Insurance Coordinator Manual

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This publication is issued by the Office of Management and Enterprise Services as authorized by Title 62, Section 34. Copies have not been printed but are available through the agency website.

New Insurance Coordinators

- EGID
- Member Services
- Resources
- IC Trainings

EGID

The Oklahoma Office of Management and Enterprise Services Employees Group Insurance Division (EGID) was created and is governed by Oklahoma law. Its purpose is to provide health, dental, vision, life and disability benefits to state, local government and education employees and other entities designated by statute, as well as the retirees and dependents from these groups.

EGID would like to thank you in advance for taking the time to learn the rules, regulations, forms and electronic systems needed to be an effective insurance coordinator (IC) for your employer and employees. We understand your duties as an IC are just part of your responsibilities, and our goal is to make your continuing experience with us as easy as possible.

Member Services

Member services is charged with assisting employees and ICs with the annual Option Period, answering benefit and eligibility questions, and providing general information regarding insurance coverage for the plans offered through EGID.

For general questions or non-urgent issues, call the member services call center at 405-717-8780 or toll-free 800-752-9475, Monday through Friday from 7:30 a.m. to 4:30 p.m. Central Time. TDD users call 405-949-2281 or toll-free 866-447-0436.

Resources

- **Member services group management specialist** – The specialist assigned to your account is your personal source for guidelines, eligibility, forms, meetings and all other group insurance related information. Keep your specialist's contact information handy for when you need assistance. The easiest way to contact your specialist is by email.
- **EGID website** (**www.sib.ok.gov**) – You can access current EGID news and materials, the EGID calendar, the IC web page, *Administrative Rules*, legal notices and more.
- **IC web page** – On the EGID website, go to Coordinators in the top menu bar, then select Insurance Coordinator. You can access reminders, forms and retirement and COBRA materials and request other materials. Sensitive information, such as certain COBRA forms, can be accessed only after you register for web enrollment. You can log in through the application link on the IC web page.
- **Insurance Coordinator Manual** – This convenient, online manual is maintained on the IC web page.

- **FAQ (Frequently Asked Questions)** – Accessed from the top menu bar of the EGID website, the FAQs instantly provide general plan information by entering a question, keyword or phrase.
- **IC Option Period meetings** – Held throughout the state in September, these meetings provide information about insurance options for the upcoming plan year.

IC Trainings

EGID holds numerous trainings throughout the year, including:

- **New IC Training** – Available as an online webinar, you can register through the EGID website calendar. You can also request that your group management specialist come to your site for a one-on-one session. Training includes information from this manual and provides the basic information you need to successfully perform your duties as an IC.
- **Web Enrollment Training** – You are strongly encouraged to take this training so you can process enrollments and eligibility changes using EGID's web enrollment application instead of mailing or faxing forms to EGID for processing. Upon completion of training, web enrollment sends you a link to register for access to the web enrollment application.
- **Spring Training** – Offered by group management as an annual refresher course, training sessions are available by webinar. Spring Training provides opportunities to voice comments or suggestions you have about EGID plans or materials.
- **Option Period Training** – Offered by group management to provide training to coordinators and members in reference to Option Period plan changes. Training sessions are available by webinar and at various locations across the state; or upon special request.

Eligibility

- Employees
- Dependents
- Divorce Proceedings
- DHS-Directed Dependent Additions (National Medical Support Notice)
- Surviving Dependents
- Transfer Employees
- Returning to Work After Leaving Employment

Employees

To be eligible to participate in the plans offered through EGID:

- **An education employee** must be eligible to participate in the Teachers Retirement System and work a minimum of four hours per day or 20 hours per week.
- **A local government employee** must be employed in a position requiring a minimum of 1,000 hours per year and not be listed as a seasonal or temporary employee.
- **Other persons** must be elected by popular vote or on approved leave without pay status (not to exceed 24 months).

A new employee has 30 days from their entry-on-duty date or the end of their probationary period to elect coverage at initial enrollment. Coverage is effective the first day of the month following their entry-on-duty date or the end of their probationary period.

An employee must be enrolled in one of the health plans offered through EGID or provide proof of other health coverage* to be eligible for dental or life coverage. Proof of other health coverage includes:

- A certificate of health plan coverage;
- An ID card for military health benefits or Indian Health Service; or
- A letter from the previous employer that lists dates of coverage and all covered dependents.

*Other health coverage cannot be an excepted benefit. Refer to Excepted Benefits in the Glossary section.

Vision coverage is the only benefit that is available without proof of other health coverage.

A new employee is eligible for the Guaranteed Issue amount of Supplemental Life only at initial enrollment.

A new employee has 30 days from their eligibility date to make changes to their initial coverage by completing a new Insurance Enrollment Form. These changes are effective the first day of the month following the date of the change. Changes outside this 30-day window can be made only if a midyear qualifying event occurs or during the annual Option Period. Contact your group management specialist if you have member issues.

Dependents

An employee can enroll their eligible dependents, i.e., spouse and children, at initial enrollment, within 30 days of a qualifying event, or during the annual Option Period. Refer to Midyear Enrollment Changes in the Enrollment section.

An employee must be enrolled in coverage for their dependents to be enrolled in that same coverage.

If dependent coverage is selected, all eligible dependents must be covered. An employee's eligible dependents can be excluded with proof of other health coverage that is not an excepted benefit and/or other group dental, vision or life coverage, or eligibility for Indian or military health benefits. Dependents can also be excluded if they do not reside with the employee, are married or are not financially dependent on the employee. Refer to Excepted Benefits in the Glossary section.

Dependents are not required to have health coverage to be eligible for dental or life coverage. Only the primary member must have health coverage.

Effective Dates of Coverage for Dependents

Coverage is effective the first day of the month following enrollment. Coverage for enrollment during Option Period is effective Jan. 1. Exceptions include:

- **Newborn** – The effective date of coverage is the first day of the month of birth.
- **Adoption or legal guardianship** – At the employee's option, the effective date of coverage is either the first day of the month in which the employee gains physical custody or the first day of the following month.
- **Court order** – The court dictates the effective date of coverage.

Spouse

A spouse can be enrolled in coverage as long as a divorce or legal separation has not been filed. Likewise, a spouse cannot be dropped from coverage while in the process of divorce or legal separation. Refer to Divorce Proceedings later in this section. Please note the following:

Common-law spouse – EGID recognizes common-law marriages. An employee's common-law spouse must sign the Common-Law Spouse Certification on the appropriate form. Once a common-law marriage is publicly declared, it can be dissolved only through a legal divorce.

Excluding a Spouse

An employee can exclude their spouse from health and/or dental coverage without proof of other coverage, even if they cover dependent children. To exclude their spouse while covering dependent children, the spouse must sign the Spouse Exclusion Certification on the appropriate form. To exclude a spouse from vision coverage while covering dependent children, the spouse must provide proof of other group vision coverage.

Dependent Children

Eligible dependent children include:

- Daughter, son, stepdaughter, stepson, eligible foster child, adopted child, child for whom the employee has been granted legal guardianship, or child legally placed with the employee for adoption, up to age 26, whether married or unmarried.
- A dependent, regardless of age, who is incapable of self-support due to a disability diagnosed prior to age 26. For additional information, refer to Special Rules for a Disabled Dependent below.
- Other unmarried dependent children up to age 26, upon completion and approval of an Application for Coverage for Other Dependent Children. Other dependents include grandchildren, nieces, nephews and other children who reside with the employee. A tax return showing dependency can be provided in lieu of the application.

If both parents are primary members under EGID, dependent children can be covered under either parent's health, dental and vision plan (but not both). However, both parents can cover dependents under Dependent Life.

Special Rules for a Disabled Dependent

A disabled dependent child must be incapable of self-support because of mental or physical incapacity that existed prior to age 26. The dependent is eligible to continue coverage as long as they meet all eligibility rules. To apply to continue coverage for a disabled dependent beyond age 25, the primary member must:

- Submit a copy of their most recent federal or state tax returns to provide proof of dependent status.
- Complete a Disabled Dependent Assessment form and return it to EGID according to the time frames below:
  - New employees must submit the form within 30 days of enrollment.
  - Current employees must submit the form at least 30 days prior to the dependent's 26th birthday.
  - Former employees who added or continued coverage on a disabled dependent at retirement must submit the form at least 30 days prior to the dependent's 26th birthday.

NOTE: The Disabled Dependent Assessment form must be approved by EGID before coverage begins or is continued. If the form is not received within the designated time frame, coverage or continuation of coverage is denied.

Policies for Newborn Coverage

For all health plans, employees have 30 days from the date of birth to enroll a newborn for coverage beyond a routine delivery. The newborn must be enrolled effective the first day of the month of birth.

Enrolling a newborn in coverage:

- A newborn must be enrolled in coverage the first day of the month of the child's birth. A member has 30 days from the date of birth to enroll a newborn. An Insurance Change Form must be completed and submitted to you or EGID.

- Premiums for the full month of the child's birth must be paid.
- Unless there is proof of other coverage, when one or more eligible dependents are currently covered, a newborn must be enrolled in the same coverage. Current employees must provide you with proof of the other coverage.
- When enrolling a newborn in coverage, all other eligible dependents must be enrolled (if they are not already enrolled). A member can exclude a spouse from health and/or dental coverage.
- A member can request coverage for a newborn grandchild by completing an Application for Coverage for Other Dependent Children. Coverage for a grandchild is effective the first day of the month following the receipt and approval of the application and payment of premiums. Coverage is not retroactive to the month of birth, except in the case of a newborn which shall be added the first of the month of birth.
- A newborn's Social Security number is not required at the time of initial enrollment, but must be provided when received from the Social Security Administration.

Accepting the Newborn Limited Benefit when **not** enrolling the newborn:

- There is no additional premium for the Newborn Limited Benefit.
- Enrollment of other eligible dependents is not required.
- The Newborn Limited Benefit applies only if the mother or father of the newborn is covered under a HealthChoice health plan.

  Plan Details:

  - Aetna, CommunityCare and GlobalHealth HMOs – A newborn is covered for 31 days without an additional premium.
  - HealthChoice – A newborn has limited coverage for a routine birth for the first 48 hours following a vaginal delivery or for the first 96 hours following a C-section delivery without an additional premium.
    - There are no benefits for services in addition to a routine hospital stay if the newborn is not enrolled and premiums are not paid for the month of birth.
    - The member is responsible for any charges over and above the Newborn Limited Benefit regardless of the facility's network or non-network status. A separate calendar year deductible and coinsurance apply.

Declining the HealthChoice Newborn Limited Benefit

To decline the Newborn Limited Benefit, a Newborn Benefit Waiver must be completed. This action is not recommended.

Divorce Proceedings

Oklahoma law prohibits dropping a spouse or dependent from coverage while in the process of a divorce or legal separation at any time. It is important employees contact their legal counsel for advice before making any changes to their coverage. Refer to Oklahoma Statutes Title 43, Section 110 (43 O.S. § 110).

If an employee is court-ordered to provide (pay for) insurance for a former spouse, the former spouse is not an eligible dependent and cannot enroll in or keep coverage under the employee through EGID.

A former spouse covered by the employee as a dependent at the time of the final divorce decree is eligible for coverage under COBRA. A former spouse is not eligible for COBRA coverage through EGID if they were not covered at the time of the final divorce decree.

DHS-Directed Dependent Additions (National Medical Support Notice)

You may receive a document called a National Medical Support Notice, which is a court order requiring an employee to insure one or more of their children. This notice includes the following parts:

- **Part A** – Notice to Withhold for Health Care Coverage (your part).
- **Part B** – Medical Support Notice to Plan Administrator (EGID's part).

You are required to complete the employer response in Part A and return it to the issuing agency. You are also required to forward Part B to the plan administrator (EGID). **Please do not complete Part B yourself.** The employee may be required to add additional benefits or change carriers when they receive this notice. Please do not make changes to the employee's coverage through web enrollment in response to this notice.

