there is a conflict between documents provided by Hometown Health and federal or state regulation, the regulation will prevail. "Regulation" includes interpretive bulletins and sub-regulatory guidance issued by the Centers for Medicare and Medicaid Services (CMS), the Department of Labor (DOL) and the Nevada Division of Insurance (DOI).[1]

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[1] Hometown Health will ensure all plan offerings, and operations comply with insurance law and do not conflict with Internal Revenue Service (IRS) and Department of Labor (DOL) requirements. However, it is the employer's sole responsibility to ensure compliance with IRS and DOL regulation when offering group coverage.

Hometown Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

1. GROUP ELIGIBILITY

a. Generally, Hometown Health Association Health Plan products are available to any employer that is an approved membership type of the applicable association. For instance, if an association has a full membership and an associate membership, but only full members are eligible for coverage, employers that are associate members would not be eligible. Enrollment will not be effectuated until Hometown Health receives proof of the group's membership in the association.

b. Sole Proprietors not Eligible – *Unless otherwise approved by the association and Hometown Health*, Sole Proprietors are not eligible for association health plan coverage. A Sole Proprietor is an employer with no employees other than the owner's spouse or dependents (as defined by the Internal Revenue Code). A business owner without one non-familial employee (any employee other than one's spouse or dependents) is considered a Sole Proprietor and is therefore not eligible for small group coverage. However, an owner with at least one non-familial employee is not a Sole Proprietor and is eligible for coverage even if all non-familial employees waive under small group coverage.

c. Contract Plan Modifications (No Break in Contract) – Employers may submit plan changes at renewal. A group may only add or remove a plan during their anniversary month.

d. Change in Tax ID or Business Name – To ensure compliance with IRS 1094 and 1095 reporting requirements, if the business owner obtains a new Tax identification number or the business name changes, Hometown Health will require a letter from the business indicating the new Tax Identification Number and business name and the effective date of the change.

e. Guaranteed Issue and Renewability – Hometown Health will issue and renew the health plans offered to the applicable association to each employer that is a member of the association and who is eligible for the health plan.

f. Geographic Service Area – For an employer group to be eligible for coverage they must have a physical address located in the product's geographic service area.
   i. If the employer's business address is in the product's geographic service area, the rates will be based on the Rating Area[2] where the business is located.

g. Exceptions to Guaranteed Issue and Renewability – These rules do not apply under certain circumstances. Additionally, Hometown Health may refuse to issue coverage or to renew coverage for any of the following reasons:
   i. Fraud – Misrepresentation of information regarding the employer or its employees;

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[2] Rating Areas are defined by the DOI as follows:
Rating Area 1 is Clark and Nye Counties.
Rating Area 2 is Washoe County.
Rating Area 3 is Carson City, Douglas, Lyon and Storey Counties and, if applicable, eastern California.
Rating Area 4 is all other Nevada counties.

ii. Non-payment of premiums;
iii. Non-payment of association dues;
iv. Inability to meet association eligibility requirements;
v. Inability to meet participation requirements (see Section 5 below);
vi. Inability to meet employer contribution requirements (see Section 6 below);
vii. Sole proprietor – An association may choose to exclude sole proprietors from their association health plan;
viii. Termination of Product – Hometown Health no longer offers a coverage in a particular market;
ix. Discontinuation of Product – Hometown Health discontinues offering a particular product in the group market;
x. Enrollee movement outside the service area – There is no longer any enrollee under the plan who lives, resides or works in the service area;
xi. Discontinuation of All Coverage – As allowed by state law; and
xii. Incorrect Market – If the group size does not meet the definition of a Small Group or a bona fide employer-employee relationship does not exist.

2. PREMIUM QUOTE CALCULATION

a. Number of Plans Selected by Employers – Hometown Health allows employers to select one (1) plan if only one (1) employee enrolls, up to two (2) plans for less than five (5) enrolled employees and up to three (3) plans for five or more (5+) enrolled employees. There is no restriction of metal levels offered. Employer groups that are covered under a plan with composite rates may select up to two (2) plans.

b. Supplemental benefits. The following supplemental benefits may be purchased for an additional cost:
   i. Dental – A group's dental selection must be clearly noted with the confirmed plan selection. Modifications to the dental plan will not be allowed for the contract period.
   ii. Vision – A group's vision selection must be clearly noted with the confirmed plan selection. Modifications to the vision plan will not be allowed for the contract period.
   iii. Healthy Tracks – A group's Healthy Tracks selection must be clearly noted with the confirmed plan selection. If a group opts to join the Healthy Tracks program in the middle of a policy year, the Healthy Tracks team will confirm when the group will be effective.

