OPEH&W Health Plan
www.opehw.com

Health Plan Administration Manual for Employer Benefit Coordinators

Last Revised on 05/17/2017

Introduction

July 1st, 2017

To: Employer Benefit Coordinators

This handbook contains step-by-step information to assist you in your daily administrative duties of the Health Plan. You should replace your old Benefit Coordinator Administration Manual with this new one. If you have any questions or needs that should arise, please do not hesitate to contact us and our staff will be happy to assist you. You can also check out our website at www.opehw.com for Health Plan documents, forms, information, and much more.

Please note that this handbook is an informational tool for Benefit Coordinators and is superseded by the Health Plans' Benefit Book. The Health Plan reserves the right to make changes to this document as needed. If changes are made, the Health Plan will send you the updated version.

Sincerely,

OPEH&W Health Plan Administration Office
3851 E. Tuxedo Blvd, Suite C

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Plan & Vendor Contact Information

OPEH&W Health Plan Administration Office

Customer Service:	800.468.5744
General FAX:	918.333.5220
Website:	www.opehw.com
HEART Website for Employees:	www.opehwheart.com
HEART Website for Employers:	www.opehwheart.com/ERLogin

Medical and Dental Coverage

Vendor:	BlueCross BlueShield of Oklahoma	
Website:	www.bcbsok.com	
Medical Customer Service:	800.672.2567	Group# YN9727
Dental Customer Service:	888.381.9727	Group# DN9727

Prescription Drug Coverage

Vendor:	Express Scripts
Website:	www.express-scripts.com
Customer Service/Mail Order:	855.315.2460
Accredo Specialty Pharmacy	800.803.2523

Vision Coverage

Vendor:	VSP (Vision Service Plan)
Website:	www.vsp.com
Customer Service:	800.877.7195

Life Coverage

Vendor:	Dearborn National
Website:	www.dearbornnational.com
Customer Service:	800.348.4512

Health Plan Administrator Responsibilities

McElroy & Associates, Inc. acts as the Health Plan Administration Office for the Oklahoma Public Employees Health & Welfare Plan. As the Health Plan Administration Office, we offer a vast array of services and support for each participating employer.

Here is an overview of our primary responsibilities:

- **Provide each employer with the necessary forms with which to enroll or terminate employees, make changes to benefits, addresses or beneficiaries, etc.**
- **Provide the Annual Renewal Period packets and materials to each employer**
- **Provide monthly billing reports, along with a reconciliation of each**
- **Process employer and employee premium payments**
- **Provide full COBRA & HIPPA administration**
- **Administer the Section 125 Premium-Only Plan for those employers who participate**
- **Assist with the filing of life claims for employees and eligible dependents**
- **Provide employer and employee support**
- **Maintain the OPEH&W website**
- **Maintain the HEART online enrollment system**
- **Produce the IRS Forms 1094-C & 1095-C**
- **Secure Plan members personal information**
- **Produce and distribute a quarterly member newsletter**
- **Provide leadership education about the Health Plan**

McElroy & Associates Inc.

Employer Benefit Coordinator Responsibilities

As the Benefit Coordinator for your employer, you play an important role in the administration of the Health Plan benefits for your employees. Proper administration of the Health Plan is critical, as improper administration can lead to an array of problems, such as employees not having coverage, claims not being paid correctly or even loss of benefits. The contents of this handbook should provide you with the necessary information to administer the Health Plan on a day-to-day basis, however, please keep in mind that the provisions of the Health Plan's Benefit Book ultimately control the Health Plan.

Here is an overview of your responsibilities pertaining to the Health Plan:

- **Provide new employees with the appropriate information to enroll themselves in the Health Plan's online enrollment system – HEART;**
- **For existing employees that need to make changes, provide them with the appropriate forms to makes necessary changes. Submit the forms to the Health Plan in a timely manner;**
- **Submit Termination Forms to the Health Plan in a timely manner so that we can administer COBRA properly and/or offer Retiree benefits if applicable;**
- **Notify the Health Plan as soon as possible of employees on FMLA, Workman's Compensation, or any other type of extended leave of absence;**
- **Notify the Health Plan of deaths (employee or dependent) so that plan products can be cancelled and life claims can be filed, as applicable;**
- **Prepare and submit monthly premiums, notifying the Health Plan of any changes;**
- **Secure and protect your employees' private information;**
- **Maintain all employee records pertaining to eligibility, effective dates, enrollments and terminations;**
- **Provide Section 125 Cafeteria Plan documents to your employees and maintain Section 125 documents (only applicable if your employer group has the OPEH&W Section 125 Premium-Only Plan);**
- **Provide IRS Forms 1095-C to your employees/former employees and submit IRS Forms 1094-C and 1095-C to the IRS.**

Available Health Plan Benefits

The following benefits are available to each employer. However, each employer may choose which benefits they want to offer to their employees and how they want to offer and pay for these benefits.

1. **Health** (Bundled package consisting of Medical and Prescription Drug coverage)
2. **Dental***
3. **Vision**
4. **Group Term-Life Insurance**
5. **Additional Life Coverage**
6. **Ancillary Products:**

   There are some employer's that have ancillary products with the Health Plan, like Allstate, 5 Star and FDL (i.e.: Universal Life, Heart/Stroke, Cancer, Critical Illness, Short Term Disability and Accident Plans). Although we are no longer offering these ancillary products, we still administer them for those who still have these products.

*In addition to the group dental, there is also a voluntary dental program through MetLife that includes Orthodontic coverage for children as well as adults. Ask the Health Plan for more details.

Please refer to your employer-specific rate sheet for benefit options available to your employer group.

Please refer to the Health Plan's Benefit Book for benefit & coverage details.

Who's Eligible for Health Plan Benefits?

A. Employees

- **Full time employees**: one who is actively working the employer's required hours to be considered a full-time employee. The Health Plan requires the work week to be not less than **20** hours. If the employer's work week requires more than **20** hours, then the employer's requirement will supersede. The employee cannot be classified as temporary, part-time or seasonal. Employees who have not completed their employers probationary period are considered temporary employees.

- **Elected Officials or Board Members**: a person elected by popular vote will be considered an eligible employee during the person's tenure in office.

B. Spouse & Dependent Children

- **The employee's spouse,** including common-law* (same or opposite gender);

  *Employees and their common-law spouse must be able to complete and submit the Affidavit of Common-Law Marriage form. The affidavit has to be approved by the Plan Administrator to qualify a common-law spouse as an eligible dependent under the Health Plan. This affidavit can be found under "Forms" on the OPEH&W website.

- **The employee's child(ren) under the age of 26,** regardless of student or marital status. If one eligible dependent child is enrolled, then all eligible dependent children must be enrolled, unless the dependent(s) not being enrolled is covered under another health plan or is eligible to use Indian or Military health services;

- **Children other than the Employees', under the age of 26**:
  - Stepchildren;
  - Children adopted by the employee (proof required);
  - Children placed for adoption with the employee (proof required);
  - Foster Children (proof required);
  - Children who are not living with the employee, but the eligible employee is court ordered to provide health coverage (copy of court order required);
  - Grandchildren who are under the grandparents' legal guardianship and/or whose grandparents can claim them on their taxes as a dependent. (Court order and/or tax return required, plus employee must complete a Dependent Child Other Than Own form).

Continued…….

Who's Eligible for Health Plan Benefits?

- **Dependents with disabilities over the age of 26,** Employee must complete a Dependents with Disabilities form and provide proof of the disability; The child's disability must have begun before the child attained age 26.

- **Surviving Spouses and/or Dependents,** if a covered employee dies, covered Surviving Spouses/and or Dependents children have **60** days following the employee's death to notify the Health Plan if they wish to continue their coverage (please see the Health Plan's Benefit Book for eligibility rules).

When does Benefit Coverage Begin?

A. New Employees and their Spouse & Dependents

For a newly eligible employee and any spouse or dependents they might enroll, the effective date for coverage will be determined by the employer's selected waiting period. Coverage always begins on the 1st day of the month. The waiting period options are:

1. The first day of the month following the full-time employment date.
2. The first day of the month following **30** days after the full-time employment date.
3. The first day of the month following **60** days after the full-time employment date.