Our web support unit handles all National Medical Support Notices. When EGID receives Part B, we make the appropriate changes to the employee's coverage and contact you to review them. All changes to coverage are effective the first day of the month following receipt of the notice. Please forward Part B to:

EGID
Attn: Web Support
P.O. Box 58010
Oklahoma City, OK 73157-8010

Surviving Dependents

In the event of an employee's death, please complete and return an Insurance Termination Form to EGID, and we will mail a survivor packet to all eligible dependents. To continue coverage, a surviving spouse and dependents have 60 days following the employee's death to complete and return the Surviving Spouse and Dependent Election Form. Coverage is effective the first day of the month following the employee's death.

- A surviving spouse is eligible to continue coverage as long as premiums are paid.
- Surviving dependent children are eligible to continue coverage until age 26.
- Disabled dependent children are eligible to continue coverage as long as they meet the EGID definition of a disabled dependent.
- If a survivor is age 65 or older, they must enroll in a Medicare supplement plan.
- Premium Notices are sent to the survivors' addresses, and premiums must be paid through the last day of active coverage.

NOTE: A surviving spouse is billed the primary member rate and dependent children are billed the appropriate dependent rate. When an adult is not listed as the primary member, each surviving dependent child is enrolled under a separate account and billed the child premium.

Transfer Employees

A transfer employee is someone who moves from one EGID participating employer to another. The break in coverage cannot be more than 30 days. A transfer employee is treated as a new employee with the following options:

- Enroll with coverage effective the first month of employment if the previous coverage ended the month prior. The employee is responsible for paying plan premiums for this first month of coverage.
- Continue coverage through their previous employer for one month until they are eligible to enroll through the new employer.
- Enroll in COBRA coverage for the gap in coverage.
- Enroll in the Guaranteed Issue amount of life insurance.
- Continue any amount of life insurance they had through their previous employer without a Life Insurance Application.

If your employee transfers to another employer, you must terminate their current coverage immediately. Failure to terminate their account in a timely manner can result in a gap in coverage and possible payroll deduction errors with the new employer.

Returning to Work After Leaving Employment

If a previous employee returns to work for your employer after a break of less than 30 days, they are eligible to enroll in only the coverage they had in effect when they left employment.

If a previous employee returns to work for your employer after a break of 30 days or more, enroll them as a new hire, except for life insurance. If the employee returns within 24 months, they can enroll in only the amount of life insurance they had when their previous employment ended unless a Life Insurance Application is approved for a greater amount of coverage. Additionally, the total amount of life insurance cannot exceed the Guaranteed Issue amount based on the employee's current salary unless a Life Insurance Application is approved.

If the returning employee is retired, they can elect the employer group coverage or continue coverage as a former employee. If they are on Medicare, the following applies:

- If an employee elects the employer group health coverage, they must contact Medicare before the new coverage begins. They also need to contact Medicare when they terminate employment.
- If an employee chooses to keep coverage as a former employee, Medicare continues to be the primary payer.

Enrollment

- Web Enrollment
- Employee Enrollment
- Midyear Enrollment Change
- Initial Enrollment Checklist

Web Enrollment

EGID offers a web-based enrollment application called Employer Self Service. You can make real-time changes to employee coverage, print Confirmation Statements and print or view both monthly premium bills and estimated future bills.

You must attend a training session and register with EGID to use this valuable tool. If you are interested in attending one of our web enrollment training sessions, please contact web support at 405-717-8707 or toll-free 800-543-6044, ext. 8707 to enroll.

An employee must still complete the proper form even if you use web enrollment. If a review is not required by EGID, keep the form and any midyear change documentation in the employee's file.

Employee Enrollment

The Insurance Enrollment Form is used at initial enrollment for new hires or when a current employee has a midyear qualifying event that allows them to enroll. The employee must list all eligible dependents in the Dependent Information section of the form. They must also provide their dependents' Social Security numbers, with an exception for newborns per the Policies for Newborn Coverage in the Eligibility section. It is important to review the form with new employees and inform them of any benefit allowance provided by your employer. Refer to the Eligibility section for guidelines on coverage elections and effective dates.

Midyear Enrollment Changes

If an employee is enrolled in coverage through EGID but declined enrollment in certain coverage for themselves and/or their dependents because of other health or group dental, vision or life coverage, they and their dependents can enroll within 30 days of the loss of the other coverage. They must provide proof of the loss and complete an Insurance Change Form within 30 days of the event. Otherwise, they must wait until the next annual Option Period to enroll.

If an employee gains a new dependent, this is also a qualifying event to enroll a dependent midyear. The employee must complete an Insurance Change Form and provide the appropriate documentation, such as:

- A birth, marriage or death certificate, or divorce decree.
- A portion of the employee's latest tax return listing dependents for income tax deduction purposes.

- Adoption or legal guardianship papers or other court records.
- A Disabled Dependent Assessment form.
- An Application for Coverage for Other Dependent Children.

Note: The Disabled Dependent Assessment form and Application for Coverage for Other Dependent Children must be approved by EGID.

Initial Enrollment Checklist

Enrolling an Employee as a New Hire

- ☐ Confirm the employee is eligible for insurance.
- ☐ From the IC web page, print a current Insurance Enrollment Form and the General Notice of COBRA Continuation Coverage Rights.
- ☐ Complete the Employer Information section of the form and indicate this is a new hire enrollment.
- ☐ The effective date of coverage is normally the first day of the month following the entry-on-duty date or the end of a mandated employer probationary period.
- ☐ Inform the employee of the insurance options offered through your employer.
- ☐ Give the Insurance Enrollment Form and General Notice of COBRA Continuation Coverage Rights to the employee and inform them of your deadline to complete and return the form.
- ☐ Verify the employee has completed and signed the form and confirm elections with the employee.
- ☐ If the employee elects dental or life insurance without electing health insurance, you must obtain proof of other health coverage that is not an excepted benefit. Refer to Excepted Benefits in the Glossary section.
- ☐ Review the back of the form to make sure the employee has completed all required signatures and dates.
- ☐ If the employee elects Supplemental Life in excess of Guaranteed Issue, a Life Insurance Application is required.
- ☐ Sign and date the form in the Insurance Coordinator Signature section.
- ☐ If you use web enrollment, enter the information online.
- ☐ If you do not use web enrollment, make a copy of the front and back of the form and mail the original to EGID, Attn: Member Accounts, P.O. Box 58010, Oklahoma City, OK 73157-8010; or fax to 405-717-8939 or 405-717-8942.
- ☐ Keep a copy of the form in the employee's file.

The Employee Benefit Options Presentation for new employees is available on the IC web page.

Qualifying Events

- Qualifying Events
- Reminders
- Leave Without Pay
- USERRA
- Midyear Change Checklist

Qualifying Events

Certain life changes, known as qualifying events, allow employees to change benefits. Also known as midyear qualifying events, these events can happen any time during the year, and more than one event can happen at a time. To make a change, an Insurance Enrollment Form or Insurance Change Form must be completed within 30 days of the qualifying event. Requests for changes received after the deadline are denied.

Qualifying events include:

- A change in marital status, such as marriage, divorce or the death of a spouse.
- A change in the number of dependents, such as the birth of a child.
- A change in employment status that affects an employee's eligibility.
- A change in the coverage of a spouse or dependent under another employer's plan.
- A change in a dependent's status that causes them to gain or lose eligibility.
- The gain or loss of other health coverage that is not an excepted benefit or other group, dental, vision or life coverage. Refer to Excepted Benefits in the Glossary section.
- The commencement or termination of adoption procedures.
- Court judgments, decrees or orders.
- Medicare or Medicaid eligiblity for an employee or dependent.
- An employee's eligibility for leave under the *Family and Medical Leave Act* (FMLA).
- When an employee no longer lives or works within their HMO ZIP code service area (only a change of health plans is allowed).

NOTE: Changes in coverage due to Medicaid eligibility are limited to two changes per plan year; once out and once back in or vice versa.

When an employee becomes Medicare eligible, they have two options:

- Continue coverage through the employer group health plan and defer Part B enrollment. The employer's plan will remain the primary payer.
- Discontinue coverage through the employer group health plan. Medicare becomes the primary payer for Medicare-covered services. An employer cannot provide a Medicare supplement plan, or pay a subsidy for such coverage.

Midyear elections are allowed under the circumstances outlined in Title 26, Section 125 of the Internal Revenue Code. An employee must notify and provide documentation to you within 30 days of a qualifying

event. You are required to keep documentation to support a qualifying event and provide that documentation to EGID upon request.

Employees who do not elect to have their benefit costs withheld through a pre-tax payroll deduction and/or employers who do not administer their employees' benefits under a Section 125 plan must still follow the rules for midyear changes under Section 125 guidelines.

Reminders

Employee coverage can be added or dropped only within 30 days of an employee's eligibility date, during the annual Option Period, or with a Section 125 qualifying event. These same rules apply to dependent coverage. Most changes are effective the first day of the month following notification. Financial hardship is not a valid qualifying event that allows an employee to drop coverage.

If an employee did not elect coverage at initial enrollment, coverage can be added only during the annual Option Period or with a qualifying event.

If an employee's provider leaves their plan, it is not a qualifying event that allows the employee to change plans midyear. The employee must choose another provider within their plan's network, or pay non-network charges if this option is available.

Oklahoma law prohibits dropping a spouse or dependent child from coverage while in the process of a divorce or legal separation. It is important the employee contact their legal counsel for advice before making any changes to their coverage.

Leave Without Pay

If an employee is on leave without pay, their insurance coverage can continue for up to 24 months. The employee is responsible for payment of all premiums to the employer during this time. At the end of the 24-month period, you can terminate all coverage; however, if workers' compensation or disability insurance is involved, contact your legal counsel.

Going on and returning from leave without pay are both qualifying events that allow an employee to make certain changes to coverage.

USERRA

Under the *Uniformed Services Employment and Re-employment Rights Act* of 1994 (USERRA), coverage can be continued for up to 24 months. USERRA provides certain rights and protections for all employees called to serve our nation. All branches of the military, including the Army, Navy, Marines, Air Force, Coast Guard, and all military reserve and National Guard units, come under USERRA.

In addition to health care coverage provided by the military, employees can:

- **Retain all coverage.** You are responsible for collecting and forwarding all premiums to EGID.
- **Discontinue member coverage but retain dependent coverage.** This is the COBRA option and dependents are billed directly at 102 percent of premiums, the COBRA rate, for health, dental and/or vision coverage. Under COBRA rules, life insurance cannot be retained.
- **Discontinue all coverage except life insurance.** The member is billed directly.
- **Discontinue all member and dependent coverage.**

There is no penalty when an employee renews coverage upon discharge from active duty if coverage is elected within 30 days of their return to the same employment.

NOTE: The HealthChoice Disability Plan is not available to state and participating county employees called to active military service. However, upon return to regular employment for five consecutive days, they become eligible for disability coverage.

Midyear Change Checklist

- ☐ Make sure the employee has a recognized qualifying event and request documentation, i.e., proof of the event.
- ☐ Obtain either an Insurance Enrollment Form or Insurance Change Form as appropriate and complete the Employer Information section.
- ☐ Give the form to the employee to complete and provide the date the form must be returned to you.
- ☐ Check that the employee has completed the form and confirm elections with the employee.
- ☐ Review the back of the form to make sure the employee has all required signatures and dates completed.
- ☐ Prepare a COBRA packet for dropped dependents, if applicable.
- ☐ Sign and date the form in the Insurance Coordinator Signature section.
- ☐ If you use web enrollment, make the change to the employee's information.
- ☐ If you do not use web enrollment, make a copy of the front and back of the form and mail the original to EGID, Attn: Member Accounts, P.O. Box 58010, Oklahoma City, OK 73157-8010; or fax to 405-717-8939 or 405-717-8942.
- ☐ Keep a copy of the form and all documentation in the employee's file.