****** Required Group Application Documentation (Submit to Hometown Health)***

c. Hometown Health requires a complete application and submission of all required documents as defined below no later than the 20th of each month prior to the group's effective date. Once Underwriting receives the completed documentation listed below they will notify the Sales department within 2-3 business days if the group is initially approved. If an incomplete submission requires Underwriting to request additional information your group's effective date may be delayed.

1. Completed Application for Group Insurance (preferably on-line)
2. Plan Selection and Signed Rate Agreement

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3. Completed Business Attestation Form
4. Completed Common Ownership Attestation Form
5. Signed Application and Adoption Agreement – Must be completed during the group's open enrollment period; otherwise, group is subject to termination.
6. Enrollment applications or enrollment file for electronic eligibility.
7. Waiver of Health Coverage for all Eligible Employees who are waiving coverage or who are eligible for and/or participation in COBRA. Underwriting reserves the right to request waivers on electronic applications to verify eligibility and participation.
6. Binder Check issued in company or owner name for first month's premium based on the census or, if actual enrollment is available, based on the actual enrollment. If there is any discrepancy between the binder amount and the final enrollment, the balance will be billed or credited on the first premium bill. Hometown Health requires at least 75% of the premium paid for new and renewing groups.
7. Most recent filed State Wage & Quarterly stating employee's status.
    i. Business Verification Form and two weeks of payroll receipts may be submitted for employees not listed on the Wage & Quarterly. Payroll must include company name, dates of payroll period, employee name, wages paid, and withholdings
8. Confirmation of physical business location for the selected product.
9. Hometown Health reserves the right to request an additional State Wage & Quarterly to verify the employer census in the following circumstances:
    a. Upon group renewal (60 day compliance letter released to group and broker with request). Group will not be renewed if documentation is not returned by Group's date of renewal.
    b. Verification of National Network
10. Business License Number
11. Contractor License for select AHP's
12. Businesses with owners that do not appear on the State Wage & Quarterly must provide of the following:
    i. Form 1040 Schedule C
    ii. US Return of Partnership Income Form 1065 (Schedule K-1)
    iii. US Return of Shareholder Income Form 1120S (Schedule K-1)
13. The groups enrollment in the applicable association must be complete and verifiable with the applicable association. Additionally, any other documentation required of the association, such as eligibility attestations or other documents, must be submitted to Hometown Health for verification.

3. Renewals

a. Timing – Notice of upcoming employer group renewals will be sent to Sales via eQuote's automated system prior to the groups 60 day advance notice. Hometown Health will conduct a review of the renewing group to determine if the group meets participation and contribution requirements and will notify sales of any groups with potential failures to comply. Renewal packages will be mailed or sent electronically to the group and broker 60 days prior to the anticipated renewal date.

b. Default Plan – If the employer does not submit renewal documentation that indicates their plan selection by the 9th of the month prior to the effective date of the renewal, the employees and their dependents will be defaulted to the mapped plan upon renewal. If the same plan does not exist, the employees and their dependents with be defaulted to a similar plan, as determined by Hometown Health.

4. Member Eligibility and Enrollment

a. Enrollment Periods – Hometown Health will comply with the open enrollment, special enrollment and limited enrollment provisions listed in the applicable EOC.

b. Eligible Employee – An Eligible Employee is generally an employee who:
   i. Works an average of at least 30 hours of service per week or 130 hours of service per month;[3]
   ii. Is compensated for work by the employer and subject to withholding as it appears on a W-2 form;[4] and
   iii. Meets the employer defined waiting period[5]

   The owner/employer and any partners are considered an Eligible Employee for the purposes of obtaining association health plan coverage. Hometown Health coverage shall be made available to all eligible employees. A retiree who is collecting a pension from the Public Employees' Retirement System, whose last employer is the small group and who is eligible to continue coverage with the small group pursuant to NRS 287.023 and pursuant to the group's health plan is considered an Eligible Employee for the purposes of obtaining association health plan coverage.

c. Service Area Eligibility – Some employees who live out of the service area or outside the state may not be eligible for coverage.[6]
   i. HMO Out of Service Area Eligibility – Hometown Health will not offer association health plan HMO coverage to any employee that lives outside of Nevada.
   ii. PPO Out of State Eligibility – Hometown Health will not offer any new association health plan PPO coverage to any employee that lives and works outside the PPO Network Service Area[7] in the following circumstances:[8]
      1. New Small Groups that have more than 15% of their employees who live outside the State of Nevada may not enroll their employees who live and work outside the State of Nevada in Hometown Health coverage.