Example of Option 3: If Employment date is: 7/05/2016
Then **60** days is: 9/03/2016
Coverage will begin on: 10/01/2016

Exception: Elected officials do not have to satisfy any probationary or waiting periods.

Failure to Enroll: If a newly eligible employee does not enroll him or herself and/or his or her spouse and/or eligible dependents within **31** days of first becoming eligible for benefits under the Health Plan, then that employee cannot enroll in or make changes to any benefits until the next Annual Renewal Period*, or if/until the employee has a qualifying event that opens up a Special Enrollment Period**.

B. Existing Employees Who Need to Add or Make Changes to their Current Coverage

Due to the Health Plan's Annual Renewal Period rules, changes to coverage of an existing eligible employee can only be made during one of the following periods:

1. Annual Renewal Period* (ARP) or
2. Special Enrollment Period** (SEP) or
3. Change in Status Disenrollment Period**

The effective date of the change depends on the event.

* **See page 15-16 for Annual Renewal Period Rules & effective dates**

** **See pages 17-19 for Special Enrollment Period & Change in Status Disenrollment period rules and effective dates.**

Health Plan Enrollment

Summary of Benefits & Coverage (SBC)

Due to new laws under the Affordable Care Act (Health Care Reform), it is **MANDATORY** that each new employee is provided with a Summary of Benefits & Coverage prior to making decisions on enrolling in the Health Plan. This document is universally known as the SBC. It must be provided to each new employee **BEFORE** they enroll in the Health Plan, not after. This is so that each employee can make informed decisions on their benefit selections and easily compare benefits with other health plans as needed. This form can be found on the Health Plan's website at **www.opehw1.com/documents.html#SBC**

How to Enroll a New Employee - (HEART)

The Health Plan has implemented an online enrollment system for new employees to enroll in the Health Plan. The new system is called **HEART,** which stands for **H**ealth Plan **E**nrollment, **A**dministration and **R**esource **T**ool. All new employees will need to enroll in the Health Plan via the HEART system, as paper enrollment forms for new employees will no longer be accepted.

Previously, you were required to provide new employees with specific Health Plan documents when they enroll, including a Premium Rate Sheet, the Quick Start Guide To Your Benefits and the Plan's Privacy Notice. However, when employees enroll via the HEART system, they will be given the opportunity to download or print these documents. Therefore, you will no longer be required to provide any Plan documents to your employees, **except** for the Summary of Benefits & Coverage as mentioned above.

Following are the steps for employees to enroll on the HEART system and the steps for you as the benefit coordinator:

1. Provide the employee with the web address: **www.opehwheart.com.** Advise the employee to gather the information they might need before they start, for example the SSN and date of birth for their spouse and/or children, or the name and contact information for their life insurance beneficiary.

2. When the employee logs on to this site, they will be required to create a username and password, then the online enrollment system will guide them through each step of the enrollment process. If they need to stop at any time during the enrollment process, they can save their progress, log-out and finish at a later time.

Continued……..

.....Health Plan Enrollment

3. During the enrollment process, they will be given the opportunity to view, print and/or save various Health Plan documents that contain important information for the employee, such as the Summary of Benefits & Coverage, the Quick Start Guide to Your Benefits and the Health Plan's Privacy Notice.

4. As the Benefit Coordinator, you will be able to log-in to the HEART system as an Employer Representative to see which employees are currently enrolling in the Health Plan and where they are in the process. For those that haven't completed the process, you can send a friendly reminder to that employee via email through the HEART system. The HEART web address for the Employer Representative is: **https://www.opehwheart.com/ERlogin.aspx**

5. Once an employee has finished the enrollment process, you will be required to complete the verification process before the enrollment can be completed by the Health Plan. Simply click the "Verify" check box after you verify the following items are correct:

a. That the individual is actually an employee of your organization; and
b. That the following items are accurate: employment date, benefit start date, annual pay and employee class.

6. If you find that anything is incorrect, the system will tell you how it needs to be corrected. Some information can be corrected by the employee simply logging back in to the HEART system and correcting it. However, there are other types of information that, if put in incorrectly by the employee, the only way to fix it is to delete the whole enrollment and have the employee start over. Please contact the Health Plan Administration office to reset the enrollment if this should happen.

7. Once you have verified an enrollment, you can view and print a report of the employee's selected coverage's to help you update your payroll system.

See page 14 for a summarized checklist of the steps required to enroll via HEART.

Coverage Changes for Existing Employees

The new online enrollment system, HEART, will currently only be used for new employee enrollments. For changes to existing employees' coverage, the paper forms will still be required for now (eventually, these will be done online as well). See the section titled "**Other Enrollment & Disenrollment Periods**" for when and how the paper forms should be used.

Note: Anytime the employee makes a change in coverage, a new form must be submitted.

FAX or mail completed enrollment/change forms to your Health Plan Specialist at the Health Plan Administration office. The Health Plan does not need two copies, so just pick one method of sending the forms:

FAX to Lisa:	**888-624-7628**
FAX to January:	**888-866-1899**
FAX to Kristy:	**888-860-3449**
FAX to Jennifer:	**844-626-1329**

Mail to: **OPEH&W Health Plan**
3851 E. Tuxedo Blvd, Suite C
Bartlesville, OK 74006

Post-Enrollment Documents

Once the Health Plan Administration Office has received a completed new employee enrollment from HEART, the following items (as applicable) will be mailed to the employee , typically within **7** to **10** days of their effective date:

- COBRA General Notice (Initial Notice of their COBRA Rights)
- BlueCross BlueShield identification cards (there are separate cards for medical and dental). ID cards will only have the Employee's name on them and not any enrolled dependents names.
- Express Scripts Pharmacy identification card
- There is **no ID card for the VSP vision plan**. The member simply provides his/her social security number to the VSP provider, from which they can verify the members' benefits. Spouses and dependents also use the member's SSN.

Be sure to inform the employee that they will be receiving these documents in the mail.

Please see the next page for a final checklist for enrolling employees in the online HEART system.

HEART Enrollment Checklist

Enrollment Checklist for Benefit Coordinators - HEART online enrollment system:

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- ☐ 1. Provide the new employee with the Summary of Benefits & Coverage.
- ☐ 2. Advise employee to enroll online using the online enrollment system - HEART, and give them the website address: https://www.opehwheart.com/.
- ☐ 3. The HEART system will send you periodic reminders each week to log-in to the HEART system as the Employer Representative and check to see who has started and/or completed the enrollment process.
- ☐ 4. Send reminders to employees, as necessary, to complete the enrollment process.
- ☐ 5. Once an employee has completed the enrollment process, you will then need to verify the enrollment information. Log-in to the HEART system as the Employer Representative, then select the employee you are ready to verify. If all the listed information is correct, then click "verify".
- ☐ 6. If anything is incorrect, then follow the instructions on the webpage on how that item needs to be corrected. For items that require the enrollment to be deleted so that the employee can start over, please contact the Health Plan.
- ☐ 7. Once you have verified an enrollment, you can view and print a report of the employee's selected coverage's to help you update your payroll system. Please note that the Health Plan will not receive the enrollment until you have "verified" it.

Annual Renewal Period (ARP)

What is the Annual Renewal Period?

The Annual Renewal Period (ARP) is a specified period of time available once a year when eligible employees have the opportunity to review their current benefits and then make changes to their benefits and/or their spouse and dependent child(ren)s benefits if needed. Unless a Special Enrollment* event or a Change in Status* event occurs during the plan year, the ARP is the only time that employees can make these changes.

When is the ARP?

The ARP is from **May 1st** to **May 31st** of each year. Any changes made during this period will become effective **July 1st**, the start of the new plan year**.**

Why do we have an ARP?