Common Qualifying Events

LIFE EVENT	ADD	DROP	CHANGE PLAN	COBRA	NOTES
New hire, new eligibility, or rehired after 30 days	Yes	No	No	No	An employer probationary period may affect eligibility date
Acquire a dependent	Yes	No	No	No	
Loss of eligibility for a covered dependent	No	Yes	No	May apply to dependent	Employee and spouse divorce; a child turns 26
Loss of other group coverage (member or dependent)	Yes	No	No	No	Affects only the type of coverage lost
Gain other group coverage (member or dependent)	No	Yes	No	No	Affects only the type of coverage gained
Move out of HMO plan's service area	No	No	Yes	No	If employee works in HMO service area, then no QE
Commence FMLA leave or active military duty	No	Yes	No	Yes	
Return from FMLA leave or active military duty (< 2 years)	Yes	No	No	No	Renew within 30 days of return
Loss of employment and eligibility	No	Yes	No	Yes	If termination is due to gross misconduct, employer may determine eligibility for COBRA
Rehire < 30 days with the same employer	No	No	No	No	Enrollment limited to previous coverage
Death of the member	No	Yes	No	Yes	Refer to Surviving Dependents
Court-ordered coverage	Yes	Yes	No	May apply to dependent	Must follow instructions from the court
Enrollment in coverage through Marketplace	No	Yes	No	Yes	Marketplace plan must be effective immediately following drop of coverage

Health Insurance

- HMO vs. PPO-Type Indemnity Plan
- HMO ZIP Code Service Areas
- Choosing a Health Care Provider
- Case Management
- Medical and Pharmacy Claims
- Coordination of Benefits
- More Information About the Health Plans

HMO vs. PPO-Type Indemnity Plan

An HMO is a type of managed care plan regulated by the Oklahoma State Insurance Department. To be eligible to enroll in an HMO, an employee must live or work within that HMO's ZIP code service area. When an employee enrolls in an HMO, they must designate a primary care physician (PCP) who coordinates all health care needs.

A PPO-type indemnity plan is a traditional fee-for-service plan that gives the member the freedom to visit any licensed health care professional without a referral. Members are responsible for deductibles, copays and coinsurance, and a calendar year out-of-pocket maximum typically applies. Once the out-of-pocket maximum is met, the plan typically pays 100 percent of allowable fees for covered services for the rest of that plan year.

All health plans offered through EGID provide medical and prescription drug benefits. Benefits are subject to each plan's rules and certain cost-sharing features such as copays, deductibles and coinsurance.

HMO ZIP Code Service Areas

Employees must live or work within an HMO's ZIP code service area to be eligible. Refer to the current HMO ZIP code lists in the Employee Benefit Options Guide.

Choosing a Health Care Provider

If an HMO plan is selected, the employee must designate a PCP. If they do not designate a PCP, one is selected for them. The PCP is the first point of contact when seeking health care and is responsible for coordinating and authorizing all health care. Failure to obtain authorization from the PCP can result in the denial of claims. For information on an HMO's benefits, providers or drug formulary, please contact the HMO directly.

If a HealthChoice plan is selected, the employee should confirm their medical provider or facility participates in the HealthChoice Provider Network. The most current list of network providers is available on the HealthChoice website or by calling member services. If the employee decides to use a non-network provider or facility, the employee's out-of-pocket costs can be substantially higher.

Each plan issues ID cards to its members. Providers and facilities often require a copy of the employee's plan ID card and driver license or photo ID when they receive services.

Case Management

Case management provides personalized assistance and coordination of medical services to help maximize benefits and is available with all health plans offered through EGID. Case management is helpful in the following situations:

- Cancer
- Rehabilitation
- HIV/AIDS
- Terminal illness
- Stroke
- Pregnancy and pre-term infants
- Transplants
- Mental health and substance use disorder
- Non-network emergencies

Medical and Pharmacy Claims

All HealthChoice health plans use central claims offices that process claims and track annual deductibles, out-of-pocket maximums, and services that have plan limitations.

The medical claims administrator processes an electronic Explanation of Benefits (EOB) for each claim. An EOB describes how benefits were applied, including, e.g., the amount billed by the provider, write-off amount, member copay, deductible and coinsurance, and total payment to the provider. Members can check claim status and view EOBs in ClaimLink through the HealthChoice website. If the member has not registered for ClaimLink, they will need to create a user name and password to access their information. If the member does not have online access, please have them contact member services for assistance.

In the event of an urgent eligibility issue, such as when a new employee needs a prescription and their pharmacy rejects the claim for no coverage, please contact member services for assistance.

To safeguard your employees' private health information, limit your exposure to their claims information. All the health plans available through EGID have processes in place that allow an employee or adult dependent to authorize the release of their protected health information (PHI) to another person.

Coordination of Benefits

If an employee or their dependents have medical or pharmacy costs that are also covered by another group health plan, the insurance plans coordinate their payments so that the total benefits are not greater than the billed charges, benefits allowed or amount of member responsibility. This is known as coordination of benefits (COB).

When HealthChoice needs information on a member's or dependent's other health coverage to process a claim, a Verification of Other Insurance Coverage form is sent to the member. If the member fails to provide the requested information, the claim is delayed or denied for non-compliance.

An employee's group insurance plan through their employer is always primary. If the employee is also covered as a dependent under a spouse's plan, that plan is secondary to the employee's plan.

Different guidelines apply to dependents covered under both parents. In the absence of a court order indicating the primary plan, the determination may be based on which parent's birth month is earlier in the calendar year. For example, if one parent was born in February and the other in April, the plan of the parent born in February is primary. This guideline is commonly known in the insurance industry as the *Birthday Rule*.

In cases where the *Birthday Rule* cannot apply, the determination is based on a court order, custody or financial responsibility for the dependents.

When there are two group health plans:

- Medical claims must be filed with the primary plan first. Once that claim is processed, a claim can then be filed with the secondary plan. This secondary claim can be only for amounts not paid by the primary plan, such as deductibles, coinsurance or copays. An employee must follow the COB procedures of both plans to ensure claims are processed smoothly. Under no circumstances will both plans pay as primary.
- Most pharmacies are able to electronically file claims with both the primary and secondary insurance plans; however, some pharmacies cannot file a secondary claim electronically. In this case, a paper pharmacy claim must be filed with the secondary plan after the primary plan processes the claim.

If you have questions about coordination of benefits, contact the specific plan.

More Information About the Health Plans

A current list of the available health plans and a comparison of benefits for each plan can be found in the Employee Benefit Options Guide. Contact each plan for more details. Refer to the Contact Information section.

Dental Insurance

- Dental Benefits
- Coordination of Benefits
- Choosing a Dental Provider
- More Information About the Dental Plans

Dental Benefits

If your employer participates in the dental plans offered through EGID, employees are eligible to enroll if they have health coverage through EGID or provide you with proof of other health coverage that is not an excepted benefit. Refer to Excepted Benefits in the Glossary section.

The dental plans offered through EGID provide benefits for preventive, basic and major restorative and orthodontic services. Benefits are subject to each plan's rules and cost-sharing features such as copays, deductibles and coinsurance.

All the dental plans have certain benefit limitations and plan year maximums. Charges that exceed the annual maximum are handled differently by each dental plan. Some plans also apply a waiting period for orthodontic benefits. Check with each plan for benefit details.

The dental plans do not include prescription drug benefits. Dental prescriptions, written by licensed dentists, may be covered under the prescription drug benefits of the employee's **health** plan.

Each plan issues ID cards to its members. Providers often require a copy of the employee's plan ID card and driver license or photo ID when they receive services.

Coordination of Benefits

COB is discussed in the Health Insurance section. The same rules and processes apply when a member has other group dental coverage. All dental plans offered through EGID coordinate benefits with other group dental plans.

Choosing a Dental Provider

If a prepaid dental plan is selected, the employee must designate a primary care dentist (PCD). If they do not designate a PCD, one is selected for them. The PCD is the first point of contact when seeking dental care and is responsible for coordinating and authorizing all dental care. Failure to obtain authorization from the PCD can result in denial of the claim.

If a dental indemnity plan is selected, the employee should confirm their providers participate in that plan's network. The most current list of network providers is available on each plan's website, or employees can contact the plan directly. If an employee decides to use a non-network provider, their out-of-pocket costs can be substantially higher.

More Information About the Dental Plans

All the dental plans offered through EGID are available statewide, although provider access may be limited in some areas. Encourage employees to check each plan's list of network providers before selecting a dental plan.

A current list of the available dental plans and a comparison of benefits for each plan can be found in the Employee Benefit Options Guide. Contact each plan for more details. Refer to the Contact Information section. be substantially higher.

More Information About the Dental Plans

All the dental plans offered through EGID are available statewide, although provider access may be limited in some areas. Encourage employees to check each plan's list of network providers before selecting a dental plan.

A current list of the available dental plans and a comparison of benefits for each plan can be found in the Employee Benefit Options Guide. Contact each plan for more details. Refer to the Contact Information section.

HealthChoice Life Insurance Plan

- Basic and Supplemental Life
- Dependent Life
- Life Insurance Application
- Beneficiary Designation
- Life Insurance Claims

Basic and Supplemental Life

The HealthChoice Life Insurance Plan provides group term life insurance, which does not accrue cash value. Basic Life is the first $20,000 of life insurance available to employees. Supplemental Life offers additional amounts of life insurance that an be purchased in $20,000 units.

A new hire, or an employee who has completed an employer probationary period, can elect life insurance coverage at the time of initial enrollment. Only employees who are enrolled in one of the health plans offered through EGID or in other health coverage that is not an excepted benefit are eligible for life insurance coverage. The other coverage must remain continuous. Refer to Excepted Benefits in the Glossary section.

Guaranteed Issue

When enrolling in Basic Life, a new hire can also elect Supplemental Life in an amount equal to two times their annual salary rounded up to the next $20,000 unit without submitting a Life Insurance Application. This amount is known as Guaranteed Issue and is available only to new hires. For quick calculation of this coverage amount, use the Guaranteed Issue Calculator on the IC web page.

A Life Insurance Application is required to apply for Supplemental Life coverage in an amount greater than Guaranteed Issue. Supplemental Life coverage can be requested in $20,000 units, up to a maximum of $500,000. Refer to Life Insurance Application in this section.

A Life Insurance Application is also required during the annual Option Period for employees who elect to enroll in or increase their amount of life insurance. Option Period changes are effective Jan. 1 of the following calendar year or the first of the month following approval of the application, whichever is later. EGID must receive the application by the Option Period deadline established by EGID.

Accidental Death and Dismemberment Benefits

Basic Life and the first $20,000 of Supplemental Life include Accidental Death and Dismemberment (AD&D) benefits. AD&D benefits are available only to current employees and apply when death, dismemberment and/or loss of sight occur as the result of an accident.

MEMBER LIFE		
HealthChoice Basic Life ($20,000) $4.00	First $20,000 of Supplemental Life $4.00	
Age-Rated Supplemental Life – Cost per $20,000		
< 30 --------- $1.20	45 - 49 ------ $2.80	65 - 69 ------ $14.80
30 - 34 ------ $1.20	50 - 54 ------ $5.20	70 - 74 ------ $25.60
35 - 39 ------ $1.20	55 - 59 ------ $8.00	75+ ---------- $39.20
40 - 44 ------ $1.60	60 - 64 ------ $9.20	

AD&D BENEFIT (Member Only)		
LOSS OF	**WITH BASIC LIFE**	**WITH SUPPLEMENTAL LIFE**
Life	$20,000	$20,000
Both hands, both feet or sight of both eyes	$20,000	$20,000
One hand, one foot or sight of one eye	$10,000	$10,000

Dependent Life

Dependent Life is available to any employee who is enrolled in Basic Life. A Life Insurance Application is NOT required to elect Dependent Life. There are three levels of Dependent Life coverage.

