



Employees' Group Insurance

2001 Capitol Avenue
Room 106
Cheyenne, WY 82002
800-891-9241
307-777-6835



Benefit Specialist Handbook

January 2011

**If you require this information in an
alternative format, please contact
The Employees' Group Insurance Office
at 307-777-6835 or 800-891-9241.
The State of Wyoming and this agency
actively support the ADA.**

This Handbook is being provided as a resource to Benefit Specialists in any Employees' Group Insurance sponsored entity/employer including but not limited to: State Agencies, Community Colleges and the University of Wyoming, and applicable Public School Districts who administer the State's Group Health, Dental and Life Insurance Plans and the Flexible Benefit Plan.

Hereinafter, State, University of Wyoming, Community Colleges, Public School Districts and any other employer who is part of the Employees' Group Insurance Plans will be referred to as "State" or "EGI sponsored employer."

State and Federal Law supersedes any conflict in the guidance provided in this handbook.

If you require clarification or additional information about any of the guidance provided in this Handbook please contact the Employees' Group Insurance (EGI) Staff at 307-777-6835 or 800-891-9241. Questions involving interpretation of EGI policy may be e-mailed. Responses will be promptly e-mailed in return. This will assist the EGI Staff in understanding all of the facts and respond accordingly. Thank you for your assistance.

SUBJECT INDEX

<u>SUBJECT</u>	<u>PAGE</u>
Adding Dependents (insurance).....	14, 15
Adopted Dependents Enrollment.....	14
Change of Beneficiary (life insurance).....	16
Claims (Medical, Dental, and Life) How to File.....	25, 26
COBRA.....	27
COBRA Benefits.....	29
COBRA Eligibility.....	27, 28
COBRA Notification.....	28
COBRA Period of Coverage.....	29, 30
COBRA Premium.....	29
COBRA, Conversion from.....	30, 31
COBRA, Election of.....	30, 31
COBRA, Termination.....	30
Conversion Privilege.....	30
Court Orders to Add Dependents.....	14, 15
Deceased Employee.....	25
Deductibles, Change of Plan.....	16, 17
Dental, Enrolling in Optional Plan.....	7
Dependent Care Account.....	32, 33
Dependent Eligibility (insurance).....	6
Disability.....	21, 22, 23
Disability, Short Term (voluntary benefits).....	39
Disability, Long Term (voluntary benefits).....	40
Drop Dependents (insurance).....	15, 16
Effective Dates (insurance).....	8, 9
Eligible Expenses (Flex Claims).....	37
Employee Eligibility (insurance).....	5
Enrollment Process (insurance).....	7, 8
Flex Plan Accounts.....	32
Flex Plan Changes.....	35, 36
Flex Plan Claims.....	36, 37
Flex Plan Eligibility.....	33
Flex Plan Enrollment.....	33, 34
Flex Plan – Leave of Absence.....	34
Flex Plan Termination.....	34, 35
FMLA.....	21, 22
Health, Enrolling in.....	7
Health Savings Account.....	11, 12
Late Enrollment (Health).....	12, 13
Late Enrollment (Life).....	14
Late Enrollment (Optional Dental).....	13, 14
Leave of Absence.....	20, 21, 22
Less than 80 Hours Worked.....	20
Life Insurance.....	7
Long Term Care (voluntary benefits).....	40
Medical Reimbursement Account.....	32, 37
Medicare.....	23
Military Leave.....	22

Newborn Enrollment & Claims.....	14, 15
New Employees, Enrollment (insurance).....	7
Non-eligible Expenses (Flex Claims).....	38
Open Enrollment (insurance).....	17
Payroll Deductions (Agency).....	10
Payroll Deductions (Employee).....	8
Refunds.....	10
Retirement Eligibility & Benefits.....	23, 24
RIF.....	19, 20
Split Premium.....	10, 11
Adding Spouse Enrollment (insurance).....	14
State Contribution.....	9
Termination of Insurance.....	17, 18
Voluntary Cancellation (insurance).....	39
Waiver of Premium.....	23
Worker's Comp.....	20, 21
Vision Coverage.....	39
Voluntary Benefits.....	39, 40

SECTION I

Administration of Health/Dental/Life Plans

EMPLOYEE ELIGIBILITY

Employees become eligible for insurance benefits on the first day of the month following the date their service begins.

- A. Employees who are permanent or probationary full-time or permanent or probationary, part-time employees *working at least eighty (80) regular hours per calendar month.*
- B. Temporary and At Will Contract Employees (only if their contract indicates eligibility for insurance benefits) who are expected to be in a position for at least six (6) months should be offered the insurance when the agency first knows the position will last six (6) months or longer and will be working a minimum of 80 hours per calendar month.

An At Will Contract Employee, who currently is not enrolled in the State Insurance Plans and is then hired into a position that is eligible for benefits, will be allowed to enroll in the State Plans as if they are a new hire.

- C. Employees working intermittent, irregular or less than half time positions *are not eligible.*

If an employee works part of the year as an intermittent employee and part as a full-time or part-time (at least 80 hours per calendar month) employee, then they are eligible for insurance benefits during the full-time or part-time work schedule but *not* during the intermittent work schedule. These employees are treated as new hires and must elect or waive benefits each time their work schedule changes from a non-benefited status to a benefited status.

Example:

A new employee is hired on June 15th and is eligible for the State's Group Insurance Benefits. The employees' Date of Eligibility begins on July 1st.

A new employee is hired on February 1st and is eligible for the State's Group Insurance Benefits. The employees' Date of Eligibility begins on March 1st. If the employee elects benefits on March 31st (the last day of eligibility), the effective date of coverage will be March 1st (see page8) and premiums are due for March and April.



DEPENDENT ELIGIBILITY

Dependents *may not* be enrolled in the Group Insurance Plans if the employee *is not* enrolled. Dependents must be a resident of the US or Puerto Rico to be eligible for coverage. The following are considered to be dependents for purposes of coverage under the insurance plans:

- A. The legal spouse as defined by the State of Wyoming.
- B. Dependent children under the age of twenty six (26). This includes any legal stepchildren, adopted or foster children, or any child *the employee is legally responsible to provide for on a **permanent** basis by virtue of a legal court order.* Copies of such legal documents **must be** provided at the time application for dependent coverage is made.
- C. Children who are serving in the military **are not** eligible to be covered as dependents.
- D. Any child who is not self-supporting due to developmental disabilities or physical handicap is eligible. The child *must have been covered under the insurance policy on the day before the date the child would otherwise lose dependent status due to age.* The following procedure must be initiated two (2) months prior to the dependent's twenty sixth birthday: **The employee needs to contact the health insurance carrier directly to obtain the necessary paperwork for determination of the disability or handicap.**
- E. The life insurance requires dependent children ages 19 – 25 be fulltime students. Dependent children are no longer eligible after the month they turn 25.

The following individuals are not eligible for insurance benefits: Dependent parents, Grandchildren (unless **permanent** guardianship is assigned by court order or the child(ren) is adopted by the State employed Grandparent), Domestic Partners, Girlfriends/Boyfriends, Fiancée/Fiancé.

An employee may be enrolled in the insurance as an employee **OR** the dependent of another employee but not as *both* an employee and the dependent of another employee. If two state employed spouses are electing coverage for themselves (excluding split elections), they must elect single coverage in order to be equitable to the agencies. Should both former spouses work for the State of Wyoming and have eligible children, only **one** parent may cover the dependent child(ren) under the Group Health Insurance Plan. The Group Plan cannot insure a dependent as the primary insurance under one parent and the secondary insurance under another parent if both parents are employed by any EGI sponsored employer (State, Colleges etc.). If both spouses enrolled in the life insurance they may insure each other as dependents but only one spouse may insure the dependent children for life insurance purposes.

Dependents are eligible for insurance at the same time employees become eligible. If eligible dependents are *not* enrolled when the employee first becomes eligible and the employee elects coverage, then the dependent(s) may be enrolled at a later time as "Late Applicants" or "Special Enrollees" (see page 12) or during an Open Enrollment Period (see page 17).