Due to the recent health care reform laws (specifically, the removal of pre-existing condition periods for employees, spouses or children under the age of **19** at the start of the **2011-12 plan year**, and for all ages at the start of the **2014-15 plan year**), not having an ARP could put the Health Plan at risk. In the past, we have allowed employees to enroll and dis-enroll at their convenience, which possibly even allowed people to enroll only because they became ill. These types of enrollments could be harmful to the health of the Health Plan.

What kind of benefit changes can my Employees make during the ARP?

Eligible Employees can:

- Add or Cancel their own Medical/Rx and/or Dental Coverage
- Add or Cancel Spouse and/or Dependent Medical/Rx, Dental or Vision Coverage
- Add or Cancel any available voluntary, employee paid benefits for themselves or their spouse and dependents (i.e.: voluntary Dental, voluntary Vision, Additional Life Coverage)

***See pages 17-19 for Special Enrollment & Change in Status events.**

ARP Procedure Summary

Summary of the ARP Process:

Please note that this is just a summarized version of the ARP process. We will send you the detailed step-by-step instructions when we send you the ARP Packets in step 1 below.

1. Prior to **May 1st**, ARP Packets for each eligible (and currently enrolled) employee will be mailed to each employer's Benefit Coordinator, along with instructions for the Benefit Coordinator.

2. As the Benefit Coordinator, you are responsible for distributing the ARP Packets to each employee, or give to their Supervisor for distribution.

3. Employees should review their personal information and current benefits.

4. If they want to change, add or cancel any coverage, they need to follow the instructions within the ARP Packet on how to make those changes. Some changes can be made right on the ARP Packet, while others might require a separate form to be completed; the Employee should obtain the necessary forms from the Benefit Coordinator.

5. Employees should return the ARP Packet and any additional forms to the Benefit Coordinator no later than **May 31st**, as this is the last day of the ARP. **HOWEVER**, if an employee did not make any kind of changes (address, name, benefits, etc), then they do NOT need to return the ARP packet

6. ARP Packets with changes should be returned to the Plan Administration Office no later than the date that will be specified on the ARP Instruction sheet that you will receive. You can send them throughout the month of May, which is preferred, so that you don't have to wait until the last day to send them all. Please return **ALL** pages of the ARP Packet.

7. Fax your ARP packets to the designated FAX number for your Health Plan Specialist:
   Lisa: 888-624-7628 **January: 888-866-1899** **Kristy: 888-860-3449**

8. We need to close out your June billing before we can begin your July changes, therefore, we must receive your June changes in our office no later than the date that will be specified on the ARP instruction sheet you will receive.

9. If an employee does not return their ARP Packet with changes, or if they return it but fail to make their needed changes within the allotted time, their benefits will remain unchanged and they will have to wait until the next ARP to make the changes, unless they have a qualifying event, which opens up a Special Enrollment Period* or Change in Status Disenrollment period**.**

   Once the Health Plan has made the July changes, then they will send you your July bill as soon as possible so that you have enough time to make your payroll changes.

***See pages 17-19 for Special Enrollment Periods & Change in Status Disenrollment**

Other Enrollment & Disenrollment Periods

Can Employees make any changes to their coverage outside of the Annual Renewal Period?

Yes, but only if that employee experiences a special event that opens up a Special Enrollment Period for them to enroll in coverage, or a Change in Status Disenrollment Period for them to disenroll from coverage.

What is a Special Enrollment Period (SEP)?

Normally, employees can only add, change or terminate coverage during the Annual Renewal Period. However, if an employee experiences a qualifying special event during the plan year (outside of the ARP), this opens up a **Special Enrollment Period (SEP)** for that employee. During the SEP, individuals who previously declined coverage are allowed to enroll without having to wait until the next Annual Renewal Period. The following are considered special events:

1. **Loss of other coverage for the Employee, Spouse or Dependent Child;**
2. **The Employee has a new dependent by birth, marriage, adoption or placement for adoption;**
3. **Court-Ordered Dependent Coverage; and**
4. **Loss of Medicaid or CHIP coverage as a result of loss of eligibility or new eligibility for Group Health Plan premium assistance subsidy under Medicaid or CHIP.**

A Special Enrollment event must be reported to you or the Health Plan Administration Office within **31** days of the event, unless stated otherwise in the Benefit Book (the loss of Medicaid or CHIP coverage or becoming eligible for Group Health Plan Premium Assistance subsidy under Medicaid or CHIP allows **60** days for notification). If the event is not reported within the appropriate timeframe, then the Employee will have to wait until the Health Plan's next Renewal Period to enroll.

There are special rules and qualifications for the above mentioned events. Please refer to the appropriate section of the Health Plan's Benefit Book for further details.

.....Other Enrollment & Disenrollment Periods

What is a Change in Status Disenrollment Period?

A Change in Status is an occurrence that dramatically changes the health insurance needs for the Employee or eligible Dependents. If a Change in Status occurs, it allows the Employee to cancel coverage (disenroll) to accommodate significant changes without waiting until the Health Plan's next Annual Renewal Period, but only if the change is necessary or appropriate as a result of the event giving rise to the Change in Status. **The Change in Status Disenrollment Period only applies to Employee's who participate in their Employer's Section 125 Cafeteria Plan - Premium Only Plan.**

Following are some examples of a Change of Status that would give an employee an opportunity to terminate coverage for themselves and/or their dependents:

- **Change in legal marital status**, including marriage, divorce, death of a spouse, legal separation or annulment;
- **Change in the number of Dependent children,** including birth, adoption, placement for adoption, or death of a Dependent;
- **Change in employment status of Employee**, including a change in the individual's eligibility for an employee benefit plan or reduction in hours;
- **Change in spouse or child's employment status** (e.g. Spouse changes jobs and is eligible for coverage with their new employer);
- **Dependent ceases to satisfy the eligibility requirements** (e.g. Dependent child turns age 26);
- **Change in coverage of spouse or Dependent child(ren) under another employer plan;**
- **Medicare or Medicaid Entitlement;**
- **Significant increase in the cost of an Employee benefit package during a Plan Year, or, the coverage under a benefit package is significantly curtailed;**
- **Change in residence of the Employee, spouse or Dependent child(ren).**

A Change in Status must be reported to you or the Health Plan Administration Office within **31** days of the event, unless stated otherwise in the Benefit Book. If it is not, then the employee will have to wait until the Health Plan's next Annual Renewal Period to cancel coverage, unless they DON'T participate in the Section 125 Cafeteria Plan. For additional information on election changes one can make under a Section 125 Cafeteria Plan, see the Section 125 Summary Plan Description.

If your existing employee is eligible to change their coverage outside of the Annual Renewal Period, then have them complete an **Employee Enrollment Form**.

.....Other Enrollment & Disenrollment Periods

Effective Dates for SEP Enrollments or Change in Status Disenrollments

In most cases, the effective date for changes will be the **1st of the month following the event**, with the exception of the following:

- For the birth of a child, the effective date is the date the child is born;
- For Adoption or placement for adoption of a child, the effective date is the date the child is adopted or placed with the employee for the purpose of adoption.

Documentation Requirements for Special Enrollment Period and Change in Status Events

If you have an Employee that meets the criteria for a Special Enrollment Period or a Change in Status Disenrollment and they request to make changes to their coverage due to that event, they must supply the Health Plan with the appropriate documentation as proof of that event before such changes can be made.

Examples of documentation required:

- **Marital status change** – copy of marriage certificate, last page of annulment, separation or divorce decree.
- **Birth of a child** – copy of birth certificate.
- **Adoption/Legal guardianship** – copy of document showing adoption/legal guardianship.
- **Loss of other coverage** – copy of Certificate of Coverage showing date coverage ended.
- **Acquiring new coverage** – Proof of new coverage showing effective date.
- **Court-ordered child support** – copy of the court order with date and court signature.
- **All Others** – call the Health Plan Administration office at **1-800-468-5744** to find out the requirements for a special event.

If the documentation (proof) is not provided to the Health Plan within **31 days** of the requested coverage change date, then the coverage change will not be allowed and the employee will have to wait until the next Annual Renewal Period to make that change.