DEPENDENT LIFE	LOW OPTION ($2.60 per month)	STANDARD OPTION ($4.32 per month)	PREMIER OPTION ($8.64 per month)
Spouse	$6,000	$10,000	$20,000
Child live birth to 26 years	$3,000	$5,000	$10,000

Dependent Life covers all eligible dependents from live birth to age 26. The premium is the same whether one or several dependents are covered; however, all covered dependents must be listed on the enrollment, change or Option Period form.

A new employee can elect Dependent Life at the time of initial enrollment.

A current employee can add or change the level of Dependent Life coverage during the annual Option Period or within 30 days of a qualifying event.

Proceeds for Dependent Life are always paid to the employee. Dependent Life does not include AD&D benefits.

Life Insurance Application

A Life Insurance Application **is required** if an employee elects:

- An amount greater than two times their annual salary rounded up to the next $20,000 (Guaranteed Issue) at initial enrollment (new hire).
- Any amount of life insurance during the annual Option Period.

During the annual Option Period, a Life Insurance Application **is not required** if an employee elects to:

- Keep their current amount of life insurance.
- Decrease or drop their current amount of life insurance.
- Add Dependent Life.

The Life Insurance Application has two pages. Page 1 must be completed by both you and the employee, and then the employee must complete page 2. To avoid automatic denial, the application must be filled out completely.

NOTE: Page 2 of the Life Insurance Application is the medical information section, which is used to determine an employee's medical fitness and insurability. It concerns the employee's medical history, which is considered protected health information (PHI) and protected by the *Health Insurance Portability and Accountability Act* (HIPAA). You cannot copy, view or forward this information to EGID unless the employee gives you permission.

If the application is approved, notification of approval is sent directly to you and the employee. Do not deduct premiums for life insurance until you receive the approval.

If the application is denied, only notice of the denial is sent to you. A denial letter including the reasons for the denial is sent directly to the employee.

Life Insurance Application Checklist

- ☐ Print a current copy of the Life Insurance Application from the EGID website. No other versions of the application are accepted.
- ☐ Complete the IC section at the top of page 1. You may need to assist the employee with completing the coverage amounts in Section 2, and the employee must sign and date Section 3.
- ☐ Make a copy of page 1 before you give the application to the employee to complete page 2.

It is the employee's responsibility to ensure that the Life Insurance Application is accurate, complete, signed, dated and returned by the deadline to:

EGID HCMU
P.O. Box 57830
Oklahoma City, OK 73157-7830

If preferred, the form can be faxed to 405-717-8997.

At the employee's request, you can send the Life Insurance Application to EGID; however, do not read or make copies of the medical information section as it contains PHI.

When additional medical information is needed, the employee must have their physician's office send the requested information before the deadline. The employee is responsible for any charges related to obtaining medical records.

If an employee incorrectly indicates a medical condition on the application, their physician must confirm in writing that the employee does not have the condition.

Beneficiary Designation

An employee should name a beneficiary when they enroll in life insurance coverage. Employees can print a Beneficiary Designation Form from the EGID website, obtain one from you, or request one from member services.

A beneficiary can be one person, several people, an estate, charitable organization, foundation or anyone who can provide EGID a legal receipt for life insurance proceeds. If no beneficiary is designated or there is no signed beneficiary designation, life proceeds are paid to the employee's estate.

NOTE: The employee is always the beneficiary of Dependent Life proceeds.

- **Primary Beneficiary** refers to the party who is named to receive life proceeds upon an insured employee's death. If more than one primary beneficiary is designated, life proceeds are shared equally unless the employee has provided other instructions on the form.
- **Contingent Beneficiary** refers to an alternate beneficiary designated by the employee. This party receives life proceeds only if all primary beneficiaries die prior to or simultaneously with the employee.

When a minor is named as a beneficiary and life proceeds are $10,000 or less, a claim can be made by the adult responsible for the minor. However, if life proceeds exceed $10,000, a court must appoint a guardian for the minor before life proceeds can be paid.

Beneficiary information can be updated at any time, such as when an address changes. It is important that an employee review their beneficiary designation when there are changes in their family.

Life Insurance Claims

A completed Life Insurance Claim Form and an original or certified copy of the death certificate are required to file a life insurance claim. Additional documentation may be required. For additional information, the Life Insurance Benefits brochure is available on the IC web page, where you can also print a claim form for a beneficiary.

NOTE: If any part of the form is incomplete or additional information is required, the HealthChoice life claims administrator will contact the beneficiary by mail.

In the event of an employee's death, life proceeds are paid to the beneficiary listed on the most recent signed beneficiary designation provided to EGID. If no beneficiary is designated prior to the employee's death or there is no signed beneficiary designation, proceeds are paid to the employee's estate.

In the event of a covered dependent's death, Dependent Life proceeds are always paid to the employee.

If an employee or dependent dies at the first of the month before premiums are paid, any insurance premiums due at the time of the insured's death are withheld from the life insurance proceeds.

A beneficiary can assign all or a portion of the life insurance proceeds to a funeral home to help pay for burial costs.

Vision Insurance

- Vision Benefits
- Accessing Benefits
- Choosing a Vision Provider

Vision Benefits

The vision plans offered through EGID provide routine benefits such as eye exams, frames, lenses and/or contact lenses. Some of the plans also provide discounts for laser vision correction surgery when approved facilities are used.

The vision plans do not cover cataract surgery, glaucoma or injuries to the eye. Eye injuries and diseases, including cataracts and glaucoma, are covered under the health plans.

An employee always receives the greatest benefit when they select a network provider; however, most of the vision plans cover out-of-network services at a reduced benefit with the exception of vision correction surgery. Each plan determines its premiums and copays.

If an employee elects vision coverage, they should contact their eye care provider to confirm they are contracted with any of the vision plans offered through EGID.

An employee who fails to enroll in vision coverage, or one who elected a plan in error, must wait until the next annual Option Period to make a change.

Most vision plans do not provide an ID card. In general, most plans use the employee's Social Security number to verify coverage.

A comparison of each plan's benefits can be found in the Employee Benefit Options Guide, or contact each plan for more details. Refer to the Contact Information section.

Accessing Benefits

To access vision plan benefits:

- The employee must contact their vision care provider and identify themselves as a vision plan member.
- The employee must provide their Social Security number or vision plan ID card.
- The vision care provider will then contact the employee's plan to confirm eligibility and benefits.

Choosing a Vision Provider

Each vision plan's website has their most current network provider list.

HealthChoice Disability Plan

- Disability Plan Benefits
- More Information About the Disability Plan

Disability Plan Benefits

Oklahoma Statutes limit participation in the HealthChoice Disability Plan to state employees and participating county employees.

The HealthChoice Disability Plan is designed to provide employees with partial replacement of income lost as a result of a disabling illness or injury. The plan is not unemployment insurance, workers' compensation, Social Security disability or disability retirement.

An employee is considered disabled if, as a result of injury or illness, they are unable to perform the material duties of their occupation and the condition is expected to last 31 consecutive days or longer. A disability may or may not be related to employment. After 24 months, a disability is defined as the employee's inability to perform the material duties of any gainful occupation they are or may become reasonably qualified for by training, education or experience.

Disability benefits are limited to a maximum benefit period based on the employee's disability, years of service, and age at the time of disability. Refer to Maximum Benefit Period later in this section.

Before the plan pays any benefits, the employee must complete a 30-day elimination period. Benefits are calculated using the employee's base salary at the time the disability began. Benefits are subject to state and federal taxes.

Plan benefits are offset, or reduced, by other income the employee receives that is related to their disability. Refer to Offsets/Reductions in Benefits later in this section.

To remain eligible for disability benefits, the employee must provide proof of continuing disability as required, as well as participate in a rehabilitation program as appropriate.

Disability benefits are divided into two types:

- **Short-term disability** benefits are paid for a maximum of 150 days (after the 30-day elimination period). The plan pays a monthly benefit equal to 60 percent of the employee's base salary less any offsets. The maximum monthly benefit is $2,500. There is no minimum monthly benefit.
- **Long-term disability** benefits begin after the 180 days of short-term disability ends. The plan pays a monthly benefit equal to 60 percent of the employee's base salary less any offsets. The maximum monthly benefit is $3,000, and the minimum monthly benefit is $50.

Any disability payments made for a partial month are prorated.

Maximum Benefit Period

The maximum benefit period is based on the employee's disability, years of service, and age at the time the disability occurred. Benefits end when the disability ends, when the employee reaches the end of the maximum benefit period, or when the employee dies.

AGE AT DISABILTIY	MAXIMUM BENEFIT PERIOD
EMPLOYEES WITH LESS THAN ONE YEAR OF SERVICE	
ANY AGE	6 months
EMPLOYEES WITH LESS THAN FIVE YEARS OF SERVICE	
65 AND YOUNGER	24 months
66	21 months
67	18 months
68	15 months
69 AND OLDER	12 months
EMPLOYEES WITH FIVE OR MORE YEARS OF SERVICE	
59 AND YOUNGER	Up to age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 AND OLDER	12 months

If an employee who is receiving disability benefits leaves employment and continues to meet disability eligibility requirements, they can continue to receive disability benefits until their maximum benefit period is reached.

Mental health and substance abuse disability benefits have a maximum benefit period of 24 months from the date the employee becomes disabled. There is a lifetime benefit period of 60 months for mental health and substance abuse benefits.

Offsets/Reductions in Benefits

Short-term and long-term disability benefits are offset, or reduced, by other benefits or payments the employee receives, or is eligible to receive, for any period of disability.

Offsets may include but are not limited to:

- Available sick, annual or shared leave.
- Earnings the employee receives from any other employment, exluding longevity pay and one-time bonuses.
- Unemployment compensation benefits.
- Social Security benefits related to the disability, excluding:
  - Social Security widow's/widower's benefits unrelated to the current disability.
  - Supplemental Security Income Program awards.
- Benefits paid to the employee by State of Oklahoma or county retirement systems, except those benefits that began prior to the disability.
- Disability related benefits paid under workers' or workman's compensation law, occupational disease law, or other similar act or law.
- Fifty percent of any wages earned while partially disabled or during limited return to work (rehabilitative employment).
- Subrogation.
- Overpayment of previous disability payments, including retroactive Social Security disability awards.
- Veterans Administration benefits.
- Disability benefits paid by another group plan, except for:
  - Plans funded entirely by the employee's contributions.
  - Plans where payment of benefits reduces benefits at retirement.
  - Benefits paid for conditions documented one year or more before the date of the current disability claim.
  - Profit-sharing plans, 401K plans, thrift plans, individual retirement accounts, stock ownership plans, tax-sheltered annuities, or benefits from non-qualified deferred compensation plans.

Statutory or cost of living increases from pension or pension disability programs, Social Security, or workers' compensation do not reduce monthly disability benefits.

If lump sum benefits are received, offsets are prorated over the benefit period or the employee's expected lifetime.

Benefit offsets can be estimated if they have not yet been awarded or denied, or if a denial is being appealed. The responsible party must repay any overpayment or underpayment once actual benefits are determined.

Returning to Work/Partial Disability

A time of partial disability may follow a period of total disability. An employee is considered partially disabled if they can perform at least one of the duties of any occupation, but earn less than 80 percent of their pre-disability gross base salary. If an employee is able to return to work, their disability benefits are reduced by 50 percent of any income earned from any other employment.

Partial disability must result from the same condition as the total disability. Proof of partial disability must be submitted within 31 days of the date the employee's total disability period ends.

Partial disability benefits may be available for up to 24 months, or until the employee:

- Recovers.
- Reaches the maximum benefit period.
- Earns gross wages from any employment equal to 80 percent or more of their pre-disability gross base salary.

A **recurrent disability** is related to or caused by a prior disability for which the employee received benefits under the plan. A recurrent disability is considered a continuation of the prior disability if the employee has been back to their regular full-time job for less than six months and performed all the assigned duties of that job. A recurrent disability does not alter the beginning date of a benefit period and does not require another 30-day elimination period.