ENROLLING NEW EMPLOYEES

New employees should be offered the insurance plans immediately on their first active working day. The benefit plan booklets for the health, life and dental plans should be issued at this time. If an employee does not enroll in the health and dental plans within **thirty-one days** from their date of *eligibility*, they will not be allowed to enroll at a later date, *except* at an Open Enrollment Period or unless they qualify as a *special enrollee*. If an employee elects NOT TO ENROLL in the health plan and/or dental plans, it is very important for the employee to complete the waiver section on the applications to protect their right to enroll as a “special enrollee” at a later date. If the employee does not enroll in the life insurance plan within **thirty-one days** from their date of eligibility they must follow the procedures on page 14.

- A. **Health and Preventive Dental Plan** - New employees must complete the “Group Health Insurance Application” to elect or decline health and preventive dental insurance coverage. *If an employee elects health coverage they (and dependents if applicable) are automatically enrolled in the preventive dental plan.* If an employee waives health coverage, preventive dental can be elected as indicated in C., below. Keep a copy of the application for your files and forward the application to Employees’ Group Insurance (EGI).
- B. **Optional Dental Plan** – New employees must complete the “Group Dental Insurance Application” to elect or decline optional dental coverage. *Employees may elect optional dental coverage if they are **not** enrolled in the health plan.* If the employee has elected dependent (family) health coverage, they **may not** elect *single* optional dental coverage, but **must** elect dependent coverage. The employee must elect preventive coverage if electing the optional coverage. The optional coverage must be maintained for a minimum of one year after enrollment. When the applications are completed, keep a copy for your files and forward the application to EGI.
- C. **Dental Only** –Employees may elect dental coverage without being enrolled in the health coverage. New employees must complete the “Group Dental Insurance Application”. Employees may choose to enroll in the Preventive Dental Plan only or the Preventive and Optional Dental Plan. The employee must elect preventive coverage if electing the optional coverage. The optional coverage must be maintained for a minimum of one year after enrollment.
- D. **Life Insurance Plan** – New employees must complete the “Group Life Insurance Application” to enroll in or decline life insurance benefits. Life insurance is an available option alone if the employee does not elect health or dental insurance coverage. Keep a copy of the application for your files and forward the application to EGI. Employees may elect single coverage and dependent coverage.



Help

Example: *Employee may elect single health coverage and family dental.*

Example: *Employee may waive health coverage and elect single or family dental.*

If single coverage is elected, only the employee is covered. If dependent coverage is elected, the employee and their eligible dependents, *including a State employed spouse* (if applicable), are covered. This means that employees may be covered under the life insurance plan as *both an employee and a dependent*, if spouses are employed with any of the EGI sponsored employers. If this is the case, *two* death benefits would be paid – the employee death benefit and the dependent death benefit - at the death of the dual covered employee. Both State employed spouses may **not** elect to cover eligible dependent children. Only one employed spouse may cover

the eligible dependent child(ren). Eligible dependent children are covered until they reach age 19 or until age 25 if they are full-time students.

DEDUCTION of EMPLOYEE CONTRIBUTION

The enrollment form signed by the employee authorizes EGI or the covered entity to take the appropriate deduction from the employee's pay for the monthly premium. This includes collecting retroactive premiums if the employee failed to remit the correct amount of premium for the coverage elected or if deductions were not taken due to timing of submissions or a computer error in the payroll system.

Please verify that the applications are fully completed, and that the employee *signs and dates* the applications.

The completed applications are our authorization to enter the appropriate benefit information in the payroll system so that correct deductions from pay are made. **Please** submit the appropriate application for the benefit elected to Employees' Group Insurance (EGI). Please *do not* submit an application intended for one type of request but used for a different request (i.e., using a health application to enroll in the dental program). The applications are available from our website, (<http://personnel.state.wy.us/EGI/Index.htm>).

If two spouses, with eligible dependents, are employed by an EGI sponsored employer, deductions are made under the **Split Premium Arrangement** (see page 10).

EFFECTIVE DATES OF COVERAGE

It is important to have a new employee complete the applications for all insurance benefits as soon as possible and forward the original applications to EGI. The effective date of coverage is determined by when the election/enrollment applications are received by the agency Benefit Specialist or in the EGI office whichever is earlier (as evidenced by the date stamp). To avoid a delay in coverage and/or multiple deductions for premium payments, SEND ALL APPLICATIONS IMMEDIATELY.

*Please forward the ENROLLMENT applications WITH the flexible benefit plan election if the employee has chosen to participate in the flex plan (see page 32).

- A. If the application is completed and **received** in the EGI Office *within thirty-one (31) days* from the date of eligibility, **the insurance will become effective the first of the month following the date of employment.**

A newly hired employee may **change their original elections** (from enrolled to not enrolled or vice-versa, etc.) *during the 31 day election period if the applications changing their original elections are received* in the EGI Office by the 31st day from their date of eligibility.

- B. Employees on the State Auditor's payroll, who are hired at the end of the month and complete their applications prior to the end of the month, but *after payroll has been run*, will have coverage effective the first of the following month. The EGI Office will automatically process a double or multiple deductions the next month to collect the premium owed. **Effective dates are NOT negotiable.** Employees DO NOT have the option of delaying the start of insurance coverage.

- C. Employees who are eligible to *make changes* in their elections by adding or dropping dependents due to a qualifying event, must have their changes submitted to their Benefit Specialist prior to the first of the month they want the change to be effective. If the applications are received after the first of the month, the change **will not** be effective until the first of the following month.



Example: An employee wants to drop dependent health coverage effective the end of March. The application for change is completed at the end of March but is not received by the Benefit Specialist or the EGI Office until April 2nd. In this case, the dependent coverage will continue in effect until April 30th and premium will be deducted from the employee's pay for April. The change in coverage (dropping dependents) will not become effective until May 1st.

- D. Effective dates for insurance coverage in all other circumstances are specifically stated in other sections of this Handbook.

STATE CONTRIBUTION (MATCH)

The State of Wyoming contributes a monthly amount established and appropriated by the legislature for each *eligible* employee and official enrolled in the insurance plans. The contributions are based on the level of coverage elected: **Employee only, Employee +Spouse, Employee+Children, Family or Split Contracts.**

*See EGI Website for current contributions:
<http://personnel.state.wy.us/EGI/Index.htm>*

Each EGI sponsored employer is required to pay the monthly contribution, for each employee who has elected any part of the insurance benefits, (health, dental or life) to EGI. If the monthly premium for an employee's elected insurance benefits is less than the amount the State contributes, the balance remaining is retained by EGI and used to offset the cost of the self-insured health plan for all enrollees.

Newly enrolled employees receive the match for the month in which insurance coverage begins. Other enrolled employees receive the match for each month they are paid for 80 hours or more. If employees job share positions, the amount of the match that each employee is entitled to is determined by the percent of time that the employee works in the position. If two employees job share one position half-time, each employee is eligible for 50 percent of the match. If one employee works in the position 75 percent of the time and the other person works 25 percent, then the person who works the most would get 100 percent of the match because the other person would not work enough hours to be eligible for the insurance. If one person occupies one position on a part-time basis (at least 80 hours per month), then the person is eligible for 100 percent of the match.

Deductions from the State's contribution are taken by EGI in the following order for each *eligible employee* electing insurance benefits: (1) employee life premium (2) health premium (3) preventive dental premium (4) optional dental premium.

EGI receives the monthly State contribution on behalf of an eligible employee only if the employee elects to participate in any portion of the insurance (i.e., life, health or dental insurance).

If a covered employee transfers between two State Agencies, (not including non-state employers), without a break in service, on or before the 15th of the month, the employee will receive the State's contribution for that month's premium

from the *gaining* agency. If a covered employee transfers without a break in service after the 15th of the month, the employee will receive the State's contribution for the next month's premium from the *leaving* agency.

State contributions may not be applied to any voluntary benefits.