Additional Life Coverage

What is Additional Life Coverage? How does it differ from Group-Life?

Additional Life Coverage (also known as Voluntary Term Life or VTL) is extra life insurance that employees can select for themselves and their spouse and dependent children. They pay for this Additional Life Coverage themselves via payroll deduction. The Additional Life Coverage is purchased in addition to the Group Term-Life Coverage (which is a benefit that the Employer typically chooses and pays for).

Additional Life Coverage for Employees, Spouses and Dependent Children

► **Employee:**

Additional Life Coverage starts at **$20,000**, after which it is available in **$5,000** units. The rate is determined by age (see rate table on page 24).

► **Spouse:**

If an employee selects Additional Life Coverage for themselves, then they can also select Additional Life Coverage for their Spouse, starting at **$20,000**, after which it is available in **$5,000** units. If an employee wants to select Spouse Additional Life Coverage, then the employee Additional Life Coverage must be at least **$40,000**. The Spouse Additional Life Coverage cannot exceed **50%** of the employee's Additional Life Coverage. The Spouse rate is determined by the spouses age (see rate table on Page 24).

Example: If an employee selects $50,000 in Additional Life Coverage for himself, then he can get up to $25,000 (50%) for his Spouse.

► **Dependent Children:**

If an employee selects Additional Life Coverage for themselves, then they can also select Additional Life Coverage for their Dependent Children. Two Additional Life Coverage amounts are available: **$10,000** at **$2.00** per month or **$20,000** at **$4.00** per month. One premium covers all Dependent Children, regardless of the number of Dependent Children (as previously stated, all eligible dependent children must be listed on the enrollment form in order to be covered).

.....Additional Life Coverage

When can Employees select Additional Life Coverage & how much can they get?

A. First Time Offering

Whether this is the first time that your employer group is offering Additional Life Coverage to all of its' Employees, or if you are just offering it to a newly eligible Employee, they can select up to **$150,000** of Additional Life Coverage without having to answer any health questions. However, the maximum amount an Employee can select is **5x (five times)** their annual gross pay, not to exceed **$500,000.** If they select an amount over **$150,000**, they must complete a **Health Questionnaire** and the amount over **$150,000** will be subject to approval. During this time, Employees can also select Spouse or Dependent Child Additional Life Coverage. Spouses are also subject to completing a **Health Questionnaire** if the Additional Life Coverage amount selected is over **$50,000.**

B. Previously Offered But Did Not Select

If an Employee did not take Additional Life Coverage when initially offered, they may select this coverage during the **Annual Renewal Period**. The maximum amount an Employee can select is **5x (five times)** their annual gross pay, not to exceed **$500,000**. The Employee **must** complete a **Health Questionnaire** regardless of the amount of Additional Life Coverage selected. During this time, Employees can also select Spouse or Dependent Child Additional Life Coverage. Spouses & Dependent Children are also required to complete a **Health Questionnaire** regardless of the amount of Additional Life Coverage selected.

C. Already Has Additional Life Coverage, But Would Like to Increase Coverage

If an Employee already has Additional Life Coverage, but would like to increase the amount of their Additional Life Coverage, they can do so during the Annual Renewal Period as long as they don't exceed the maximum of **5x (five times)** their annual gross pay (not to exceed **$500,000**). Employees can add an additional **$5,000** of Additional Life Coverage each year without having to answer any health questions. If they want to add more than **$5,000**, they will need to complete a **Health Questionnaire** .

D. New Employer Group's Initial Enrollment

If your employer is just joining the OPEH&W Health Plan, any amount of Additional Life Coverage that an employee already has in force will be accepted without the employee needing to complete a Health Questionnaire. **Proof of that coverage will be required.** If an employee does not already have Additional Life Coverage, then the rules in section A above will apply for the initial enrollment. Also, if an Employer Group is joining from the State plan - EGID, and their employees have the $20,000 Healthchoice Basic Life policy at $4.00 per month, they are eligible to get a **$20,000** Additional Life policy with OPEH&W for **$3.60** per month, or **$4.80** per month if they want to add-on Accidental Death & Dismemberment.

.....Additional Life Coverage

How do Employees enroll in Additional Life Coverage?

- **During Initial Enrollment:**
  If your employer group offers Additional Life Coverage and is utilizing the HEART online enrollment system, then the employee enrollment process will automatically include the Additional Life Coverage selection, including information on how much Additional Life Coverage they can get and how much it will cost.

- **During the Annual Renewal Period (ARP):**
  If it is during the ARP, then an Additional Life Coverage Worksheet will be included in the Employees' ARP Packet and they should complete the Worksheet and turn it in to you along with the rest of their ARP packet if they want to enroll in Additional Life Coverage. Be sure they have signed and dated the bottom of the Worksheet.

- **Outside of the Annual Renewal Period (ARP):**
  For Employees wanting to enroll in Additional Life Coverage outside of the ARP (this would include existing Employees who have had a qualifying event), then that Employee should complete the Additional Life Coverage Worksheet, along with an Employee Enrollment Form. Be sure they have signed and dated the bottom of the Worksheet and have selected the Additional Life Coverage on the employee enrollment form.

- **Health Questionnaire**
  Whether during initial enrollment, during the ARP or outside the ARP, if it is determined that the Employee and/or Spouse and/or Dependent Child is required to complete a Health Questionnaire (as determined on the previous page), provide the form to them to complete. However, if the employee is enrolling during Initial Enrollment on the HEART system, then the system will automatically prompt the employee to print the Health Questionnaire to complete.

  Since the Health Questionnaire will contain Private Health Information, advise your employee that they can put the completed Health Questionnaire in a sealed envelope before handing to you to forward to the Health Plan if they want. The life insurance carrier will use the Health Questionnaire to determine the employee and/or spouses' and/or dependents insurability. If the Health Questionnaire is not received when required, benefits cannot be approved. Any omission of information on the form will cause a delay in processing.

  The Additional Life Coverage will not be effective until the first of the month following approval of the Health Questionnaire from the life carrier. Therefore, you should not payroll deduct the premiums until the Health Plan notifies you of the approval.

.....Additional Life Coverage

Accidental Death & Dismemberment Coverage (AD&D)

► **Employee Only**

This is an option available only to Employees (not Spouse or Dependent Children) which provides coverage if the Employee loses a limb, or the loss of the use of a limb, or loss of speech and sight. Additionally, if an Employee were to die in an accident, it would pay double the amount of Additional Life Coverage the Employee had selected. The cost of this coverage is just **$0.03** per **$1,000** of coverage (regardless of age). AD&D must be taken out on the full amount of Additional Life Coverage selected. AD&D is automatically Included in the Group Term-Life Coverage .

Rate Table – Age-based cost per $1,000 of Coverage			
Age 34 & Under $0.07	Age 35 - 39 $0.10	Age 40 - 44 $0.14	Age 45 - 49 $0.23
Age 50 - 54 $0.39	Age 55 - 59 $0.64	Aged 60 - 64 $0.74	Age 65 - 69 $1.21
Age 70 - 74 $2.05	Age 75 & Over $3.18		

What do I need to send to the Plan Administration Office?

If the enrollment for Additional Life Coverage occurred **during the ARP**, forward the Worksheet and any applicable Health Questionnaire's to the Plan Administration office along with the employees' ARP Packet.

If the enrollment for Additional Life Coverage occurred **outside of the ARP**, forward the Worksheet and any applicable Health Questionnaire's to the Plan Administration office, along with the Employee Enrollment form.

If your employer group is utilizing the HEART web-based enrollment system, then the employee completed the Additional Life coverage "worksheet" online, so all you will have to forward to the Health Plan is the Health Questionnaire (if required).

You can **mail or fax** the required forms to the following:

FAX to Lisa: **888-624-7628**
FAX to January: **888-866-1899**
FAX to Kristy: **888-860-3449**

Mail to: **OPEH&W Health Plan**
3851 E. Tuxedo Blvd, Suite C
Bartlesville, OK 74006

Do Additional Life Coverage Rates Ever Increase?