If an employee has been back to their regular full-time job for more than six months, the recurrent disability is treated as a new disability. In this case, a new 30-day elimination period applies.

Multiple disabilities occur when an employee experiences a second, unrelated disability while already receiving disability benefits. If the second disability claim is eligible for benefits, the two claims are combined into one continuous disability period.

More Information About the Disability Plan

To participate in the plan, employees must be actively at work and regularly scheduled to work at least 1,000 hours per year. Former employees are not eligible.

Enrollment in the plan begins the first day of the month following the employment date, or the date the employee becomes eligible based on the employer's rules.

To be eligible for disability plan benefits, an employee must:

- Be a covered employee of a participating employer.
- Be on duty at least 31 consecutive days.
- File their claim within one year of the date the disability began.

An employee who is confined in a correctional institution for conviction of an offense is not eligible for disability plan benefits.

The disability must be documented and certified by a qualified physician and cannot be related to a preexisting condition.

The elimination period is the first 30 days following the onset of an illness or an injury when no benefits are paid. An employee is eligible for benefits on the 31st day of their disability.

Written notice of a claim for disability benefits must be provided to the HealthChoice disability claims administrator within 60 days following the beginning of the disability. The claims administrator has the right to waive the 60-day notice requirement for good cause.

Filing for Social Security Disability

To remain eligible for long-term disability benefits, an employee must apply for Social Security disability benefits by the seventh month of their disability. If Social Security denies the employee's application and the employee does not appeal the denial, plan benefits are terminated. If after 24 months of disability, Social Security has still not found the employee eligible for disability benefits, the employee's benefits under the plan will be terminated. Exceptions to this rule may be granted by EGID on a case-by-case basis.

The HealthChoice Disability Plan provides assistance to employees through a company called Allsup, Inc. This service is provided at no cost to the employee; however, the employee is under no obligation to use Allsup's services.

When appropriate, an employee is referred to Allsup by the HealthChoice disability claims administrator. Have your employee contact the disability claims administrator for more details.

IC Responsibility

If an employee is receiving HealthChoice Disability Plan benefits, the claims administrator sends you a monthly Employer Report Form. To avoid delays or problems with your employees' disability benefits, this form must be completed and returned as quickly as possible.

The form requests the following employee information:

- Salary at onset of disability.
- Present salary.
- Employment status.
- Insurance premiums deducted, if any.
- Leave time used.
- Any other financial compensation.

The Employer Report Form cannot be used to make eligibility changes. Coverage changes must go through normal procedures.

If you feel you need additional training, the HealthChoice disability claims administrator is available to assist you with completing forms and answering questions about how the use of leave affects disability benefits and how premium deductions are handled. Representatives can also conduct training on-site or in their office, whichever you prefer. To request training, please contact the HealthChoice disability claims administrator at 405-316-7492 or toll-free 800-722-2567, ext. 7492.

Option Period

- What is Option Period?
- When is Option Period?
- Effective Date of Option Period Changes
- Resources for Option Period
- Member Services is Available to Help During Option Period
- Important Notice About Option Period

What is Option Period?

Option Period is the annual enrollment period when employees can make the following benefit plan elections for the upcoming plan year:

- Add coverage.
- Discontinue coverage.
- Change plans.
- Apply to add or increase life insurance.

When is Option Period?

Option Period begins in October for current employees. Web enrollment for Option Period changes is available late September through mid-November. The deadlines for Option Period vary each year.

As the IC, you can enforce your own deadline for Option Period forms to be returned to you. Even after the deadline, you must correct employee or administrative errors within 60 days of notification of the error.

Effective Date of Option Period Changes

Option Period changes are effective Jan. 1 of each new plan year. One exception is when a member's Life Insurance Application is delayed for additional information. If this occurs, the effective date of the life insurance is the first day of the month following approval of the application.

Resources for Option Period

- IC web page
- Employee Benefit Options Guide
- Employee Benefit Options Presentation
- IC Option Period meetings
- ESS User Option Period Newsletter
- EGID Member Services

Member Services is Available to Help During Option Period

Prior to Option Period, member services group management offers training seminars for ICs. You are strongly encouraged to attend training to get the most current information.

If you have questions during Option Period, call member services at 405-717-8780 or toll-free 800-752-9475.

Important Notice About Option Period

In the event you receive information for employees of other entities, contact the EGID HIPAA Privacy Officer for instructions on how to handle the data. Send an email to EGIDCompliance@omes.ok.gov.

Leaving Employment

- Terminating Employee Coverage
- Coverage Termination Checklist

Terminating Employee Coverage

When an employee leaves active employment, you must complete an Insurance Termination Form and terminate the current employee account upon notice. This prevents delays and coverage errors if the employee transfers to another entity that participates with EGID. Always keep a copy of the form on file.

- Web enrollment users should process the termination online.
- If you do not use web enrollment, you must fax or mail the form to EGID.

The insurance termination date is the last month of coverage for which premiums are paid for the employee. This may or may not be the date the employee leaves employment.

- For state and local government employees, coverage terminates the end of the month the employee last worked.
- For education employees, the length of the employee's contract determines the last day of insurance coverage. For example, an employee leaves employment in May, but their contract continues through July. In this instance, the employee's insurance coverage must continue through the end of July.

NOTE: It is important that employees understand that failure to continue insurance when leaving employment results in the loss of eligibility. Late enrollment is not available.

Coverage Termination Checklist

- ☐ Verify the reason for insurance termination is valid.
- ☐ Print an Insurance Termination Form from the IC web page.
- ☐ Complete, sign and date the form.
- ☐ Terminate the employee's coverage online or send the form to EGID.
- ☐ Send the employee a COBRA packet and retirement/vesting information, if applicable.
- ☐ Keep a copy of the form and log the mail date of the COBRA packet in the employee's file.

Retirement

- Eligibility to Continue Coverage
- Dependent Coverage
- Decreasing/Dropping Coverage
- Premium Payment Options
- Assisting Retirees
- Retiree Checklist
- Additional Information

Eligibility to Continue Coverage

Eligibility to continue coverage through EGID as a former employee is defined by Oklahoma Statutes, and certain requirements must be met, including:

- The employer must continue to participate in the plans offered through EGID.
- The employee must have the required years of creditable service to continue coverage.

The minimum years of creditable service required to continue coverage as a former employee:

- **Teachers Retirement System (TRS)** – Education employees need ten years.
- **Oklahoma Public Employees Retirement System (OPERS)** – State and local government employees need eight years.
- **Oklahoma Law Enforcement Retirement System (OLERS)** – Law enforcement employees need eight years.
- **Other or no retirement system** – Employment years may qualify as creditable service to continue coverage.

An employee with the required years of creditable service can add, keep, drop or defer the health, dental and vision coverage offered by their employer if coverage is requested within 30 days of termination of employment. Life insurance must be in effect before the employee leaves active employment. It cannot be added or increased at retirement; however, it can be reduced or dropped within 30 days of leaving employment or during the annual Option Period.

Retirement Terms

Employees can continue coverage under one of the following former employee status categories:

- **Retiree** – An employee who has worked long enough to retire, draw a retirement check and keep insurance benefits.
- **Vested** – An employee who has worked long enough to keep benefits and has contributed to a retirement system, but is not ready to draw a retirement check.
- **Non-Vested** – An employee who has worked long enough to keep benefits, but did not contribute to a retirement system that participates with EGID, or has withdrawn all retirement contributions and no longer qualifies for retiree or vested status.

- **Defer** – A retiree or vested employee who chooses to transfer health, dental and/or vision coverage to their spouse's account through EGID. Life insurance must be kept in the member's account; it cannot be deferred to a spouse's account.

Discourage employees who qualify for any of the above status categories from electing COBRA, which is temporary coverage. If the employee still decides to elect COBRA, their eligibility to continue coverage through EGID ends at the same time their COBRA continuation period ends.

NOTE: There is no individual conversion option through EGID.

Deferring Coverage

If an employee's spouse works for an EGID participating employer and carries coverage through EGID, the employee can defer (transfer) their health, dental and/or vision coverage to the spouse's account as a dependent. The spouse must complete an Insurance Change Form through their employer to add the employee to their account.

An employee cannot defer life insurance; it must be carried in their own member account.

The former employee can transfer to retiree status when their spouse retires, with another qualifying event, during the annual Option Period, or when they become eligible for Medicare. Coverage through EGID must be continuous. The former employee must complete another Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage. If they are eligible for Medicare, they must also complete either the Application for Medicare Supplement Plan or Application for Medicare Advantage Prescription Drug (MA-PD) Plan.

Dependent Coverage

An employee can elect to add, keep or drop coverage for their spouse and other eligible dependents within 30 days of termination of employment.

If an employee elects to continue coverage for their eligible dependent children, all eligible dependents up to age 26 must be covered. The employee can exclude dependents from the relative coverage if the dependents have other health coverage or other group dental, vision or life coverage or are eligible for Indian or military benefits. An employee can also exclude dependents who do not reside with them, are married, or are not financially dependent on them for support.

An employee can exclude a spouse while covering other dependents. The spouse must sign the Spouse Exclusion Certification on the Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage.

A new spouse or dependent child can be added within 30 days of one of the following qualifying events:

- Birth of a child.
- The member's spouse or dependents under age 26 lose other health or group dental, vision or life coverage.

- The member marries.
- The member adopts or gains legal guardianship of a child under age 26.

Decreasing/Dropping Coverage

If an employee chooses to decrease or drop coverage, inform them they cannot regain that coverage in the future. If they drop health coverage, any retirement system contribution paid toward their health insurance premium will be lost.

Premium Payment Options

- **Retirement check deduction** – Monthly premiums are automatically deducted from the member's retirement check.
- **Direct bill** – Monthly premiums are billed directly to the member.
- **Automatic draft** – Monthly premiums are automatically drafted from the member's checking account.

To elect either the retirement check deduction or direct bill option, the employee must check the appropriate box in the Certification Signatures section of the retirement application.

If the employee wants automatic draft, they must elect the direct bill option and complete an Electronic Fund Transfer Authorization form.

Regardless of the payment option selected, any retirement system contribution toward health insurance premiums applies.

Assisting Retirees

When an employee retires and they or their covered dependents are eligible for Medicare, they must return one of the following before retirement, preferrably at least 30 days before leaving active employment:

- To enroll in one of the HealthChoice SilverScript Medicare supplement plans, an Application for Medicare Supplement with Prescription Drug Plan is required.
- To enroll in one of the MA-PD plans, an Application for Medicare Advantage Prescription Drug (MA-PD) Plan is required.

If the application is not received prior to the effective date, the former employee or covered dependent will be enrolled in a Medicare supplement plan without Part D. To prevent late enrollment, EGID requests the application be received at least 30 days before leaving employment.

Former employees who are already drawing Social Security when they become Medicare eligible are automatically enrolled in Part A and Part B. Otherwise, they must contact Social Security before turning 65 to enroll in Part A and Part B.

EGID strongly recommends that all Medicare eligible former employees enroll in Part B. The benefits of all Medicare plans offered through EGID are based on enrollment in Part A and Part B.

About two months before they turn 65, EGID notifies each former employee of their options, including how to enroll in a Medicare supplement or MA-PD plan.

If a former employee is under age 65 and becomes Medicare eligible, they must immediately notify EGID. At that time, EGID provides information about how to enroll in a Medicare supplement or MA-PD plan.

Pre-Retirement Insurance Seminars

ICs and members are strongly encouraged to attend one of the EGID pre-retirement insurance seminars. Designed to provide important information about insurance in retirement, these seminars are available online or by location throughout Oklahoma. You are encouraged to attend for useful information to assist retirees. You can access the schedule on the EGID website.