PAYROLL PROCESSING – setting up deductions

A. **Agencies on the State Auditor's Payroll System** – EGI will enter all information required for insurance elections and deductions in the State payroll system. It is the Benefit Specialist's responsibility to indicate in the space provided on the applications, the State contribution level that applies to the employee. **Corrections to pay (i.e., refunds) will be processed with the following month's payroll** or, if large sums are involved, within several days through the State Auditor's Office. Your assistance in avoiding insurance election/deduction errors is greatly appreciated.

B. **University, Community Colleges & other employers on Other Payroll Systems** – The Benefit Specialist or payroll staff establishes the employee's insurance match and deductions on their payroll system, including all refunds or pulling of missing premiums.

SPLIT PREMIUM ARRANGEMENT

If both husband and wife, *with eligible dependents*, are employed by an EGI sponsored employer, they are required to enroll in the Split Premium Arrangement if they are electing family coverage. Spouses **must** choose the same benefits under the Split Premium Arrangement (i.e., same deductible health plan and same dental benefit). The newly employed spouse **must** enroll with the same elections to match that of the longer employed spouse *within thirty-one (31) days of the date of the newly employed spouse's eligibility*. A change in plan deductible is **not** allowed at this time (i.e., the new State employed spouse must elect the same deductible as the longer State employed spouse). EGI will make the final decision if conflicting elections are made by two employed spouses. State employed spouses who have **no** eligible dependents are **not** eligible for the split premium arrangement.

If an employee is insured with the State and their spouse becomes a new employee of the State, both employees can then enroll in the Split Premium Arrangement (if they are also insuring eligible dependents). When EGI receives the applications for the new employee indicating split premium eligibility, our office will change the State contribution levels for each applicable agency.

If two state employees with dependents marry, they also are required to enroll in the split premium arrangement.

Employees who have been on Split Premium and subsequently lose all eligible dependents through death, divorce or because the dependent(s) becomes ineligible due to age, etc., **must notify their Benefit Specialist** and complete the applications to drop dependent coverage. *State employed spouses are not eligible for Split Premium if there are no eligible dependents to be covered*. Each spouse will be changed to single coverage when there are no longer any eligible dependents to be covered. If the Benefit Specialist is not notified, deductions for family coverage will continue until EGI is notified.

If one of the spouses on split coverage terminates employment, then the remaining employed spouse *automatically begins family coverage* effective the first of the month following the other spouse's termination **unless** EGI is notified that the dependents are to be dropped. In either case, the employee should complete a change application to add or drop the terminating spouse and dependents as appropriate. Premiums will change accordingly.

If one of the spouses on split coverage retires, the retiring employee may elect to cover the dependents (including the active employee spouse) under the State retiree insurance plan. The active employee spouse may not be covered as an employee (single coverage) and as a dependent of a retiree. See page 24 for the option of the retiree electing to be

covered as a dependent under the active employee. The retiree may be added to the active spouse's coverage; however the retiree may only choose this option one time.

PROCEDURE Split Premium Arrangement:



A. It is required that State employed spouses with family coverage have split premiums to make it equitable for the employing State agencies. The family health premium and contribution will be split between employee/spouse. When EGI receives the application electing family coverage and indicates a State employed spouse, EGI will set up the split premium arrangement.

B. The optional dental premium, if this benefit is elected, will be split between employee/spouse. Each spouse should complete the "Group Dental Insurance Application" marking the Preventive & Optional box or indicate waiver of coverage if they elect not to be covered by the Optional Dental Plan. In a Split Premium Arrangement, if the longer employed spouse had previously waived optional dental coverage, they may also elect to be covered at the time the newly employed spouse elects optional dental. In this case, the normal three year waiting period for electing optional dental insurance (if it was previously waived) is *not required* (see page 13).

C. The life insurance premium, if this benefit is elected, is deducted separately for each employed spouse. If the longer employed spouse had previously declined life insurance, the procedures on page 14, must be followed before they may elect coverage. See page 7, for more information on the options available to employees for electing single or dependent life insurance. If life insurance coverage is waived by the newly employed spouse, he/she *must* complete the waiver section on the application.

D. The Benefit Specialist for the newly hired employee should have the new employee complete the applications indicating the spouse is employed by the State. Submit the applications to EGI.

E. Benefit Specialists should keep copies of the health, dental and life applications, for their files. Send the original applications to EGI. If you have a question regarding the effective date of coverage, please contact the EGI Office.

F. **MEDICAL AND DENTAL CLAIMS** for all family members covered under the Split Premium Arrangement are filed under the Social Security Number (SSN)/ID number of the employee employed by the State the longest. If they have the same date of hire, claims should be filed under the spouse with the birth date that comes first in the year.



Example: *John and Mary are State employed spouses on the Split Premium Arrangement. John has been employed by the State since January 1995. His wife Mary was hired by the State in September 2001. The claims for the family are filed under John's SSN/ID number.*

HEALTH SAVINGS ACCOUNT

What is an HSA?

The IRS (Internal Revenue Service) allows employees to put aside money on a pre-tax basis to be used for future medical expenses incurred by the employee or eligible dependents. The IRS only allows you to open and contribute to a health savings account if you are enrolled in a qualified *high-deductible health plan (HDHP)*. Health savings account money can be used for future medical expenses.

Who qualifies for an HSA?

An employee *must* be enrolled in a HDHP to qualify for participation in an HSA. Please note; the HDHP through the state

has a \$1500 deductible for employee only coverage and a \$3,000 deductible for employee plus one or more coverage. Also, the HDHP's prescription coverage is part of the major medical and subject to the deductible and co-insurance.

How to enroll an employee?

Step 1

The employee must enroll in the HDHP by way of a group health insurance application. This can be done when the employee is a new hire and eligible for benefits, OR during a plan transfer period (held every November for a January effective date) when an employee may change their deductible.

Step 2

Employees' Group Insurance will make the change on the health insurance system.

Step 3

You may open a 'health savings account' at any institution; however it must be a designated HSA, not a regular checking account. A regular checking account is not acceptable. If the IRS were ever to audit the employee, they need to clearly see medical expenses versus other expenses (groceries for example).

Step 4

Once the health savings bank account has been established, the employee will need to complete a Health Savings Account Election form. This form, with a copy of a voided check or deposit slip is submitted to the Benefit Specialist. The amount is then set up in payroll to have that amount deferred pre-tax, from payroll into their bank account. Payroll deferred money can only be made while the employee is actively enrolled in the HDHP; therefore if the employee is switching to the HDHP for a January 1 effective date, that transfer of money to your HSA cannot be done until January 1 or after. For example; January premium deducted from December payroll; HSA designated funds cannot be deducted until the January payroll.

Forms can be obtained from the EGI website <http://hr.state.wy.us/EGI/Index.htm>



PROCEDURE: When a new hire who is choosing the HDHP or an existing employee who changes to the HDHP in the plan transfer period, they need to submit a HSA election form AND a copy of a voided check or deposit slip to the Benefit Specialist. Without bank account information there is no where to send the funds they want to go into the account. Also, we have to have a copy of the voided check so both EGI and the State Auditors Office can verify the routing numbers etc. Upon receipt of the HSA election, EGI (or covered entity payroll) will set up the amount to come out of the employee's next check to be deposited into their account. These deductions to the HSA will stay in force until the employee changes them with a new REVISED HSA election form OR they take coverage in a health plan that is something other than the HDHP. Please provide a HSA brochure to the employee.