Yes, the rates are updated each year **during the ARP** if an employee has "aged up" to the next age bracket (see Rate Table above).

Health Plan Terminations

Employees - Termination Notice

When an employee terminates employment or is no longer able to meet the eligibility requirements, their Health Plan coverage must be terminated. **If any of the following events occur**, **the employer must submit a Termination Notice to the Health Plan within 30 days, however, the Health Plan prefers notice as soon as possible**:

- Voluntary Termination
- Involuntary Termination
- Death of Employee
- Retirement (The Health Plan prefers 60 days notice for Retirees)
- Reduction of Hours (layoff, strike, approved leave of absence)
- Temporary Layoff
- Family Medical Leave (FMLA) exhausted
- Leave of Absence / Workers Compensation
- Voluntary Waiver of the Plans Benefits

The Benefit Coordinator should complete a Termination Notice for the employee and forward it to the Health Plan Administration office as soon as possible. **IF** the Health Plan **does not** receive a Termination Notice within **60 days** from the event date, per Federal COBRA* Law, then the individual becomes ineligible or COBRA*. In most cases, coverage ends the last day of the month in which the event occurs.

Spouse & Dependents - Termination Notice

When a dependent is no longer able to meet the eligibility requirements, their coverage must be terminated. **If any of the following events occur**, **the employer has 30 days from the date of the event to submit a Termination Notice to the Plan**:

- Death of a dependent
- Divorce or legal separation
- Dependent who is no longer a legal dependent
- Dependent who has reached the age of 26 (and not permanently disabled)

The Benefit Coordinator should complete a Termination Notice for the dependent and forward it to the Health Plan Administration office as soon as possible. **IF** the Health Plan **does not** receive a Termination Notice within **60 days** from the event date, per Federal COBRA* Law, then the individual becomes ineligible or COBRA*. In most cases, coverage ends the last day of the month in which the event occurs.

Note: Submitting a Termination Notice for a dependent requires the name and address for the dependent (not the employee) in case we need to send COBRA Continuation forms to that termed dependent.

Termination forms can be faxed to your designated Health Plan Specialist, or emailed via secure email (contact your Health Plan Specialist for their email address).

* See Page 26 for COBRA information

Employees Not Actively Working

How Long Can Employees Continue Their Coverage When They Are Still Employed, But Not Actively Working?

Full-Time Employment is a condition that deems an employee eligible for coverage under the Health Plan. Cessation of active work will terminate their eligible status. **However,** if the cessation of work is due to any of the reasons below, then the employee is eligible to continue their benefits for a specified period of time, pending premiums are paid. After the below specified period of time is exhausted, the coverage will terminate the last day of that month.

1. **Temporary Layoff -** Employees can continue coverage under the Health Plan during this period for up to **3 months**.
2. **Approved Leave of Absence -** Employees can continue coverage under the Health Plan during this period for up to **3 months**. **Exception** - Education Employees can continue coverage under the Health Plan during this period for up to **24 months**.
3. **Disability** (which prevents an employee from engaging in any occupation for compensation, profit, or gain) **-** Employees can continue coverage under the Health Plan during this period for up to **3 months** from the date of original Disability.
4. **Workers Compensation Injury or Illness** - Employees can continue coverage under the Health Plan during this period for up to **12 months** from the date of injury or illness.
5. **Approved Family and Medical Leave (FMLA) -** Employees can continue coverage under the Health Plan during this period, but the time period that they can keep the coverage depends on which type of FMLA they are on. Please refer to current Federal FMLA law to make this determination, as it could be a maximum of **12 weeks** in some cases, and up to **26 weeks** in others.

Employers **MUST notify** the Health Plan **when an employee ceases to be actively working**, as the countdown of the allowed coverage continuation time will need to begin.

Once the allowed time period ends, the **Employer must submit** to the Health Plan Administration Office a **Termination Notice**. If applicable, the Health Plan will then offer the Employee COBRA **(see page 27 for explanation of COBRA).**

IMPORTANT NOTE: It seems to be a common practice for employees to **donate** their available sick and/or vacation time to a fellow employee who is not actively working due to one of the above reasons. If this happens, please know that the time periods above still apply. For example, if a person's last day worked is March 13th, their countdown of allowed continuation time on the Health Plan would begin on March 14th. The time that other employees might donate does not increase their allowed continuation time. If fellow employees donate, for example, a total of 1 month of their time, it does **NOT** mean that the countdown would then start a month later on April 14th. It would still begin on March 14th. This is very important when it comes to Federal Laws like COBRA, as well as eligibility for life insurance.

COBRA Administration

What is COBRA?

COBRA was created under the **C**onsolidated **O**mnibus **B**udget **R**econciliation **A**ct of 1985. This law requires group health plans to offer temporary continuation of coverage to covered employees, former employees, spouses, former spouses and dependent children when group health coverage is lost due to a qualifying event (see the Health Plan's Benefit Book for a list of qualifying events).

COBRA Continuation coverage can last up to **18** months if the loss of coverage is due to end of employment or reduction of the Employee's hours of employment.

If the loss of coverage is due to the Employee's death, divorce or legal separation, the Employee's becoming entitled to Medicare benefits or a Dependent child ceasing to be a Dependent under the terms of the Health Plan, coverage may be continued for up to a total of **36** months.

What does the Employer need to Provide to the Health Plan?

The Health Plan Administration office administers the COBRA on behalf of the employer. Therefore, it is very important that we receive a **Termination Notice** as soon as possible, but no later than **30 days** after the date of the qualifying event, so that we may send out the COBRA notices within the time the law mandates. If the Termination Notice is not submitted to the Health Plan within **30 days** of the qualifying event, then COBRA will become unavailable to that employee, which therefore could become a liability risk for the employer.

How does the Employee, Spouse or Dependent Elect COBRA and how do they pay for it?

Upon receipt of the Termination Notice from the Employer, the Health Plan Administration office will mail to the eligible person a COBRA Continuation Notice, COBRA Election Form and a Certificate of Creditable Coverage. This is done within **14** days of receipt of the Termination Notice, or within **14** days of the last day of coverage.

If the eligible person wants to continue their coverage, they will need to complete the COBRA Election form, then mail the Election Form to the Health Plan Administration office within **60** days of the date the Election Form was mailed to them. The eligible person then has **45** days from the date the Health Plan receives their Election Form to make their first COBRA premium payment, however, the Health Plan will not reactivate benefits until the **1st** payment is received.

COBRA payments are made directly to the Health Plan by the COBRA Participant. If payment is more than **30** days late, the COBRA coverage will be cancelled.

HIPPA Administration

What is HIPAA?

HIPAA is the abbreviation for the **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct of 1996, part of which is the Privacy Rule. It is a federally mandated set of guidelines to protect the security of health information.

What is PHI?

PHI is the abbreviation for 'Protected Health Information'. PHI is information relating to a patient's past, present or future health or condition, the provision of health care, or payment for the provision of health care. Protected health information includes, but is not limited to:

- Patients Name
- Social Security Number
- Service Date
- Diagnosis Information
- Claim Information
- Premium Details
- Psychiatric Notes
- Sexually Transmitted Disease Status

The Health Plan takes the following steps to protect your employees PHI:

- Document Shredding, Imaging, and Security
- Qualification and Logging of Telephone Conversations
- Authorizations of release of PHI to third parties
- Reporting of disclosures of PHI
- Logging and ensuring the execution of confidential communications
- Other forms of security

How does this impact you?

- Your employer must designate whom in your employer group is authorized to talk to the Health Plan about your employees' PHI.
- This authorization must include the Benefit Coordinator. It must also include any other personnel, such as county shop secretaries who routinely call on behalf of your employees.
- This designation must be submitted in writing.

How does this impact your employees?

- The employee must submit an authorization to our office in order for us to talk to others, including a spouse and dependent child, about the employee's coverage, premiums or claims.
- When the employee calls the Health Plan, they will be asked to verify their own identity by correctly telling us their social security number, birth date or other identifying information.

What you should do to protect your employees PHI.