Retiree Checklist

- ☐ Have the employee review the information on the Planning for Insurance Needs at Retirement page of the EGID website and encourage them to attend an insurance seminar.
- ☐ Confirm the employee has the required number of years of creditable service to continue insurance.
- ☐ Give the employee an Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage.
- ☐ Inform the employee they can add, keep, drop or defer health, dental and/or vision coverage at retirement (based on benefits available through their employer). Employees cannot change plans until the next annual Option Period unless they move out of their HMO ZIP code service area.
- ☐ Inform the employee of the option to continue life insurance.
    - Life insurance cannot be added or increased at retirement.
    - Premiums are different for former employees.
    - Remind the employee to review their beneficiary information and that a new Beneficiary Designation Form can be completed at any time.
- ☐ Remind the employee they must continue to complete the tobacco-free attestation each Option Period until they **and** their covered dependents are on Medicare.
- ☐ If the employee or covered dependents are Medicare eligible and elect to continue health coverage, give each eligible individual an Application for Medicare Supplement with Prescription Drug Plan or Application for Medicare Advantage Prescription Drug (MA-PD) Plan as appropriate.
- ☐ If the employee or covered dependents have delayed enrollment in Part B, they must call Social Security toll-free at 800-772-1213 to begin Part B coverage.
- ☐ Instruct the employee to complete and return all necessary forms to EGID at least 30 days before leaving active employment. To expedite, fax all forms to Attn: Member Accounts Retirement at 405-717-8939 or 405-717-8942.
- ☐ Inform the employee that you are required by law to send a COBRA packet and to disregard it if they elect to continue coverage as a former employee.

Additional Information

Retirement is not a qualifying event to change plans; however, if an employee moves out of their plan's service area, a plan change is allowed. An employee must otherwise wait until the annual Option Period to change plans.

In the event your employer terminates coverage through EGID, Oklahoma Statutes dictate whether a retiree can continue coverage through EGID or must follow your employer to its new insurance carrier.

- **Common school or career tech employees** who retired before May 1, 1993, can continue coverage with EGID if their former employer elects another insurance carrier. If the retirement date was on or after May 1, 1993, all eligible former employees must follow their former employer to its new insurance carrier.
- **County and local government employees** who retired before Jan. 1, 2002, can continue coverage with EGID if their former employer elects another insurance carrier. If the retirement date was on or after Jan. 1, 2002, all eligible former employees must follow their former employer to its new insurance carrier.
- **Higher education and charter school employees** must follow their most recent former employer to its new insurance carrier regardless of the retirement date.
- Groups that joined EGID after the dates listed above must take all retirees with them if they terminate coverage through EGID in the future.

A retiring employee is only eligible to add or continue the benefits that their former employer offered through EGID.

COBRA

- What is COBRA?
- COBRA Packet
- Coverage Options for COBRA Participants
- Effective Dates of COBRA Coverage
- Length of COBRA Continuation of Coverage Periods
- COBRA Premiums
- Timeline for COBRA Enrollment
- COBRA Checklist

What is COBRA?

COBRA is the acronym for the *Consolidated Omnibus Budget Reconciliation Act* of 1985. In response to concerns regarding the loss of employer-sponsored group health, dental or vision insurance, Congress set rules that allow qualified employees and dependents to continue group insurance under certain conditions and for limited periods of time.

The term COBRA is used to refer to a type of member eligibility status and not a particular plan. When an employee and/or eligible dependents qualify to continue coverage under COBRA, they can continue health, dental and/or vision coverage for a limited time period.

Qualified Beneficiary

A qualified beneficiary (QB) is defined as a covered employee, their spouse (or former spouse) and dependent children who are covered under the group plan the day before the qualifying event. Federal COBRA rules state that the option to continue coverage under COBRA must be offered to all QBs enrolled in health, dental and/or vision insurance coverage when employment is terminated or a dependent loses eligibility due to a qualifying event. COBRA must always be offered regardless of other options to continue coverage.

QBs can continue coverage under COBRA until they:

- Obtain other group insurance coverage that has no preexisting conditions, limitations or exclusions.
- Cancel the COBRA coverage.
- Exhaust the coverage continuation period.
- Fail to pay premiums.

An employee is eligible to continue coverage under COBRA if they have insurance coverage at least one day before a qualifying event occurs. Employees and dependents are not required to enroll under COBRA. It is up to each QB to decide if continuing coverage under COBRA is the right option for them.

Importance of Documenting the COBRA Process

You are responsible for notifying new employees and spouses of their rights under COBRA. The General Notice of COBRA Continuation Coverage Right must be given to a new employee and also their spouse within 90 days of the coverage effective date. If you must mail the notice, send it first class. It can be included with the Summary of Benefits and Coverage.

You are required to complete various forms, meet numerous notification guidelines, and keep copies of signed forms in employees' files, as well as a log of all COBRA mailings and hand deliveries.

COBRA Packet

You are responsible for sending a COBRA packet to an employee or dependent who becomes ineligible for coverage. A COBRA packet must include the following:

- A COBRA Election Form.
- An Eligibility for Continuation of Coverage form.
- A copy of Important Information About Your COBRA Continuation Coverage Rights.
- A copy of the COBRA premium rates.

You must complete the COBRA Qualifying Event Notice and put it in the employee's file. If the QB returns a completed COBRA Election Form to you, forward both the COBRA Qualifying Event Notice and the COBRA Election Form to EGID. Keep a copy of both forms in the employee's file.

All COBRA materials are available on the IC web page. To access the COBRA Election Form and the COBRA Qualifying Event Notice, log in to web enrollment. If you are not registered for web enrollment, contact web support. You can also contact member services to have these forms sent to you.

If a dependent who loses eligibility does not reside with the employee, a packet must be sent to the dependent's last known address. Be aware that failure to notify an employee's qualified dependents of their COBRA rights is a common and potentially costly mistake.

Even if an employee is eligible to retire or vest, you must always mail a COBRA packet to all qualified beneficiaries; however, an employee who chooses to retire or vest should be instructed to disregard the COBRA packet and instead complete an Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage. A retired/vested member can continue health, dental, vision and/or life insurance coverage indefinitely.

If a COBRA packet is returned for an incorrect address and you can locate the QB's new address, mail a copy of the original packet (do not re-date it) within the 60-day COBRA election period and document the date it is re-mailed. If no other address is available or the packet is again returned, attach the returned mail forms to the COBRA Qualifying Event Notice. Keep the returned COBRA packet on file.

Coverage Options for COBRA Participants

Electing COBRA does not allow a change in plans, except when a QB moves outside, or worked but never lived in, their health plan's service area. Plan changes can be made during the annual Option Period.

A QB can continue health, dental and/or vision coverage in effect at the time of the qualifying event.

If a QB was not enrolled in health, dental and/or vision coverage, it can be added during the next annual Option Period.

Effective Dates of COBRA Coverage

COBRA coverage begins the first day after active coverage ends (no lapse in coverage is allowed). Enrollment is processed after EGID receives the first full premium payment, COBRA Qualifying Event Notice and COBRA Election Form.

Length of COBRA Continuation of Coverage Periods

A COBRA continuation period of up to 18 months is available to employees and dependents who lose coverage due to one of the following qualifying events:

- Termination of employment, whether voluntary or involuntary (except for termination due to gross misconduct).
- Reduction in hours resulting in the loss of eligibility for coverage.
- Leave of absence.
- Reduction in Force (RIF)/strike/layoff.

A COBRA continuation period of up to 36 months is available to dependents who lose coverage due to one of the following qualifying events:

- Divorce or legal separation from the employee.
- Dependent child turns 26.
- Employee becomes Medicare eligible during an 18-month COBRA continuation period.
- Employee's death.

NOTE: After an employee's death, the covered spouse and dependents are also eligible to continue coverage as surviving dependents.

A COBRA continuation period of up to 36 months is available to other dependent children who have coverage through an approved Application for Coverage for Other Dependent Children, or a tax return showing dependency. A qualifying event occurs when one of these dependents:

- Reaches age 26.
- Marries.

- No longer resides with the member.
- Is no longer financially dependent on the member.
- Is no longer in the member's care.

If a QB marries while on COBRA, they can add their new spouse and dependents to COBRA coverage within 30 days of their marriage, but only for the remainder of their established continuation period.

If a 36-month event occurs during an 18-month COBRA continuation period, a dependent QB can extend eligibility for a maximum of 36 months from the date of the original qualifying event. For example, if an employee and spouse divorce during their 17th month of COBRA coverage, the former spouse and covered dependents are eligible to continue coverage for an additional 19 months. The COBRA continuation period cannot exceed 36 months.

A QB who qualifies for Social Security disability benefits can extend coverage for up to 29 months. They must be disabled at the time of the qualifying event or become disabled within 60 days of the start of their COBRA continuation period. All covered QBs can continue coverage for up to 29 months or until their Medicare coverage becomes effective, whichever is earlier.

The QB must notify EGID within 30 days of a Social Security disability determination, or if it is determined they are no longer disabled. This determination reduces the COBRA continuation period.

Each QB has the right to continue coverage under COBRA and elect separate benefit options, e.g., an employee may elect to keep health and dental coverage under COBRA while their spouse may elect to keep only health coverage.

A QB is eligible to continue only the coverage they had in effect the day before the qualifying event. COBRA eligibility does not allow a QB to add benefits or change plans. Coverage or plan changes are allowed only during the annual Option Period.

When a QB gains other group health, dental or vision insurance during the COBRA continuation period, they must notify EGID, and COBRA coverage must be terminated for that benefit.

When a QB's COBRA continuation period expires, they must seek other coverage unless they qualify for coverage as a dependent on a primary member's plan through EGID.

Employees and dependents are not required to elect COBRA. It is up to each QB to decide if continuing coverage under COBRA is the right option.

NOTE: In the event a retiring or vesting employee elects COBRA, they forfeit their right to continue insurance coverage through EGID as a retired or vested member. When the COBRA continuation period ends, they are not eligible for further coverage through EGID.

COBRA Premiums

COBRA premiums are categorized by member, spouse, child and children.

EGID policy states that for any benefit continued under COBRA, one person must always pay the primary member premium. In cases where a spouse, child or children are insured under a particular benefit and the member did not retain that coverage, one person is always billed the primary member rate.

All premiums from the effective date of coverage through the current month of coverage are due within 45 days of the QB's signature on the COBRA Election Form.

Premiums can be paid by check, bank draft or money order. Partial or cash payments are never accepted. Premiums for a COBRA dependent cannot be deducted from a current employee's payroll check.