ENROLLING AFTER 31 DAYS

LATE ENROLLMENT – If *eligible employees* or their *eligible dependents* do NOT enroll in the insurance plans within 31 days of eligibility and they later want coverage, they will be allowed to enroll **only under the specific circumstances** listed for each benefit:

A. **Health Insurance Plan** (including preventive dental insurance) – Employees and dependents who do not enroll within 31 days of eligibility will be *Late Applicants* or *Special Enrollees*. *Late Applicants* can enroll in the Health and Preventive Dental Plan **only** during Open Enrollment (during the month of November of odd numbered years). Health insurance elected during an Open Enrollment becomes effective the next Plan Year on January 1st, following the Open Enrollment period (see page 17). There is no option to enroll between Open Enrollment Periods unless the eligible employee or dependent meets the definition of a *Special Enrollee*. An *employee* is NOT considered to be a *Late Applicant* **if**, since they first became eligible, they **experience a change in family status** because they acquired a dependent through marriage, birth or adoption (see page 14). A *Special Enrollee* is a person who was eligible for the State Health Insurance Plan but did not enroll within the 31 days of eligibility because they were covered under another health insurance plan or arrangement (other plan). *Special Enrollees* may elect coverage under the State Health Insurance Plan **if** they:

Lose coverage under the other plan as a result of exhausting COBRA coverage **or**
Loss of eligibility for the other plan's coverage due to legal separation, divorce or death of spouse or spouse's termination of employment (including retirement) **or**
Reduction in the hours worked making them ineligible for the insurance **or**
Termination of the employer's contribution for the other plan's coverage **or**
Change of benefits resulting in at least a 35% increase in out of pocket.

And

Request coverage under the State's plan within **60 days of the date coverage is lost** under the other plan.



PROCEDURE: If the employee (or employee's dependents) meets one or more of the conditions above, the employee must complete a change application. Send the application and documentation showing the names, dates and reason for loss of coverage under the other plan (i.e., letter from other plan administrator, court document, etc.) to EGI. Keep a copy of the application for the Benefit Specialist's file.

The *effective date for insurance coverage for a Late Applicant* is the beginning of the Plan Year (January 1) following Open Enrollment. The *effective date of insurance coverage for a Special Enrollee* is the first day of the month beginning after the qualifying event; and the date the change application **and** applicable documentation is received by the Benefit Specialist or EGI as evidenced by the date stamp.

B. **Optional Dental Plan** – Employees and dependents who do not enroll in the State's Optional Dental Plan within 31 days of eligibility (i.e., waive optional dental coverage), and later want coverage, will be able to enroll if they have met the three-year waiting period (coverage becomes effective at the beginning of the next plan year on January 1st); **or** they may be able to enroll by submitting a letter from their dentist (see Exception (1) below).

Employees and dependents who enroll in the Optional Dental Plan within 31 days of eligibility but then subsequently **drop** this insurance will not be able to enroll again until a *three year waiting period* has been met, unless they meet the Exceptions below. This three-year period starts from the date the optional dental insurance was terminated. Once the three-year period has been met, the employee may complete the dental application, marking the preventive and optional box, to enroll themselves and their dependents (if applicable). However, **coverage will not become effective** until the beginning of the next Plan Year (January 1). There is no open enrollment available for optional dental coverage.

Employees who have not been enrolled in optional dental insurance for at least three (3) years may enroll after satisfying the three year waiting period. The coverage begins at the start of the new plan year, January 1.

Exceptions:

(1) If an employee enrolls for dependent optional dental insurance and later drops the insurance because the dependent(s) became covered under another group plan sponsored by the spouse's employer, and such coverage was later terminated due to: termination of the spouse's employment **or** temporary lay-off or labor strike, resulting in loss of dental benefits **or** termination of the other plan, then the employee will be allowed to re-enroll the dependent(s) without waiting the full three (3) years otherwise required under this plan. This enrollment is possible as long as the employee applies for coverage **within 60 days** of the date on which the spouse's coverage terminated under the group dental plan sponsored by his/her employer. The coverage must be maintained for one full year.

(2) Employees and dependents may apply to be enrolled in the optional dental plan **prior** to the three year waiting period by submitting a letter from their dentist that states the employee nor the dependents (if applicable) are in need of *any dental care based on examination* (if the dependent being added is under one year of age, he/she may be added without the above mentioned letter). This statement must be submitted with the dental application. EGI will make the final determination on whether the employee and dependents (if applicable) will be covered by the optional dental plan upon receipt of this information. Coverage becomes **effective at the beginning of the month following approval by EGI**. The coverage must be maintained for one full year.



PROCEDURE: If the employee meets one or more of the conditions above, they must complete a Group Dental Insurance Application for the optional dental insurance. The application and the Dentist Statement (if applicable) are sent to EGI. Retain a copy of the application in the Benefit Specialist's file.

C. Life Insurance Plan – If an *employee* does not enroll themselves or their dependent spouse for life insurance within 31 days of eligibility and later wants coverage, they must complete a “Proof of Good Health” statement/form required by the insurance carrier.



PROCEDURE: The employee contacts the Benefit Specialist who, in turn, contacts the EGI Staff. EGI will send the “Proof of Good Health” form to the employee for completion. The employee returns the form to the insurance carrier who makes the determination if the employee/dependent is insurable. The insurance carrier notifies EGI of the action being taken. If additional information is required (such as a physical exam or physician's records), the employee is responsible for obtaining the information and for any associated costs.

If the request is denied, the insurance carrier will send the notification to the employee, and a copy to EGI. If the request is approved, **the effective date will be the first of the month following approval.** The employee *must* complete and submit the Group Life Insurance Application **within 60 days** of the effective date if an application was not previously submitted that initiated the application process. If the application is not received within this timeframe, the employee must start the “Proof of Good Health” process over again.

ADDING DEPENDENTS

If an insured employee acquires eligible dependents or ceases to have eligible dependents they may make corresponding changes in their insurance benefit elections. *It is the employee's responsibility to notify the agency Benefit Specialist and EGI of any family status changes.*

A. **Employee wants to add newly acquired (by adoption) eligible dependents.** Any adopted dependent(s) will be covered from the earlier of the date the petition for adoption is filed; or the date the child enters the adoptive home, except when the child is in the custody of the state, coverage will be provided upon entry of a final decree of adoption. Coverage for an adoptive child will terminate on the date on which the petition for adoption is dismissed or denied. The appropriate documentation and change application for the new dependent(s) must be received by EGI within 60 days of the date the dependents are acquired. A birth or adoption that occurs overseas will have an effective date of the date they enter the home.

B. **Employee wants to add newly acquired (by marriage) eligible dependents.** Coverage for a newly acquired spouse must be applied for within 60 days of the marriage. Coverage would then begin on the date of marriage. Employee must submit the change application and a copy of the marriage certificate. If the effective date is the 1st through the 15th of the month, a premium will be due for that month. No premium will be due for the month if the effective date is after the 15th. When the marriage has occurred overseas, the effective date will be the date the spouse enters the country.

C. **Adding dependents based on court order.** Coverage for a dependent not previously covered but now mandated by State Statute and court order (i.e., State Child Support Services) may be applied for and may become effective within the timeframes stated in the court document if application is made in a timely manner. Otherwise, the effective date of coverage is the first of the month following receipt of the application or State Order by EGI. Be aware that if court order mandates the State to add dependents, enrollment is required regardless if applications are submitted. These situations are reviewed on a case by case basis.

The employee must submit the application for change and a copy of the support order to EGI. A review and determination will be made and the Benefit Specialist will be notified of the decision. A “court order” in this case does *not* include a mandate by a court for an employee to provide insurance for a dependent or former dependent as the result of legal separation or a divorce settlement. These situations *do not* entitle the employee to add (or drop if pre-tax) a dependent(s) not previously covered, to the insurance. These dependents may be added to the insurance if the dependent is eligible as a “dependent” **and** as a “special enrollee” or “late applicant” under the policy applicable to the State’s Health Insurance Plan.



PROCEDURE: For the situations mentioned above, the employee must complete a Group Health Insurance Application for change in order to enroll new dependents in the health insurance. The dependents must be listed individually. The dependents listed will automatically be “added” to the optional dental insurance (if the employee has this coverage); therefore, it is not necessary to complete a new dental application. The employee must complete a Group Life Insurance Application to add newly acquired dependents to the life insurance plan, if not already carrying dependent life coverage. If the employee already has dependent life insurance, any newly acquired dependents will automatically be covered. Send applications and the appropriate documentation (copy of marriage certificate, adoption papers, court order, etc.), if required, to EGI. Retain the copies for your files.

D. Employee wants to add newborn dependent children – The child is covered from the date of birth for up to 31 days after the birth even if dependent coverage has not been in place.