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[3] 26 CFR § 54.4980H-1(a)(21)
[4] 26 CFR § 54.4980H-1(a)(15)
[5] 45 CFR § 147.116
[6] 45 CFR § 147.104(c)(i)(1) & NRS 689C.200
[7] The PPO Network Service Area is generally defined as the State of Nevada as well as those areas of eastern California that are east of the Sierra and near Lake Tahoe.
[8] This paragraph does not determine eligibility for the national network. To determine which employees are eligible to receive in-network benefits from Hometown Health's national network providers, see Paragraph 9.

A. At renewal Small Groups will be audited by Underwriting to ensure that the group has remained within the 15% threshold Hometown Health reserves the right to not renew groups that fall outside the national network guidelines.

d. Dependent Eligibility – Dependents must meet the eligibility requirements for dependents listed in the Enrollment and Eligibility section of the applicable EOC. Additionally, Employers may restrict dependent eligibility to one of the four following coverage options prior to open enrollment:[9]
   i. Employees only
   ii. Employees and children;
   iii. Employees, spouses and children; or
   iv. Employees, spouses, domestic partners and children.

e. COBRA and FMLA – Employers shall be required to comply with COBRA, state mini-COBRA and FMLA notice requirements and collection of premium as applicable. Hometown Health will continue coverage under COBRA and FMLA as required by law as long as the employer provides proper notice to Hometown Health.

f. Required Enrollment Information – Hometown Health prefers receiving enrollment information via electronic file or through iChoose with the required information listed below. If the employer does not have access to electronic submission methods, a paper application for each applicant may be submitted. Enrollment information must be provided within thirty (30) days of the effective date of change. The following information is required for each employee and dependent who chooses to enroll in Hometown Health coverage:
   i. Employee (Subscriber) Last Name
   ii. Employee (Subscriber) First Name
   iii. Employee (Subscriber) Date of Birth
   iv. Employee (Subscriber) Social Security Number
   v. Employee (Subscriber) Gender
   vi. Enrolling Dependent(s) First Name(s)
   vii. Enrolling Dependent(s) Last Name(s)
   viii. Enrolling Dependent(s) Date of Birth
   ix. Enrolling Dependent(s) Social Security Number
   x. Enrolling Dependent(s) Gender
   xi. Effective Date of Coverage
   xii. Employee (Subscriber) Date of Hire
   xiii. Employee (Subscriber) Complete Home Address
   xiv. Plan Selection
   xv. Signature of Employee (Subscriber) (on paper applications; employer should keep a copy of employee's selection and signature for their records)
   xvi. Signature of Employer

[9] Hometown Health recommends that, if an employer chooses to cover dependents, the employer should also pay for a portion of the dependent's coverage. If an employer does not wish to pay for a portion of the dependents' coverage, the employer should probably not cover dependents to allow the dependent to receive Advance Premium Tax Credits on the state exchange.

g. Termination – Employers shall immediately advise Hometown Health when a Member is no longer employed or otherwise does not meet membership requirements. No person will be kept on an employer's payroll or otherwise be represented as a Member for the sole purpose of obtaining or maintaining coverage. Hometown Health shall be held harmless for all costs and fees incurred or associated with such an ineligible individual, including, without limitation, attorney fees and liability incurred in the defense of any claim or suit brought at any time by a person ineligible for coverage.

****** Required Eligibility and Enrollment Documentation (Employer Keep On File)***

It is the employer's responsibility to collect the appropriate documentation to support qualifying life events. This documentation includes birth certificates, adoption certificates or guardianship papers, marriage licenses, certificates of domestic partnership, death certificates, certifications of loss of coverage from an employee's previous insurer and any other documentation that substantiates the qualifying live event. Hometown Health or the applicable association may request a copy of any or all of this documentation in accordance with established audit criteria. Additionally, Hometown Health or the applicable association may request other documentation for the purpose of enrolling Members, processing terminations, affecting changes due to a Member becoming eligible for Medicare, affecting changes due to a Member becoming disabled or being eligible for short-term or long-term disability, determining the amount payable by the Member Employer Groups under the Contract, or for any other purpose reasonably related to the administration of the Contract. Hometown Health, the applicable association or their representative may perform a payroll audit upon five (5) business day's prior written notice.