- Shred unneeded paperwork containing PHI.
- Secure paperwork containing PHI in locked filing cabinets.
- Document all transfers of PHI outside normal business processes.
- Do not disclose PHI to any unauthorized entity or individual.

Retiree Benefits - Who's Eligible?

Notice of Retirement

It is very important that the Employer submit a Termination Notice to the Health Plan as soon as they know that an eligible employee is planning to retire. It is preferred that a Termination Notice be submitted at least **60 days** before the employees retirement date so as to allow the Health Plan enough time to send the appropriate paperwork to the employee, to receive it back from the employee, and for the Health Plan Administration office to make applicable changes and/or send forms to the appropriate Medicare product vendors if applicable.

Who's Eligible For Retiree Health Benefits?

A. **Retiree Eligibility criteria for Employees who are participating in an Oklahoma public entity retirement system**:
   During the period immediately prior to retirement, you must have at least **6** years of continuous group health coverage with a Participating Governmental Agency **AND** you must be eligible to receive a retirement benefit from one of the public employee retirement programs established by the State of Oklahoma, such as the Oklahoma Public Employees Retirement System or the Oklahoma Teachers Retirement System (excluding private retirement enterprises); or

B. **Eligibility criteria for Employees who do NOT participate in an Oklahoma public entity retirement system:**
   During the period immediately prior to retirement, you must have at least **6** years of continuous group health coverage with a Participating Governmental Agency or a Plan-approved entity **AND** the sum of your age plus your years of service (starting with your employment date) with that Employer equals at least the number **80** when you retire.

If an employee had a spouse or dependent covered on the Health Plan at the time of retirement, then they can also continue their coverage under the employee's retiree status.

The retired employee and their spouse/dependents can continue retiree coverage through the Health Plan, as long as they remain eligible and the employer from which they retired or vested continues to participate in the Plan. If the employer terminates its' participation in the Health Plan, the retiree and dependents must follow the employer to their new insurance carrier.

The Retiree and any spouse or dependents may not take more coverage than what they had through the Health Plan at the time of the employee's retirement. For example, if an employee did not have vision coverage the day before retirement, then they are not eligible to add it when they retire. On that same note, if an employee is eligible for a particular coverage line and they don't continue that coverage when they retire, they are not allowed to add it at a later time.

Retiree Coverage Options

Retiree Coverage Options

When the Health Plan receives notice of an eligible employee's retirement, they will mail a Retiree Enrollment package to that employee. Following are the employee's options for retiree coverage under the Health Plan (these coverage options are available for eligible spouses and dependents too):

Medical Coverage

Under 65 Years of Age - Retirees may continue the exact same health coverage that they had as an active employee. They will even continue to use the same ID card.

65 Years of Age or Older - When Retiree's turn **65** and become entitled to Medicare, they are no longer eligible to keep the Health Plan's medical coverage. Instead, the Health Plan has Employer Group Medicare Supplement options available through BlueCross BlueShield of Oklahoma, which supplements the retirees' Medicare Parts A & B. The Health Plan will send them the appropriate enrollment forms for these plans.

Prescription Drug Coverage

Under 65 years of age - Retirees may continue the exact same prescription drug coverage that they had as an active employee. This is bundled with the Medical Coverage, so the Retiree must elect Medical Coverage in order to get the Prescription Drug Coverage. They will continue to use the same ID card.

65 Years of Age or Older - When Retiree's turn **65** and become entitled to Medicare, they are no longer eligible to keep the Health Plan's Prescription Drug coverage. Instead, the Health Plan will assist the retiree in finding a Medicare Part D Prescription Drug Plan. The Retiree will pay the Prescription Drug Plan directly.

Dental Coverage

All ages - Retirees may continue the exact same Dental coverage that they had as an active employee. They will even continue to use the same ID card. Dental is not bundled with Medical, so they can choose to continue Dental without Medical, or Medical without Dental.

Vision Coverage

All ages - Retirees may continue the exact same Vision coverage that they had as an active employee. There are no ID cards with the vision plan.

Continued....

.....Retiree Coverage Options

Life Insurance

All ages - Retirees can choose from 4 different Group Term-Life Insurance amounts: **$5,000, $10,000, $15,000 or $20,000**. The Life Insurance is guaranteed issue (which means the retiree does not have to complete a health questionnaire and be subject to underwriting). The retiree's chosen beneficiary(ies) will receive the full amount of coverage elected, as there is no age reduction under the retiree group life policy.

The Retiree Group Term-Life also includes coverage for the retirees' spouse at no extra cost. The spouse does not have to participate in the Health Plan's health coverage in order to be eligible for this coverage. In the event of the retiree spouse's death, the retiree will receive a life benefit equal to **50%** of the retirees' selected life coverage amount.

Medical Subsidy from Retirement Program

If the employee participates in an Oklahoma Public Entity Retirement Program (like OPERS or OTRS) and they are vested when they retire, then that employee is most likely eligible to receive a subsidy from their Retirement Program to offset the cost of their Medical Insurance (it cannot be applied to dental, vision or life premiums) if they continue their coverage through their employer group. The Health Plan will collect the eligible amount (Typically **$105** for OPERS and **$101 - $105** for OTRS) from the Retirement Program, thereby only charging the retiree the amount of their premiums less their subsidy. The Retiree needs to check with their Retirement Program to make sure they are eligible for this subsidy.

Key Points

1. Retiree coverage must be elected within **30** days of the retirement effective date. However, there cannot be a lapse in coverage.

2. Retiree cannot add more coverage than they had as an active employee. For example, if they didn't have vision coverage at the time of retirement, then they cannot elect vision coverage as a retiree.

3. Additional benefits cannot be added after initial Retiree enrollment, but coverage can be terminated or decreased at any time.

4. Once coverage is terminated or decreased, it can never be reinstated or increased.

5. For Retirees **65** years of age or older and therefore enrolling in a Medicare Supplement, they must first enroll in Medicare Parts A & B. They can contact their local Social Security Office if they have any questions about Medicare Part A or Part B.

Premiums & Monthly Billing

Premiums

Premiums are due by the **10th** of the following month. For example, May premiums are due on June 10th. If payment is not received within 30 days of the due date, the Health Plan has the right to cancel or suspend the payment of benefits.

Please note that premiums cannot be prorated by the day. If an employee works, for example, just 2 days of the month and then he/she terminates, then that whole months' premiums will be due and the employees' benefits will continue through the end of the month. If you cannot collect premiums from your terminated employee for the whole month, then coverage will be terminated back to the 1st of the month due to non-payment of premiums.

Monthly Billing

Your assigned Health Plan Specialist will mail, email or fax to you your monthly billing, which will include a reconciliation of the previous month in case of any balance due or credit forward. The billing will typically be sent to you around the middle of the month.

Review the billing reports to ensure that all your employees are listed for that month and with the correct coverage and premiums. If an employee is not listed or is listed and shouldn't be, it could mean that the Health Plan did not receive an Enrollment Form or Termination Notice. Please call or email your Health Plan Specialist to see if the appropriate forms were received.

If you have last minute additions, changes or deletions that need to be made, there is a page provided on the billing for that purpose so that you can adjust your billing and payment accordingly.

When you mail your monthly premium checks, you don't need to send a copy of the whole bill, but it is helpful to your Plan Specialist if you include a copy of just the Total's page(s), along with any adjustments (additions, changes, or deletions) or notes, so that the billing can be more easily reconciled.

Section 125 Premium-Only Plan

If your entity does not participate in the OPEH&W Section 125 Plan, then this section does not pertain to you. If you are interested in having OPEH&W administer your Section 125 Plan, please contact the Plan Administration office.

What is the Section 125 Premium-Only Plan (POP)?

The Section 125 Premium-Only Plan allows employees to make premium payments for certain employer-sponsored benefits on a pre-tax basis, meaning that the premiums for these certain benefits are deducted from the employees' gross pay before Federal or Social Security taxes are calculated. This means that they will pay less tax and have more money to spend and save. As the employer, this also reduces your tax liability. **For a full explanation of the Premium-Only Plan and what benefit premiums can be paid on a pre-tax basis, please refer to your Section 125 Premium-Only Plan Administration Kit .**

As the employer, what will I receive?