PROCEDURE: To continue the coverage beyond the 31 days, *the employee* must complete a health insurance application for change to add the child’s name and change their coverage if applicable. The application and a copy of the birth certificate or hospital document (showing DOB, parent’s and child’s names) must be submitted to EGI within 60 days from the date of birth. Premium for dependent coverage begins the first of the month following the birth of the child. Therefore, depending on the date of birth, and if the employee changes his/her election to Employee+child tier or family, the newborn may not have the full 31 days of premium free coverage.

The addition of a newborn child **does** allow an employee to *add other family members who were previously eligible but not enrolled within 31 (or 60 for a qualifying event) days of their eligibility. These dependents would be effective the first of the month following receipt of applications.*

To continue the health coverage beyond the 31 days, *the employee on family coverage*, must complete a change application to add the child to the existing family coverage. The employee must complete a Group Health Insurance Application. Send the application and a copy of the birth certificate or hospital document (showing DOB, parent’s and child’s names to EGI within 60 days from the date of birth.

Claims processing for newborns – When the health insurance administrator receives a claim for a newborn child on an existing family policy, they will process all claims incurred within 31 days from the date of birth. All explanation of benefits (EOBs) sent to the employee will remind them that “continuous coverage requires enrollment, contact your Benefit Specialist”. Any claims incurred and denied beyond the 31 days from the date of birth will be re-processed after the child has been added to the family policy.

DROPPING DEPENDENTS

Employee wants to drop dependents. Employees who **are not** enrolled in the Flexible Benefits Plan may drop dependent (family) health, optional dental (must have maintained optional dental coverage for one year) and/or life insurance coverage at any time. Employees who **are** enrolled in the Flexible Benefits Plan may drop dependent insurance coverage *only upon a qualifying change in family status events* (see page 35) or during the plan transfer period described on page 16). Employees who have dependents that become ineligible due to death, divorce, or age, **must notify** the agency Benefit Specialist. Be aware that a divorce decree ordering the other parent to maintain coverage for the children does not allow the employee to drop dependent coverage if he/she is pre-tax. If the employee *participates* in the Flexible

Spending Account (i.e., elects pre-tax insurance deductions), they must submit a copy of a divorce decree, death certificate or other documentation to show proof of the dependent's ineligibility (except in the case of a child who becomes ineligible due to age). If the employee *does not participate* in the Flexible Spending Account (i.e., insurance deductions are taken on an after-tax basis), they may drop dependents at any time without providing any documentation.

*Note: Employees enrolled in the Flexible Benefits Plan may also complete applications to **drop dependents** during the month of November during the annual "plan transfer period". The effective date of the change (dropping dependents) is January 1, the beginning of the next Plan Year. Employees in the Flex Plan who choose to drop dependents during November **must** have the applications into EGI by November 30th.

REFUNDS: It is the responsibility of the insured to notify the Benefit Specialist of ANY changes in dependent status immediately. If a refund is warranted (i.e., the plan did not assume any risk), refunds are made for any premium paid by the employee for an ineligible dependent. These refunds are processed through the payroll system and therefore reflected on the employee's pay check. A maximum of three years will be subject to a refund.

Example: John was married with dependent coverage for his wife (no eligible children). He divorces and fails to notify his Benefit Specialist that he no longer has eligible dependents. Payroll deductions for employee plus spouse coverage continue for two years before John asks his Benefit Specialist about the deduction for insurance from his paycheck. It appears to be more than it should be. The Benefit Specialist becomes aware that John was divorced two years ago. John asks for a refund of the excess premium he has paid for employee plus spouse coverage (he only needed single coverage). After an application for change and documentation of the divorce, will a refund be processed for the difference between the single coverage and the employee plus spouse premium. Repayment of claims incurred after eligibility terminated will be pursued.

LIFE INSURANCE CHANGE

Change of Beneficiary or Name Change – A change of beneficiary for the life insurance benefit may be done at any time. A name change is appropriate upon marriage or based on a court order.

PROCEDURE: For a beneficiary change, complete the Group Life Insurance Application marking the box "Change Beneficiary" and must be signed by a witness that is not a beneficiary.

To request a name change, complete the applicable applications for change and submit to EGI with a copy of the documentation (Social Security Card, marriage certificate, or court order).

Change in Beneficiary – If the designated beneficiary does not survive the employee, or there is no named beneficiary on a life insurance policy, the insurance carrier will pay in order of succession. This order goes first to the executor of the estate or surviving spouse; if none, then to surviving child(ren) – if none, then to surviving parent(s); if none then to the estate. The most current designation on file in EGI is the one to be used for distribution of benefits.

PLAN TRANSFER PERIOD

Employees may change the deductible amount (plan option) for the health plan during Open Enrollment **or** during a "plan transfer period" prior to the beginning of each plan year (January 1). The application must be submitted to EGI by November 30th. If the employee changes their plan option in November during Open

Enrollment or the plan transfer period prior to the beginning of the plan year, the effective date of the change is January 1st. Deductibles start over at the beginning of each calendar year.



PROCEDURE: The employee completes the “Group Health Insurance Application”, marking the “Change Deductible” box and indicating the new deductible choice. Write “OE” (for “open enrollment”) in the upper right-hand corner of the application if the change is being made during a regular Open Enrollment period. Verify that the employee is not already in the plan option they have indicated on the application. Keep a copy of the application for your file and send the application to EGI. The application must be received to the agency Benefit Specialist by November 30th. Applications received after this date will not be accepted.

If the employee is participating in the Split Premium Arrangement, please remind them that their spouse must also change their plan option (deductible) with their employing agency.

OPEN ENROLLMENT

The Wyoming State Employees’ Group Insurance policy authorizes a general Open Enrollment in November of odd numbered years. Changes made during Open Enrollment are effective January 1 following the Open Enrollment period. This period allows employees and or dependents that are currently NOT enrolled in the health and optional dental (subject to dental waiting period) benefit plans to enroll. This period* also allows *employees enrolled in the Flexible Benefits Plan the opportunity to drop insurance* on themselves and/or dependents if they have not had a qualifying family status change during the plan year that would otherwise allow them to drop coverage under the State’s health plan. The Open Enrollment does **not** provide employees/dependents an opportunity to enroll in the life insurance plan. Please refer to page 14, for options to enroll in the Life Insurance Plan.

*Note: Employees enrolled in the Flexible Benefits Plan may also complete applications to **drop dependents** during the month of November during the annual “plan transfer period”. The effective date of the change (dropping dependents) is January 1, the beginning of the next Plan Year. Employees in the Flex Plan who choose to drop dependents during November **must** have the applications into their agency Benefit Specialist by November 30th.



PROCEDURE: The employee completes the Group Health Insurance Application indicating “Change Enrollment Options”, if they are enrolling themselves and dependents during Open Enrollment. This form is also used if the employee is currently enrolled but is now adding or dropping eligible dependents during Open Enrollment.

If an employee is enrolling themselves and/or dependents in the Optional Dental Plan during open enrollment, they complete a Group Dental Insurance Application marking the Preventive and Optional box. (Must have completed the three year waiting period if previously waived.) The names and dates of birth of all the dependents to be covered must be listed on the application. If the employee has elected dependent coverage for health and elects the optional dental coverage, dependent coverage must be elected for the optional dental plan also.

TERMINATION

When an employee terminates employment or ceases to be in a class eligible for insurance, their insurance is terminated. Employees are considered “not eligible” when they fail to receive pay for a minimum of 80 hours

or more in one calendar month, or when they are reclassified as irregular, intermittent or less than ½ time. Employees who terminate employment are covered through the end of the month that service terminated. Employees who terminate and are then rehired are considered new employees upon rehire as long as there was at least a five-business day (5) break in service. These employees' eligibility for insurance benefits begins again based on the date of rehire.



PROCEDURE: Insurance will terminate the end of the month the employee's status changes. The Benefit Specialist must notify EGI of the employee's termination by submitting the Termination/Less than 80/Transfer Checklist at this time. EGI will update the payroll system expiring the employees insurance deduction codes. If an employee terminates late in the month (after payroll has run) and premium is deducted, they will be reimbursed by way of a hand warrant through SAO.