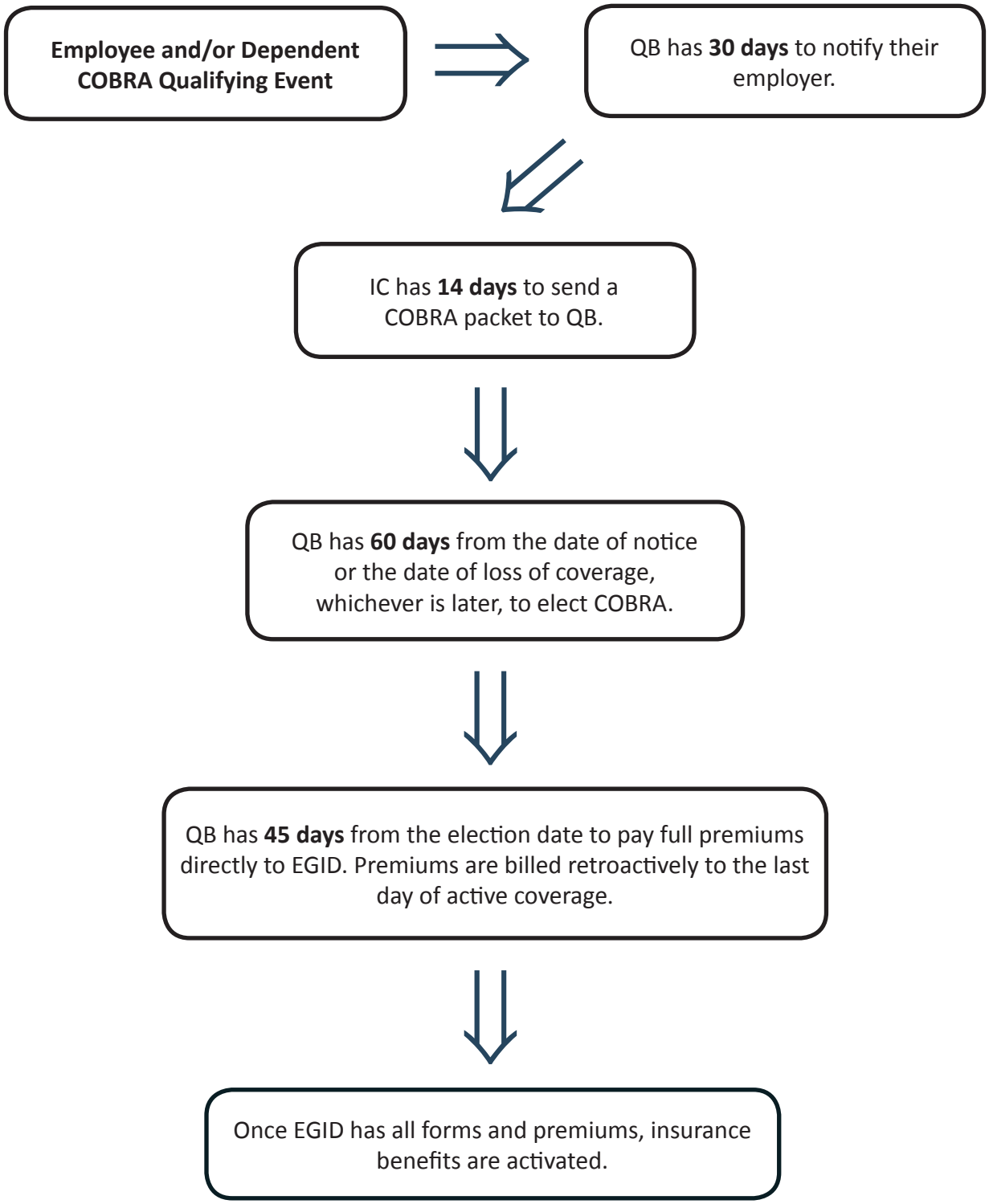
New Employers

When an employer enrolls with EGID or merges with an EGID participating employer, you must use a COBRA to COBRA Form to enroll QBs who already participate in COBRA through their previous employer. Complete this form and include the QB's name and Social Security number, as well as the effective date and end date of the original COBRA continuation period. COBRA to COBRA QBs can continue coverage only for the remainder of their original continuation period, e.g., a QB exhausted 12 months of COBRA coverage before enrollment through EGID; since their continuation period was 18 months, there are still six months of continuation coverage remaining.

Terminating Employers

If the employer terminates its group coverage through EGID, QBs must be offered COBRA continuation coverage through the new carrier. All coverage through EGID, including coverage for COBRA members, ends on the employer's last day of coverage through EGID.

Timeline for COBRA Enrollment



COBRA Checklist

When you receive notice of an employee's or dependent's COBRA qualifying event:

- ☐ Complete either the Insurance Change Form or Insurance Termination Form, whichever is appropriate.
- ☐ Enter the change in web enrollment or send the form to EGID.
- ☐ Complete the COBRA Qualifying Event Notice and put it in the employee's file.
- ☐ Mail a COBRA packet within 14 days by first class mail to the last known mailing address on file. Address the packet to all covered individuals, e.g., John and Mary Smith and Children. If the covered dependents do not live with the employee, mail a separate COBRA packet to each dependent.
- ☐ Keep a mailing and hand delivery log of all COBRA materials.
- ☐ If the COBRA packet is returned as non-deliverable, check your records for an updated address and mail the packet again. If no updated address is available, keep proof of the returned packet in the employee's file. If a new mailing address becomes available, remail the original packet and log the information.
- ☐ When a QB returns the COBRA Election Form, verify it is still within the 60-day election period. Attach the COBRA Qualifying Event Notice to the COBRA Election Form and fax or mail them to EGID. Keep a copy of both forms in the employee's file.
- ☐ If the QB sends the premium payment with the COBRA Election Form, make a photocopy of the payment for the employee's file. Mail the payment with the COBRA forms to EGID.

Note: COBRA payments must be sent in full to EGID separately from the employer's regular monthly premium payment to ensure proper credit to the QB's account. Per EGID policy, cash payments are never accepted.

HIPAA

- Definition of HIPAA
- Disclosure of Health Information
- Certificates of Coverage
- Privacy Issues for ICs

Definition of HIPAA

HIPAA is the acronym for the *Health Insurance Portability and Accountability Act* of 1996. It provides employees and dependents certain rights and protections related to their ability to transfer group health insurance from one employer to another. HIPAA includes protections against limitations or exclusions for preexisting conditions and prohibits discrimination against employees and dependents based on their health status. As amended in 2013, HIPAA also includes provisions related to the security and privacy of protected health information and the way it is used, shared and stored by medical providers and insurance plans. The *Health Information Technology for Economic and Clinical Health* (HITECH) *Act* imposes additional administrative, physical and technical safeguards for protected health information under HIPAA. For more information, visit www.hhs.gov/ocr/hipaa/.

Disclosure of Health Information

All of the health plans available through EGID, as well as the HealthChoice Dental, Life, and Disability Plans, have processes in place that allow an employee and adult dependents to authorize the release of their personal health information, also known as protected health information (PHI). For specific information, the employee should contact their plan directly.

For all HealthChoice plans, a HIPAA Authorization to Disclose HealthChoice Information must be on file for each person authorized to access the member's or dependent's information. An authorization remains in effect for one year unless an expiration date is indicated. To revoke their authorization, the member or adult dependent must complete and submit a HIPAA Revocation of Authorization to Disclose HealthChoice Information. An authorization can be revoked at any time.

Members can authorize a family member, friend or provider to access their PHI. Members can also limit the information to a specific claim, medical condition or time frame. Limitations must be indicated on the appropriate line of the authorization form. Members should keep a copy of the original authorization.

Certificates of Coverage

Upon request, EGID provides a Certificate of Group Health Plan Coverage, also referred to as a HIPAA Certificate, to employees and covered dependents when health coverage terminates.

If necessary, member services can provide a copy of a previously issued certificate or issue a certificate prior to the date coverage ends; however, the termination date must first be in our eligibility system.

Requests for certificates from anyone other than covered employees, covered dependents or ICs are not accepted. To request a HIPAA Certificate, call member services at 405-717-8780 or toll-free 800-752-9475. TDD users call 405-949-2281 or toll-free 866-447-0436.

Privacy Issues for ICs

As an IC, it is your responsibility to maintain the security and privacy of the health and personal information of employees and their dependents. Disclosure of this information to others, such as when completing insurance forms, granting medical leave, or discussing the *Family and Medical Leave Act* (FMLA), must be limited to a need-to-know basis

Correspondence with EGID must include the employee's name and member ID number or Social Security number. Due to privacy issues, please include only the last four digits of an employee's Social Security number in email correspondence.

If an employee asks for your help dealing with a specific claim, know that HIPAA regulations require EGID to protect the privacy of our member's health information. EGID discloses a member's health information according to the terms of the EGID Privacy Notice. You can assist an employee with eligibility or other enrollment issues; however, to discuss a specific claim issue with customer service, the employee must submit a completed HIPAA authorization granting you permission. Please instruct the employee to limit the scope of their authorization to the specific claim or issue. If the claim is with an HMO plan, the employee must contact the HMO for an authorization.

NOTE: In the event you receive information for employees of other entities, contact the EGID HIPAA Privacy Officer for instructions on how to handle the data. Send an email to EGIDCompliance@omes.ok.gov.

Billing and Reconciliation

- Billing and Reconciliation Processes
- Billing and Reconciliation Assistance

Billing and Reconciliation Processes

The following notices and forms are part of the monthly premium billing and reconciliation processes:

- **Premium Billing Statement** – monthly group premium bill
- **Payment Voucher** – last page of the monthly Premium Billing Statement
- **Group Audit Report** – lists insurance premium discrepancies for each employee
- **Discrepancy Report** – prepared by you to explain differences in the amounts billed to your employer and what is owed to EGID
- **Request for Insurance Premium Refund** – used to request a refund of premium overpayment
- **Late Notice** – email or written notice that indicates a payment is past due

Billing Statements

Two types of billing statements are available:

- **Online billing statement** – If you use web enrollment, you can access your original bill or estimated bill online at any time. The manual received during web enrollment training has more information on the bill retrieval process. If you are not registered to use web enrollment, you can obtain limited access to only download the billing statements.
- **Electronic Billing Statement** – The Electronic Billing Statement is available only through EGID's secure portal, and an email is sent each month when your statement is ready to access. The bill shows each employee's name, member ID, the premium for each benefit, and the total amount billed. It does not include adjustments made to coverage for previous months.

The following steps can help ensure the payment process goes smoothly:

1. Verify the insurance premiums deducted from your employees' checks are correct.
2. Audit your billing statement to make sure it is accurate.
3. Collect premiums from any employees who are on leave.
4. Send your monthly premium payment to EGID by the tenth of the month following the month of coverage.
5. Maintain payroll records regarding premium deductions.

Payment and Payment Vouchers

Payments are due by the tenth of the month following the month of coverage. If payment is not received by the end of the month in which the payment is due, coverage shall be canceled effective the end of the month for which payment was last received. Prompt payment of group premiums ensures employees' access to benefits.

Use the Payment Voucher included in your billing statement to list all checks and warrants you are sending to EGID. Warrants and checks listed on the voucher should equal the total amount due. If the totals do not match, please explain the differences and note changes or corrections as a Discrepancy Report on a copy of your billing statement.

Auditing the Premium Billing Statement

Use the following steps to reconcile your group bill and payroll records:

1. Compare the amounts on your billing statement with your employer's payroll records and identify any discrepancies. You must research discrepancies to determine if adjustments are needed.
2. Review premium adjustments to determine if they were calculated into the previous month's payment. If not, premiums may be outstanding or a refund may be due.
3. Correct discrepancies by changing your next payroll, correcting eligibility through web enrollment, or mailing or faxing the appropriate form to EGID.
4. Prepare a Discrepancy Report. Copy your billing statement and indicate changes or corrections on the pages that list the employees with discrepancies.
5. Prepare warrants and checks for premium payment.
6. Submit a copy of your Discrepancy Report with your Payment Voucher.

Please return the Payment Voucher, Discrepancy Report and actual warrants and checks to:

EGID Member Accounts
P.O. Box 269022
Oklahoma City, OK 73157-8010

Member accounts researches all discrepancies listed on your Discrepancy Report. Discrepancies that cannot be resolved are listed on a Group Audit Report and returned to you. Review the Group Audit Report as soon as it is received.

Refunds

When possible, a premium overpayment should be handled through your payroll department by adjusting the employee's withholding for the next payroll period.

Refunds are issued only after EGID is notified in writing of a premium overpayment. Notification must be made within 60 days of the overpayment, unless the lack of notification is beyond your control as determined by EGID.

Complete a Request for Insurance Premium Refund form, which is available on the EGID website.

Refund requests are usually processed within ten days. Any refund issued on behalf of an employee is paid directly to the employer.

NOTE: EGID cannot process a refund request if our records do not indicate an adequate group credit or the refund does not meet the criteria listed in the *Administrative Rules*. A denied refund request is returned to you along with a letter explaining the reasons for denial.

Submit your Request for Insurance Premium Refund form with supporting documentation, such as an Insurance Change Form or Insurance Termination Form, to:

EGID Member Accounts
P.O. Box 58010
Oklahoma City, OK 73157-8010

Common Billing Issues

If a terminated or ineligible employee appears on your billing statement, do not make payment for that employee. Strike through the employee's information and subtract their premium amount from the total due.