Is this your group's first time under the OPEH&W Premium-Only Plan ?

Yes ► Then you will receive a bound copy of the Section 125 POP Administration Kit, which Includes instructions and all of the forms that you will need to provide to your employees.

No ► You should already have a bound copy of the Section 125 POP Administration Kit, therefore at the start of each plan year, we will only send you the pages that have changed for the new Plan year (which will include the forms you will need to provide to your employees). Included will be instructions for inserting the "changed" pages and taking out the old ones.

How do I notify my employees of the Premium-Only Plan?

Before the start of each new Plan year, you will need to provide your employees a copy of the Premium-Only Plan Summary Plan Description for the new Plan year. They also need to view the Premium-Only Plan video on CD that explains the provisions of the plan (the CD is located in your Administration Kit). They can also view the video online at **www.ezpop.com/POPv_ee.html**. Once they have received the Summary Plan Description and have watched the video, they need to sign the Acknowledgement of Receipt sheet located in your Administration Kit. Keep this acknowledgement for your records.

What forms do my employees need to complete?

Before the start of each new Plan year, each employee must complete either the **Election to Participate** or the **Election NOT to Participate** form. If the employee fails to complete either form, then they will be considered as to have elected **NOT** to participate in the Premium-Only Plan for the upcoming Plan year and no salary redirections should be allowed for the start of the new plan year.

...Section 125 Premium-Only Plan

As the employer, what forms do I need to collect and keep?

You will need to collect the **Election to Participate** or the **Election NOT to Participate** form for each employee and retain those forms for your records and also use them to make any necessary payroll changes. The Health Plan Administration office **does not** need a copy of these forms.

Section 125 Checklist for Benefit Coordinators

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- ☐ **1. Receive new Plan Year documents from the Health Plan.**
- ☐ **2. Distribute the Section 125 Premium Only Plan - Summary Plan Description to each employee.**
- ☐ **3. Have employee(s) view the Premium-Only Plan video on CD or online.**
- ☐ **4. Have employee sign the Acknowledgment of Receipt form (located behind Tab 3 in your Kit).**
- ☐ **5. Provide each employee either the Election to Participate or Election NOT to Participate form.**
- ☐ **6. Collect forms and use to make any applicable payroll changes. Retain for your records.**

IRS Forms 1094-C and 1095-C

The IRS requires Employers to report information to the IRS and to employees about individuals who have minimum essential coverage under an employer group plan. These informational forms, the 1094-C and 1095-C, have two major purposes:

- **Firstly,** to report to the federal government that an employer has offered health insurance coverage, which meets the Affordable Care Act's Minimum Essential Coverage and Affordability requirements. Failure to properly offer Affordable Minimum Essential Coverage to eligible employees will subject an employer to a monetary penalty per employee. While the Health Plan's coverage meets the requirements of Minimum Essential Coverage, the Affordability requirement is determined by comparing the Employee's contribution amount to individual coverage with their annual pay, and so varies greatly between Employer Groups and individual Employees.

- **Secondly**, they provide individual employees with proof for their personal tax returns, showing that they were offered and/or enrolled in health coverage, which met the Affordable Minimum Essential Coverage requirements, thereby avoiding the individual mandate (personal penalty) component of the Affordable Care Act.

These new forms must be generated and sent by the IRS deadline each year. As the Health Plan is designated an Applicable Large Entity (ALE) under this new requirement, all participating employer groups must have these forms generated by the Health Plan with no exceptions. Additionally, for employer groups of less than 50 employees, because of the Health Plan's Applicable Large Entity status, the Affordable Care Act's *safe harbor* to avoid these regulations do not apply.

For more information on these forms, go to **www.irs.gov/form1094c and www.irs.gov/form1095c**.

Although the Health Plan is not responsible for providing these forms to your employees or to the IRS, the Health Plan's Administration Office will provide the administrative oversight and production of these forms for our participating employer groups.

Both the 1094-C and 1095-C can be printed and/or downloaded from the online HEART system via your Employer login at **www.opehwheart.com/ERLogin**. See the next page for step-by-step instructions.

IRS Forms 1094-C and 1095-C

1. Using your Employer Representative user account, log-in to the HEART platform - **https://www.opehwheart.com/ERlogin.aspx**.
2. Click on the box that says Generate 1094 & 1095C report.
3. Select the appropriate period (tax year).
4. Click the "Select All Members" box.
5. Click on the 1094-C Report to start the download. Depending on what browser you use, it may come up automatically as a PDF file, or you may have to save it as a PDF file to your computer.
6. After you have completed step #5, you can then check the "Select All Members" box again and run the 1095-C reports.
7. The larger your group is, the longer your file may take to download.
8. Every internet browser is different. When we used Mozilla Firefox to download the files, it kept popping up a message and we had to keep clicking "Resend". If yours does this, just do the same. If it wants you to choose a program to open the file with, select Adobe Acrobat (pdf).
9. Your 1095-C's also include forms for terminated employees, COBRA members, and Retired members that you'll need to mail.
10. Print 2 copies of the form 1095-C. Distribute one copy to your employees/former employees and the other copy goes to the IRS along with your form 1094-C.
11. Per the IRS guidelines, the 1094-C and 1095-C have to be filed (postmarked) with the IRS no later than February 28th, 2017.
12. HOWEVER, if your group has 250 or more form 1095-C's to file, then you are required by the IRS to file your forms electronically. If your group meets this requirement, then you will see another green button on the same page where you generate your 1095-C's that says "Generate XML File". If this applies to you, then please follow the separate set of instruct tions that you will receive via email. Be sure to submit your Electronic file by the IRS dead line.

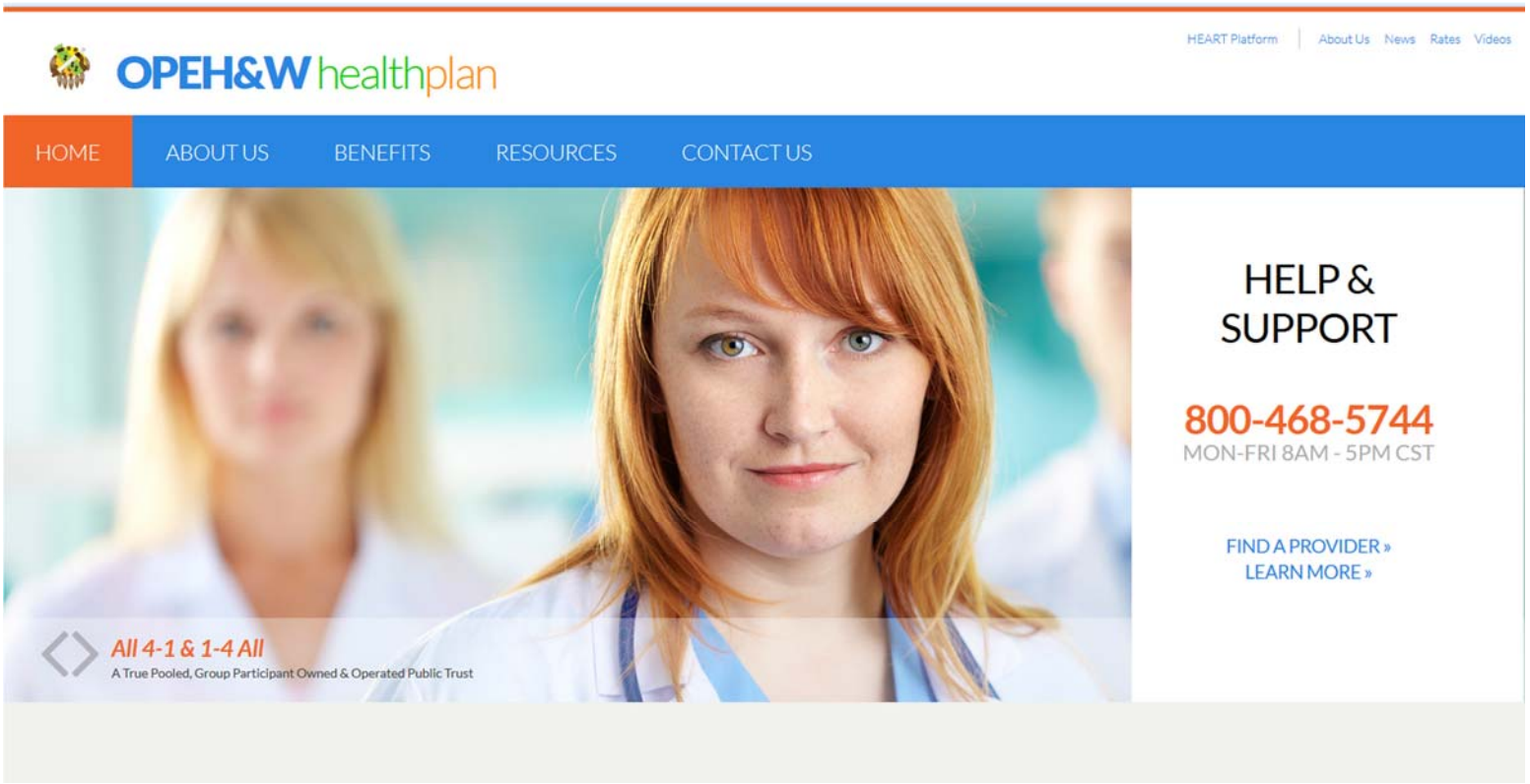
For the IRS Instructions, including filing for an extension (if needed) and where to mail your returns, follow this link: **https://www.irs.gov/instructions/i109495c/ar01.html**