Example: If John's status is changed from temporary full-time to less than ½ time on March 2nd, his insurance will end on March 31st.

It is the Benefit Specialist's responsibility to inform the employee of their insurance cancellation date and determine eligibility for retiree coverage (refer to the retiree and sections of this Handbook). Once EGI is notified of an employee's termination, EGI will update the payroll system to expire the insurance deduction payroll codes. The Benefit Specialist must notify EGI of the employee's termination by submitting the Termination/Less than 80/Transfer Checklist at this time.

J. Employee wants to voluntarily cancel insurance – If the employee is **not** enrolled in the Flexible Benefits Plan, they may drop coverage on themselves and/or their dependents at any time. (Subject to any benefit commitments i.e. 12 months of optional dental, 2 year vision commitment) The voluntary withdrawal of insurance coverage is effective the *end of the month in which the signed application is received*. If premium deductions have been taken for the next month, a refund will be processed.



PROCEDURE: To withdraw from coverage in the health plan while still eligible, employees must complete a Group Health Insurance Application. To withdraw from the Preventive and Optional Dental Plan, the employee must complete a Group Dental Insurance Application. Send the withdrawal to EGI and a copy should be retained by the agency Benefit Specialist. Optional dental coverage must be maintained for a minimum of one year.

To withdraw from coverage in the life insurance plan while still eligible, employees must complete a Group Life Insurance Application. The withdrawal is sent to EGI and a copy is retained by the agency Benefit Specialist.

CONVERSION COVERAGE

If the insurance terminates for any reason except failure to make a required payment, the employee may be able to convert the *group health* and *life insurance* coverage to conversion coverage.

Health Insurance – If the group health policy is still in force, only employees who are actively covered under the health plan for 90 days or more may apply for conversion. Conversion coverage is available **only** after the full length of the COBRA continuation has expired. This means if an employee has lost coverage under the group plan due to termination or reduction in hours worked, they then **must** have elected continuation coverage under COBRA and the COBRA coverage must be within 31 days of expiring before they may apply for conversion coverage.



PROCEDURE: EGI will notify COBRA participants of their conversion privilege one (1) month prior to the COBRA coverage expiration date (see page 30).

Life insurance – If all or part of the Group Term Life Insurance terminates, the employee may convert to an individual life insurance policy. Proof of Good Health will not be required if application is made within 31 days of such termination. The life insurance conversion/portability information should be provided to the employee at the time of termination.

- a. If the insurance **is not** being continued under the waiver of premium benefit, employees are eligible if:

All or part of the Group Term Life insurance terminates due to (1) termination of the employee’s service (2) age or retirement reductions

- b. If the insurance **is** being continued under the waiver of premium benefit, the employee is eligible if:

All of the insurance terminates; or

Part of the insurance terminates due to age or retirement reductions at the time the employee became disabled.

REDUCTION IN FORCE (RIF)

Wyoming State Statute 9-3-105 defines RIF as the involuntary separation of any employee from **State Employment** because of a shortfall of funding, lack of work or organizational changes requiring a reduction in the number of positions of **State Employment**. According to the statute, RIF’d **employees will receive the state’s contribution (match) toward their health (and dental) insurance coverage for six (6) months following separation or until the separated employee acquires employment (of any kind – benefited or non-benefited), whichever occurs first.**

* Statute does not apply to University and colleges; however same procedures are followed.



PROCEDURE: The Agency Benefit Specialist is responsible for notifying EGI when the agency is administering a Reduction in Force. Please give the employee’s name(s), agency number, SSN and effective date(s) to the EGI Staff, using the Terminations/Transfer/Less than 80 form.

A. RIF’d employees must be offered COBRA continuation benefits at the time they are RIF’d. Complete the Termination/Transfer/Less than 80 form as usual. Write “RIF” next to the termination date. The six months the RIF’d employee is given the state contribution counts toward the total number of months they are allowed to be covered by COBRA. The employee must elect COBRA benefits within the 60 day timeframe (see COBRA Administration, page 27). The RIF’d employee is charged the appropriate COBRA premium for the election he/she makes. **The employee pays for any monthly premium that exceeds the State contribution during the six months following termination.** RIF’d employees are not eligible to continue participation in the Group Life Insurance Plan. They may convert coverage per instructions on page 18.

Example: If an employee is RIF’d effective April 30, the agency will continue to contribute the state contribution for the next six months, or through October. If the employee has family coverage, they will pay the monthly COBRA premium amount – less the state contribution for the six months. The employee will be given

their COBRA election form in April. When the employee elects COBRA, they will only be allowed COBRA coverage for twelve months following the six months they received the state contribution. The six months they were receiving RIF benefits plus the twelve months of COBRA coverage total the eighteen months employees are allowed under the COBRA law. The complete COBRA premium would not be payable by the employee until November, the seventh month after the employee was RIF'd.

B. RIF'd employees must send their COBRA election form to EGI within the 60 day timeframe. *There are no exceptions to this election period.* EGI will send a notice to the employee about their responsibility for paying COBRA premiums that are in excess of the State's contribution for the first six months and for paying COBRA premium beginning the seventh month following RIF.

B. The Benefit Specialist notifies the RIF'd employee if they are eligible to retain the State Health Plan as a retiree (see page 23). The Benefit Specialist must notify EGI to request retiree benefits information be sent to the affected employee. RIF'd employees eligible for the State Health Plan as a retiree will also receive the state contribution for the first six months following termination.

LEAVE OF ABSENCE

When an employee is not actively at work due to a leave of absence, worker's compensation, disability, family medical leave, military leave, leave without pay, or works less than 80 hours in a month, the insurance benefits may be continued per the conditions described below. (If the employee is not actively at work but is receiving paid leave, they continue to be eligible for the State Contribution and benefit deductions are continued through the normal payroll process.)

Workers Compensation – If an employee is covered by Worker's Compensation, the employee is eligible for coverage at the active employee premium, for up to six (6) months from the **date of injury**. The employee receives the state contribution for the first two months following the **date of injury**. During this time the employee must pay the monthly premium for coverage that is in excess of the state contribution. The employee's entire insurance premium, including family portion if applicable (except for dependent life insurance and voluntary benefits) is paid by the employing agency during months three, four, five and six following the **date of injury**. If employee is maintaining the required eighty (80) calendar hours (worked, sick, or annual) the employee continues payroll deductions as normal. Additional agency contribution applies **if** employee falls below the required 80 hours.

*Example: Joe, a State Employee enrolled in family coverage, is injured at work on July 13th and is placed on Worker's Compensation. He receives the State contribution for August and September. He pays any premium for his family coverage that is in excess of the State contribution for both of these months. Joe continues to be injured and does not work in October, November, December and January. For these months, **his agency pays the entire cost of his family coverage** (except for the dependent life and voluntary benefits premium). EGI sends Joe a COBRA notification form in January to notify him that his coverage under the Group Plan will terminate on January 31. Joe elects COBRA coverage for his family and is responsible for paying the entire monthly COBRA premium for the months of February, March, April and May (Joe goes back to work on May 8th). Since Joe worked 80 hours in May he is entitled to the State contribution and Group benefits in June. Joe cancels his COBRA coverage effective May 31st and his active employee premium for family coverage in June is deducted from his payroll check at the end of May (Joe goes back on payroll). Joe completes enrollment applications for insurance (health, dental, life). This in affect will cancel the COBRA and will re-enroll him as active status. The enrollment applications must be received by EGI within 31 days of the date he returned to work.*



PROCEDURE: For those employees on workers compensation, EGI will pull the State contribution for the month in question, along with any monies owed by the employee. Letters are sent to the employee for any past due amounts with a copy sent to the agency. If the employee is actively back to work, the premium will be deducted from their next payroll check. Depending on the amount, it is sometimes separated into two payroll periods. If they are still out on leave, a letter is sent directly to the employee at their home address with a request for payment by a designated date. If payment is not received for back premiums owed, the coverage is cancelled back to the end of the month that premiums were last paid.

If the employee does not return to work at the end of the six-month period, they will be offered COBRA.