****** Required Eligibility and Enrollment Documentation (Submit to Hometown Health)***

The employer must provide the following documentation:

1. Large Families – To effectuate coverage, families on age banded plans with more than 3 dependents under the age of 21 will be required to furnish a birth certificate for all covered dependents under the age of 21, families on composite rated plans with more than one dependent will be required to furnish a birth certificate for all covered dependents This documentation must be provided either at open enrollment or during a special enrollment.

5. Participation Requirements

a. Inability to meet Participation Requirements – Groups that cannot meet the minimum participation requirements described in this section on initial enrollment may not enroll in association health plan coverage.

b. Minimum Participation – Minimum participation requirements are as follows:
   i. Groups with two (2) eligible employees who do not have creditable coverage – Both employees must enroll in coverage;
   ii. Groups with three (3) eligible employees who do not have creditable coverage – Two (2) employees must enroll in coverage; and
   iii. Groups with four or more (4+) eligible employees who do not have creditable coverage – At least 50% of eligible employees must enroll in coverage.

   For the purposes of the minimum participation requirement calculation, employees with other creditable coverage will not be considered "eligible employees." Additionally,

Hometown Health will provide coverage to a single person (a "group" of one) as long as the employer is considered an employer, is not a sole proprietor (*unless the applicable association allows sole proprietors*) and all other Eligible Employees have other creditable coverage.

c. New Employees Counted – Employees who have submitted an Enrollment Application and who are within the waiting period of their effective date will be considered when determining participation compliance.

6. Employer Contribution Requirements

a. Minimum Contribution – An employer must contribute a minimum of 50% of the cost of coverage for employee only coverage for each enrolled employee.
   i. Multiple Plans – If an employer offers multiple plan options, the minimum 50% contribution will be based on the lowest premium plan available to each employee.

b. No Contribution Requirement for Dependents – Employers are not required to pay for any portion of dependent coverage, though it is recommended (see Paragraph 4.d above and the accompanying footnote).

c. Additional Contribution Allowed – An employer may choose to pay for any portion of the cost of coverage above the minimums described in this section.

d. Full Premium Due – Regardless of the amount of contribution the employer elects to pay, full premium must be paid by the due date on the applicable invoice, regardless of whether the employer has collected the appropriate amount of premium from the employer's employees.

7. Waiting Periods

An employer may not have a waiting period with coverage that begins later than 60 days on or following the date of benefit eligible employment. An employer may elect to include a reasonable and bona fide orientation period, not to exceed 30 days, prior to the start of the waiting period.[10]

8. New Group Deductible Credit

For new groups, Hometown Health will provide credit for medical or combined deductibles met under prior group health coverage. Proof of the deductible amount must be submitted in a format defined by Hometown Health within 90 days of the group's effective date of coverage.

Hometown Health will not provide credit for any new employee who applies for coverage after the initial group deductible credit has been completed.

[10] 45 CFR § 147.116

Hometown Health will not reprocess claims that were processed prior to the date the deductible credit list was received.

9. National Network

National Network – Hometown Health's national network is the network of providers who are included in the network leased by Hometown Health.

a. HMO National Network Eligibility – Hometown Health does not offer its national network to any HMO member.

b. PPO National Network Eligibility – Hometown Health has a comprehensive network within the PPO Network Service Area as defined in section 4.c.ii and the accompanying footnote. The national network will only be available to employees in the following circumstances:
   i. The subscriber lives and works outside the PPO Network Service Area. Please see Paragraph 4.c.ii above for additional restrictions regarding this eligibility.
   ii. The subscriber's covered dependent is attending a college which requires the dependent's physical attendance at the college outside the PPO Network Service Area; or
   iii. The subscriber's covered dependent under the age of 19 who lives outside the PPO Network Service Area with the dependent's primary guardian.

A spouse will not have access to the national network unless the subscriber lives and works outside the PPO Network Service Area as described in (i) above. A dependent will not have access to the national network unless one of the conditions described in (i) through (iii) above apply.

To gain access to the national network, the employer or broker must provide Hometown Health the applicable eligibility provision above which applies to the member.

The national network shall be available to a member effective on the first of the month following Hometown Health's receipt of a valid, approved request to provide access to the national network for that member.