To the right of the employee premium line, indicate the termination date or date the employee became ineligible. Complete an Insurance Termination Form and process the termination through web enrollment. If you do not use web enrollment, send the form to EGID. Keep a copy of the form in the employee's file.

NOTE: Education employees who terminate employment at the end of the school year can continue coverage until their contract ends.

If an eligible employee is not listed on the billing statement, verify the employee's enrollment and the effective date of coverage using web enrollment or call member mervices. If information is incorrect or missing, correct the information in web enrollment or submit an Insurance Enrollment Form to EGID.

Enter the employee's name, member ID and premium amount on the billing statement. Then add the premium to the total amount due.

If an employee's premiums do not add up correctly, you can verify coverage and correct any errors within 30 days of the employee's enrollment or change date through web enrollment or call member services.

If a coverage change is not reflected in your billing statement, the change may have been made after the bill was generated. Verify the correct coverage and effective date using web enrollment or call member services. Locate the employee's name on the billing statement and change the amount billed to the correct amount. Always provide a brief explanation of the reason for the adjustment in the Explanation of Differences box, e.g., added a dependent child on 01/01/17.

NOTE: It is important that web enrollment is updated, or all forms are faxed or mailed, immediately. This includes all forms for terminations, changes and refunds.

An employee is eligible to continue coverage while on leave without pay for up to 24 months. The employee will still be listed on your billing statement, but it is their responsibility to pay premiums to you to forward to EGID.

Age-rated supplemental life premiums increase Jan. 1 of the year following a birthday that advances a member into the next age bracket.

If a payment is returned for insufficient funds, EGID sends a letter to you requesting a replacement of funds by money order or cashier's check.

An employee must have continuous coverage and premiums must be paid in full to continue coverage under retirement, vested, disability or COBRA.

NOTE: You must send COBRA and retirement premiums separately. These payments are processed individually and should not be included with the group premium payment.

Billing and Reconciliation Assistance

If you need help with any billing or reconciliation issue, contact member accounts for assistance. Refer to the Contact Information section.

Contact Information

EGID

Member Services
405-717-8780 or 800-752-9475
TDD 405-949-2281 or 866-447-0436
Fax 405-717-8942
www.sib.ok.gov

Web Support
405-717-8707 or 800-543-6044, ext. 8707

Member Accounts Billing and Reconciliation
405-717-8746 or 800-543-6044, ext. 8746
Fax 405-717-8939

HMO Plans

Aetna INTEGRIS or Aetna St. John
800-459-7791
www.stateofok.aetna.com

CommunityCare
800-777-4890
TDD 800-722-0353
state.ccok.com

GlobalHealth, Inc.
405-280-5600 or 877-280-5600
TDD 711
www.globalhealth.com

HealthChoice

Health, Dental and Life Claims, Benefits, Eligibility and ID Cards
405-416-1800 or 800-782-5218
TDD 405-416-1525 or 800-941-2160

Pharmacy Claims, Formulary and ID Cards
877-720-9375
TDD 711
www.caremark.com

American Fidelity Health Services Administration
405-523-5699 or 866-326-3600
www.afhsa.com

Dental Plans

Assurant Inc. Dental
PPO Freedom Preferred 800-442-7742
Prepaid Heritage Plans 800-443-2995
www.assurantemployeebenefits.com

CIGNA Prepaid Dental
800-244-6224
Hearing Impaired Relay 800-654-5988
www.cigna.com

Delta Dental
405-607-2100 or 800-522-0188
www.DeltaDentalOK.org

MetLife
800-942-0854
www.metlife.com

Contact Information

Vision Plans

Primary Vision Care Services (PVCS)
888-357-6912
TDD 800-722-0353
www.pvcs-usa.com

Superior Vision
800-507-3800
TDD 916-852-2382
www.superiorvision.com

Vision Care Direct
877-488-8900
TDD 877-488-8900
visioncaredirect.com

Vision Service Plan (VSP)
800-877-7195
TDD 800-428-4833
www.vsp.com

Other Helpful Contact Information

Medicare
800-633-4227
TTY 877-486-2048
www.medicare.gov

Social Security
800-772-1213
TTY 800-325-0778
www.socialsecurity.gov

Oklahoma Public Employees Retirement System (OPERS)
405-858-6737 or 800-733-9008
www.opers.ok.gov

Teachers Retirement System (TRS)
405-521-2387 or 877-738-6395
www.ok.gov/trs

Glossary

Accidental Death and Dismemberment (AD&D): AD&D benefits are available only to current employees and apply when death, dismemberment or loss of sight occurs as the result of an accident.

Accidental Injury: Bodily injury sustained as the direct result of an accident, independent of any other cause, which occurs while insurance coverage is in force.

Allowable Fee: The set dollar amount allowed under an insurance plan for a covered service or supply.

Base Salary: The rate of earnings in effect on the date disability begins. Base salary does not include overtime, commissions, bonuses, longevity pay, productivity enhancement program payments, or any other compensation.

Basic Life: The first $20,000 of term life insurance coverage available to an eligible employee under the HealthChoice Life Insurance Plan.

Benefit Period: The period during which benefits are paid. The first day of the benefit period is the day the member becomes eligible for benefits. The end of the benefit period is the last day of eligibility as determined by the maximum benefit period and/or eligibility limits.

Case Management: The function of coordinating a patient's medical care. The care usually involves multiple services from multiple providers.

Centers for Medicare & Medicaid Services (CMS): The federal agency that manages the Medicare and Medicaid programs.

COBRA: The acronym for the *Consolidated Omnibus Budget Reconciliation Act* of 1985 which gives workers and their families who lose their health, dental and/or vision benefits the right to continue group coverage provided by their group insurance plan. COBRA is available for limited periods of time and under certain circumstances, such as voluntary or involuntary job loss, reduction in hours worked, transition between jobs, death, divorce, and other life events.

COBRA Qualifying Event: Certain events resulting in a loss of health, dental and/or vision coverage for an employee and/or covered dependent that allow them to continue coverage under COBRA.

Coinsurance: The percentage of allowable fees paid by the member once the deductible is satisfied.

Copay: A set amount the member pays for certain services as a cost-sharing agreement.

Current Annual Salary: An individual's annual gross pay. Current annual salary does not include overtime, longevity pay, benefit allowance or retirement contribution.

Deductible: The out-of-pocket amount that typically must be paid before the insurance pays benefits.

Disability: The inability to perform each of the material duties of any gainful occupation an employee is or may become reasonably qualified for by training, education or experience.

EGID: The Office of Management and Enterprise Services Employees Group Insurance Division.

Eligible Dependent:

- An employee's legal spouse (including common-law).
- An employee's daughter, son, stepdaughter, stepson, eligible foster child, child for whom the employee has been granted legal guardianship, or child legally placed with the employee for adoption, up to age 26, whether married or unmarried.
- An employee's dependent, regardless of age, who is incapable of self-support due to a disability that was diagnosed prior to age 26. Refer to Special Rules for a Disabled Dependent.
- Other unmarried dependent children up to age 26, upon approval of an Application for Coverage for Other Dependent Children. A tax return showing dependency may be provided in lieu of the application.

Eligible Employee: An employee of a participating employer who receives compensation for services rendered and is listed on that employer's payroll.

Eligible Participating Former Employee: An employee who participates in any of the plans authorized by or through the *Oklahoma Employees Insurance and Benefits Act* who retired or vested their rights with a state funded retirement plan, or has the required years of service with a participating employer.

Elimination Period: The first 30 consecutive calendar days of disability when no benefits are paid.

Excepted Benefits: The four categories of benefits as established in section 2791 of the PHS Act, section 733 of ERISA and section 9832 of the Internal Revenue Code, as summarized in IRS Bulletin 2015-14 and subsequent regulatory guidance. These excepted benefits include but are not limited to vision coverage, dental coverage, long-term care insurance, Medicare supplement coverage, automobile liability insurance, workers compensation, accidental death and dismemberment insurance and specific disease coverage (such as cancer).

Guaranteed Issue: Two times an employee's current annual salary rounded up to the next $20,000. This is available only during the employee's initial enrollment. A Life Insurance Application is not required.

HealthChoice: The name for the insurance plans administered by EGID.

Health Maintenance Organization (HMO): A type of managed care plan that contracts with doctors, hospitals, clinics, and other health care providers such as pharmacies, labs, X-ray centers and medical equipment vendors. An HMO typically requires the use of a primary care physician to manage and coordinate all care.

Indemnity Plan: A traditional fee-for-service insurance plan that gives the employee the freedom to visit any licensed health care professional without a referral. The member is responsible for deductibles and coinsurance, and a calendar year out-of-pocket maximum typically applies. Once the out-of-pocket maximum is reached, the plan typically pays 100 percent of allowable fees for covered services for the rest of the year.

Initial Enrollment: The 30 days following an employee's date of employment or date they become eligible with a participating employer. An initial enrollment is not created when an employee transfers employment between participating employers sharing the same Section 125 Plan, e.g., state agency to state agency or school to school within the same district.

Life Insurance Application: Documentation of an employee's medical fitness for review of insurability.

Medically Necessary: Health care services or supplies within the standards of good medical practice that are necessary to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms.

Network Provider: A provider who has entered into a contract with an insurance plan to accept the plan's allowable fees for services and/or supplies provided to plan participants.

Non-Covered Service: Any service, procedure or supply excluded from coverage and not paid for by a plan.

Non-Vested: An employee who has worked long enough to keep benefits but did not contribute to a retirement system, or who has withdrawn all contributions and no longer qualifies for retirement or vested status.

Option Period: The annual time period established by EGID when changes can be made to coverage.

Orthodontic Limitation: A waiting period for orthodontic benefits.

Out-of-Pocket Maximum: The amount for which a member is responsible based on the use of network or non-network providers, including deductible and coinsurance, before eligible charges are paid at 100 percent of allowable fees. The out-of-pocket maximum does not include charges for non-covered services or balance billing charges from non-network providers.

Participant: An employee or former employee of a participating employer who is eligible and is participating in coverage through EGID.

Participating Employer: Any municipality, county, education employer, or state agency whose employees or members are eligible to participate in any plan authorized by or through the *Oklahoma Employees Insurance and Benefits Act*.

Plan: The insurance product for a specific benefit, such as health or dental.

Preexisting Condition: A preexisting condition refers to an illness or injury for which the employee received medical care, diagnosis, consultation or treatment, or took prescribed drugs or medicines, during the 90-day period immediately preceding the employee's employment date. The term preexisting condition also includes any condition which is related to such injury or illness.

Proof of Claim: Written documentation submitted to EGID and/or the disability claims administrator confirming a claim for benefits.

Qualified Beneficiary (QB): An employee, their spouse and/or dependent children who were covered under the employee's group health, dental and/or vision plan on the day before a COBRA qualifying event. This includes any child who is born to, or placed for adoption with, the employee during COBRA coverage.

Qualifying Event: A life status change that allows an individual to make midyear changes to insurance benefits.

Reconciliation: The process of making the net difference in credits and debits of a premium bill agree with the balance.

Retiree: An employee who has worked long enough to retire and draw a retirement check.

Section 125 Plan: A type of employee benefit plan offered pursuant to Section 125 of the Internal Revenue Code that allows employees to participate pre-tax in different types of benefits.

Social Security Disability: An insurance program offered by the federal government that pays benefits to those who are determined to be unable to work.

Term Life: A policy that furnishes life insurance for a limited period of time. If death occurs during this period of time, insurance benefits are paid. If death occurs after the policy has expired, no insurance benefits are paid. A term policy has no cash surrender value.

Third-Party Administrator (TPA): An entity or company that an insurance company contracts with to process claims and administer certain business functions; also called claims administrator.

Vested: An employee who has worked long enough to keep benefits and contributed to a retirement system, but is not ready to retire or draw retirement benefits.

Years of Service: Time spent as an active employee performing full-time duties with an employer that participates in one of the State of Oklahoma retirement systems.