Disability – If an employee does not work due to illness or injury that is **not** the result of a Worker’s Compensation claim, they may continue insurance coverage through COBRA when paid leave and FMLA are exhausted.

If an ill or injured employee becomes eligible for social security benefits based on disability but does NOT qualify for the State’s disability retirement, they may continue COBRA coverage for a maximum of 29 months if proof of the disability is submitted in the first 60 days of COBRA coverage. This extended period of COBRA coverage is available so the disabled person may continue health benefits (if elected) until they become covered by Medicare (24 months following the date they become eligible for Social Security benefits based on disability). They are eligible to retain the State’s Insurance Plan as secondary coverage to Medicare.



PROCEDURE: When an employee, who is enrolled in the State’s insurance benefits, experiences a long-term illness or injury and they are no longer eligible for the State’s contribution (i.e., less than 80 hours of pay per calendar month), they are offered COBRA by EGI.

Family Medical Leave Act (FMLA) – Federal regulations allow an employee to take a maximum of 12 weeks of leave in any 12 month period for the following events: birth of the employee’s child, child’s placement with employee for adoption or foster care, care for seriously ill family member or for the employee’s own serious illness. To qualify, the employee must have been employed for at least 12 months; worked 1250 hours during the previous 12 months and be covered under this plan. The 12 week period includes the employee’s accrued sick leave and annual leave or any donated sick leave allowed. If an employee’s accrued sick and annual (vacation) leave total less than 12 weeks, the time remaining can be taken as unpaid FMLA leave. The agency will pay the state contribution toward the employee’s insurance benefits for a maximum of 12 weeks of FMLA leave.



PROCEDURE: For those employees on FMLA leave, EGI will pull the State contribution for the month in question, along with any monies owed by the employee. Letters are sent to the employee for any past due amounts with a copy sent to the agency. If the employee is actively back to work, the premium will be deducted from their next payroll check. Depending on the amount, it is sometimes separated into two payroll periods. If they are still out on leave, a letter is sent directly to the employee at their home address with a request for payment by a designated date. If payment is not received for back premiums owed, the coverage is cancelled back to the end of the month that premiums were last paid.

If the employee is on a *split premium*, and elects not to pay the premium while on FMLA, their coverage will be transferred to their spouse. This will result in the spouse being charged for family coverage rather than a split premium. This family deduction will continue until the employee returns to work.

If the employee does not return to work for at least 5 days after the 12 weeks of FMLA leave, they will be required to repay the State's contribution for benefits that was received unless the reason the employee did not return was because of the continuation, recurrence, or onset of a serious health condition which would entitle them to FMLA leave.

If additional leave without pay is granted in conjunction with a period of FMLA leave, the employee will be offered COBRA after the maximum 12 weeks FMLA period ends.

Military Leave – Employees are granted a leave of absence if they are called to **active duty** in the military. State law requires that these employees have the option of continuing participation in the State Group Health Plan.



PROCEDURE: The agency does pay the State contribution for employees who choose to continue participation while on active duty with the military. The employee must pay the cost of the insurance premium in excess of the State contribution. If the employee chooses not to continue participating in the insurance benefits, then they will be treated as a newly hired employee upon return to State service. The employee would be allowed, at that time, to enroll themselves and dependents with no pre-existing condition limitations.

Employees working less than 80 hours per calendar month – If an employee does not work or receive pay for a minimum of eighty (80) regular hours during the calendar month, they are not entitled to receive the State contribution (exceptions are FMLA and Worker's Compensation).



PROCEDURE: For those employees working under 80 hours in a calendar month and are actively working, they will receive a letter from EGI to their home address requesting payment by a designated date, or contact EGI to make payment arrangements within the State payroll system. If payment is not received for back premiums owed, the coverage is cancelled back to the end of the month that premiums were last paid. The employee will only be allowed to remain on the agency for **one month** before they must enroll for COBRA coverage due to reduction in hours.

When the employee returns to work 80 hours or more per calendar month, they must complete enrollment applications for insurance (health, dental, life). This in affect will cancel the COBRA and re-enroll the employee as active status. The enrollment applications must be received by EGI within 60 days of returning, and active coverage will be effective the first of the month following them **obtaining** over 80 hours in a calendar month.

Employees may continue life insurance benefits for a maximum of one-month following the last month they were still eligible for the State contribution. The employee must pay the appropriate premium due for this month of coverage. If the non-pay (less than 80 hours) status continues for more than one month, the employee may convert the life insurance to an individual plan with the Group Life Insurance carrier. If the life insurance is not converted then coverage ends after the one-month period. If the employee subsequently returns to work in a regular pay status for 80 hours or more in a month, then they may elect to participate in the life insurance plan again at that time.

If the employee working less than 80 hours is on the *Split Premium Arrangement*, the benefit premiums will be transferred to the spouse. This will result in the spouse being charged for family coverage rather than a split premium. This family premium deduction will continue until the employee returns to work more than 80 hours in a calendar month on a regular basis.

WAIVER OF PREMIUM

The purpose of the waiver of premium (WOP) is to assist employees with their life premiums when they are disabled. In order to become eligible for waiver of life premiums, an employee must be unable to perform the duties of his/her own occupation. Refer to the Life Insurance Plan Booklet for more detailed information on disability and waiver of premium.



PROCEDURE: The employee can contact the Life Insurance Carrier to request the necessary paperwork to request the Waiver of Premium. The employee will be required to obtain a physician's statement and the employing agency will have to fill out a portion of the paperwork to verify their working status.

MEDICARE PREMIUM

Any *employee* over the age of sixty-five (65) is eligible for Medicare. We encourage employees, as well as spouses, who are nearing age sixty-five to enroll in Medicare, Parts A and B. If enrollment is done after the sixty-fifth birthday, there is a waiting period and penalty applied. This results in a higher Medicare premium.

Due to the Tax Equity Fiscal Responsibility Act of 1984 (TEFRA), any *active* full-time *employee* who is age sixty-five and over, as well as any dependent spouse, over the age of sixty-five, of an *active* full-time *employee*, can choose between the State insurance or Medicare as their primary payer of benefits. Should the employee or the spouse choose Medicare as primary, (filling out applications to DROP state coverage) **they will be removed from the State Plan**. The date the election will become effective will be the first of the month in which the applications are received and the employee has 60 days from the date Medicare begins to submit applications.

RETIREMENT AND/OR TERMINATION

If an employee meets the following qualifications, he/she may continue with the State of Wyoming Group Insurance Plan at retirement **or** termination of active employment:

- 1) The retiring employee must have had coverage in effect under the State plan continuously for at least one year just prior to termination.
- 2) The retiring employee must have at least 20 years of service with the State.
AND
- 3) The retiring employee must be eligible for State of Wyoming Retirement Benefits or TIAA Cref.
OR
 - 1) The terminating employee must be fifty (50) years of age or over
AND
 - 2) The terminating employee must have completed at least 4 years of service for the State and is eligible for the State of Wyoming Retirement Benefits or TIAA Cref.
AND
 - 3) The terminating employee must have had single and/or dependent coverage in effect continuously for one (1) year just prior to termination.

If the terminating employee **does not** meet any of the qualifications above, the employee must be offered COBRA (see COBRA Procedures, page 27). If the employee does meet the qualifications above they may choose to elect COBRA coverage rather than continue the group insurance benefits as a retiree. This is generally not to their advantage because COBRA is time-limited coverage whereas the group plan offers continuous coverage. Please notify EGI when an employee is retiring and a retirement packet will be forwarded to him/her.

Retiree Benefits – A retiree who meets the qualifications listed above may elect to continue the same benefits as they had as an active employee except retirees are not eligible for the \$350 deductible health plans. If the retiree had life, health and preventive and optional dental insurance as an active employee, they may continue all of these benefits or they may elect to continue the health insurance only or the health insurance and the preventive dental insurance, or the health insurance, preventive dental and the optional dental, or preventive and optional dental insurance or just life. Vision and long term care insurance may also be continued.