Incorrect 1095-C's:
If you find a 1095-C that is not correct, you may correct it yourself. Be sure to correct both the employees' copy and the copy you will send to the IRS. For instance, an employee's 1095-C may be incorrect on the months they had group health coverage if we received an enrollment form or termination notice late.

The Health Plan's Website

www.opehw.com

What can you find on the Health Plan's Website?



- About Us
- All Health Plan Forms - Employer & Employee
- Benefit Book
- The Board of Trustees - List & Contact Details
- Benefit Videos
- Health Plan Coverage Details & the SBC
- Health Plan Rates
- Provider Finder
- HEART platform link for Employees

Board Representatives

The Health Plan is supervised by a Board of Review, which consists of 15 voting members. Each Participating Employer which is not represented on the Board of Review shall have the option of appointing an elected official to act as their non-voting Board Representative (also known as an Ex Officio). Participating Employers should immediately notify the Health Plan, in writing, of Board Representative changes.

For an up-to-date list of the Plan's Board Representatives, see the Plan's website at the following link: **http://www.opehw1.com/boardMembers.html**

Health Plan Forms

All of the Health Plan forms that you will need for yourself and/or your employees are listed below. These forms are available on the OPEH&W website at **www.opehw.com** (click on *Resources*, then *Forms*), or, they can also be emailed to you upon request.

1. **Employee Enrollment Form**: To be used by existing employees who are in a Special Enrollment Period and need to make changes to their coverage. New Employees will not complete a paper enrollment form, as they will use the Health Plan's online enrollment System - HEART.
2. **Termination Notice:** This form should be used by the Benefit Coordinator to notify the Health Plan of employee, spouse or dependent terminations, or cessation of active work.
3. **Name or Address Change Form:** For employees to use at any time to notify the Health Plan of name or address changes.
4. **Beneficiary Change Form:** For employees to use at any time to change or add a beneficiary for their Group Life Coverage and/or their Additional Life Coverage. A beneficiary is one who would receive the life insurance benefit if the employee should decease. Multiple beneficiaries can be listed (both primary and secondary).
5. **PHI Release Authorization Form:** For employees to use at any time to change or update the person(s) to whom they want the Health Plan to release **P**rotected **H**ealth **I**nformation.
6. **Dependents Other Than Own Form:** For employees to use when enrolling a dependent that is not their own, but for which they are legally responsible and can supply the Health Plan with supporting documentation of such. This form should accompany the Employee Enrollment Form.
7. **Dependents with Disabilities Form:** For employees to use when enrolling an eligible disabled dependent that is over the Health Plan's dependent child age limit of 26. This form should accompany the Employee Enrollment Form.
8. **Additional Dependents Form**: For employees to use when completing the Employee Enrollment Form and they need additional space to list dependents.
9. **Additional Life Coverage Worksheet:** For employees to use during the Annual Renewal Period, or during a Special Enrollment Period to select Additional Term Life coverage for themselves, their spouses and/or dependent children. This worksheet lets them know how much they can get and how much it will cost. For new employees using the Health Plan's online enrollment system - HEART, then they will complete this online rather than in paper form.
10. **Health Questionnaire:** Employees and/or spouses or dependents may need to complete this form when applying for Additional Life Coverage (the worksheet in #9 above will help determine if they are required to complete this form or not). The Health Plan's Life Insurance Carrier uses this form to determine the insurability of an individual.

Other Health Plan Forms

Following are some additional Health Plan forms and documents that are available on the Health Plan's website at **www.opehw.com** (click on *Resources*, then *Forms)*, or they can be emailed to you upon request:

1. **Quick Start Guide** - This is a quick reference summary of Health Plan benefits , as well as contact information for each vendor.

2. **Claim Forms for Medical, Prescription, Dental and Vision** - Manual claim forms are available for each of these coverage lines. These forms can be used for out-of-network claims, as well as for claims where a particular provider either doesn't take insurance or they don't file insurance claims. In these cases, the member will need to obtain a claim form for either themselves or the provider to submit to the appropriate vendor for reimbursement or payment.

3. **Express Scripts Mail Order Form** - For those who would like to participate in the money-saving prescription mail order service through Express Scripts Pharmacy, they will need to complete this form, enclose original prescriptions and payment information, then send directly to Express Scripts to establish this service.

4. **Benefit Book (formerly known as the Summary Plan Description (SPD)) -** This is the Health Plan document that explains every aspect of the Health Plan, including, but not limited to, what benefits are covered under the Health Plan, what is excluded from coverage, how claims are paid and who is eligible for benefits under the Health Plan. This document is updated from time-to-time, but the latest version can always be found on the Health Plan's website.

5. **Summary of Benefits & Coverage (SBC)**
The SBC is the Affordable Care Acts required format document which explains the benefits the Health Plan offers and is designed to allow the individual to compare any two health insurance plans in Oklahoma with easily comparable data and format.

6. **HIPAA Privacy Notice**
The HIPAA privacy notice outlines all the steps the Health Plan takes in securing your Private Health Information (PHI), including your rights under HIPAA to receive an accounting of disclosures of PHI.

7. **Common-Law Marriage Affidavit**
Employees and their common-law spouse must be able to complete and submit the Affidavit of Common-Law Marriage form. The affidavit has to be approved by the Plan Administrator to qualify a common-law spouse as an eligible dependent under the Health Plan.

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Other Health Plan Forms

8. **Life Insurance Portability and Conversion Applications**
   When an active employees' coverage ends and they had life insurance, they could be eligible to convert or port the life coverage they had into an individual policy directly with Dearborn National, the Health Plan's life insurance vendor. If an employee receives an offer of Life Conversion in the mail from the Health Plan and they want to convert or port it, they would need to complete one of these applications.

9. **Dependent Deductible Reimbursement Form** - If a covered dependent child meets more than $375 of their plan year deductible (in or out of network) during the Plan year, the member is eligible to apply for a reimbursement for the amount they paid out-of-pocket between $375 and $750.

10. **Dependent Accident Reimbursement Form** - If a covered dependent child receives covered services in an emergency room, urgent care facility or minor emergency center for an accidental injury, the Plan will pay for the first $500 of the member's out-of-pocket costs for that claim, or, if their out-of-pockets costs for that claim are less than $500, the lesser amount.

[End]