Retiree and Dependent Eligibility - A retiree who meets the eligibility above and elects to continue participation in the State's Group Plan as a retiree may continue to cover eligible dependents as long as they were previously covered by the plan for one (1) year just prior to the retirement/termination date. .

If an employee retires and elects to continue enrollment for him/herself and dependents as a retiree, then the employee and dependents **are waiving COBRA coverage**. If the dependents subsequently have a qualifying event under COBRA rules (see page 27), they *are eligible* for continuation coverage (COBRA) for up to 36 months from the date of the first qualifying event (i.e., retirement).

*Any former employee or retiree who has continued to participate in the State's Group Health Plan based on the qualifications above and who **acquires** an eligible dependent after leaving active employment with the State, may add a newly acquired eligible dependent within sixty (60) days of acquisition. The effective date of coverage is the date the dependent was acquired.*

Retiree Married to Active Employee – State-employed spouses participating in the State's Group Plan may continue the group insurance benefits *only one* time as a retiree unless they return to work as an active employee and then retire again. An active employee who is retiring may elect retiree coverage either when they retire or when their spouse terminates or retires from State employment. This means that when an employee, who is married to an active State employee, retires he/she may elect to be a dependent of their State employed spouse at the time of retirement. Then at a later time (i.e., when the spouse retires or terminates employment) elect to continue participation in the State's Group Plan as a retiree and not a dependent. When the actively employed spouse retires, he/she may elect retiree coverage as a primary insured or elect to become a dependent of the spouse who retired earlier. It is usually more beneficial financially (i.e. premium rate) for an employee to continue the insurance as a retiree (primary insured) rather than as a dependent of a retiree.

When a *retiree*, who has continued participation in the State Group Health Plan, turns age 65 or becomes eligible for Medicare Parts A and B, they may elect to continue the State Group Health Plan as a secondary insurance. This means that medical claims are first paid by Medicare and secondly by the State Plan. The State Plan is considered to be a secondary insurance, not a Medigap (Medicare Supplement) insurance policy. If the retiree elects to cancel participation in the State Group Health Plan upon reaching Medicare eligibility, **they may continue the dental coverage they had at the time the health coverage was canceled.**

If the Medicare eligible retiree has covered dependents that are also Medicare eligible, the dependents may also elect to continue the dental coverage in effect at the time the health coverage was canceled. If the Medicare eligible retiree has dependents that are *not* Medicare eligible, then these dependents lose both health and dental

coverage if the retiree cancels participation in the health plan. In order for dependents of a retiree to be covered by the State's Group Insurance, *the retiree must also be covered.*

A Medicare supplement type plan (Medicare Wrap Around) plan, is available to members covered by Medicare. This plan assists in paying Medicare's deductible and coinsurance. If covering a spouse, both must be Medicare eligible to enroll in the Medicare Wrap Around plan.



PROCEDURE: The Benefit Specialist must notify EGI of any terminating employee meeting the qualifications (above) to continue coverage under the State Group Health Plan. EGI will send a retiree packet to the terminating/retiring employee, if they are in an agency on the State Auditor's payroll, applicable school district, and community colleges, explaining the insurance coverage they now have and the cost of continuing this coverage as a "retiree". UW notifies their own retiring employees. EGI will process all insurance matters for terminating/retiring employees who meet the qualifications above *after they have retired.*

DECEASED EMPLOYEES

Health and dental claims incurred by the deceased employee are processed for services provided through the date of death. Reimbursement, in most cases, goes directly to the provider. If reimbursement is made to the member, the check will be made out to the estate of the deceased.

If the employee was enrolled in family health coverage at the time of death, dependents are eligible to remain in the State's Group Health Plan as survivors. Eligible spouses can remain covered until they remarry or premiums cease to be paid. Eligible children may stay on until they reach the maximum dependent age limit of twenty six (26) or until the surviving spouse remarries. Handicapped children may remain covered as long as they are handicapped or premiums cease to be paid. The premium cost is the same as an active employee with dependents for surviving dependents under age 60. From age 60 to age 65, the premium is the same as that of a retiree. At age 65 the premium changes to that of a Medicare-eligible retiree. There is no state contribution available toward this premium. *Surviving spouses and other dependents are not eligible to continue the life insurance coverage.*



PROCEDURE: When an active employee dies, the Benefit Specialist must notify EGI. EGI will then send the surviving spouse information on the options to continue the State Group Health Plan. EGI also sends the beneficiaries (this may or may not be a surviving spouse) information about filing a death claim if the deceased employee was covered by the group life insurance. **Please do not release the names of beneficiaries to anyone.** Refer the survivors to EGI for information about filing claims.

HOW TO FILE A MEDICAL CLAIM

Claim forms are available on the EGI website (<http://hr.wv.us/EGI/Index.htm> or Great West's website; www.mycignaforhealth.com). The long claim form is used for the first claim submitted each calendar year. The employee submits the short claim form for any subsequent claims during the same calendar year.

How To File A Dental Claim – Dental claims are filed by the provider if the dentist is part of the network. The employee gives the insurance information to the dentist at the time the service is provided. If the

dentist's office does not file the claim, there are dental claim forms available for employees to use. These forms must be completed and signed by the dentist before being sent to the claims administrator for processing.

How To File A Life Claim – Once EGI is notified of the death of an active or retired employee, EGI will send a Life Claim Form to the designated beneficiary(ies). Part II of the Life Claim Form is completed by the beneficiary. A certified copy of the Death Certificate must be returned with the Life Claim Form to the EGI Office. EGI will forward the form to the claims administrator for processing. It normally takes four (4) to six (6) weeks for the claims administrator to process the life claim.

SECTION II

Administration of Cobra

The following is an introduction to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This Section should give an outline of what the legislation is, why it was implemented and the affect it has on employers. This Section is based on the COBRA law and the proposed regulations including changes contained in OBRA-89, the June 8, 1998 U.S. Supreme Court decision and the 1998 proposed regulations.

Under the federal laws listed above, employers are required to offer continuation of group health coverage to qualified beneficiaries upon the occurrence of certain “qualifying events”. The qualifying events will be described later in this Section.

The law stipulates that certain employer groups must comply with the legislation. COBRA applies to any employer who maintains a group health plan and who normally employs at least twenty employees on at least 50 percent of the working days during that year. The law includes group health plans of state and local governments if the state receives federal funds under the Public Health Services Act. COBRA *does not* apply to Church plans and the federal government health plan.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides that Employees and their covered Dependents may be able to continue the State’s Group Health Plan coverage beyond the date it would normally terminate.

ELIGIBILITY

A *Qualified beneficiary* is any individual (covered employee, spouse or dependent child of covered employee) who is eligible to elect COBRA coverage if a qualifying event occurs and *if the individual was covered by the State’s Group Health Plan on the day before the qualifying event*. Any child born to or placed for adoption with a Qualified Beneficiary (as long as the beneficiary was the *covered employee*) during the COBRA period may be added to the COBRA coverage and becomes a Qualified Beneficiary. If the covered employee has a qualifying event and elects COBRA coverage, he/she may also add a newly acquired spouse if the marriage takes place during the COBRA period. The spouse, however, does not become a qualified beneficiary (because the spouse was not covered on the day before the first qualifying event). This means the spouse would not be allowed to elect COBRA coverage if the covered employee died.

Employees who participate in the State’s Group Health Plan and their covered Dependents have the option to continue health coverage under the State’s Plan if their coverage terminates due to any of the following **Qualifying Events**:

A) In the case of a covered Employee and his/her eligible Dependents upon:

- 1) Termination of the employee’s service (*including retirement) for any reason except gross misconduct;
- 2) Reduction of hours, affecting eligibility, worked by the employee;
(For these events, the maximum COBRA coverage is 18 months)

B) In the case of a Spouse and Dependents upon:

- 1) Employee’s death;
- 2) Employee’s divorce or legal separation;

3) Employee's entitlement to Medicare (the June 8, 1998 U.S. Supreme Court decision clarified that an employee who was entitled to Medicare before the date of the qualifying event-termination or reduction in hours-
Or becomes entitled to Medicare during the COBRA election period is eligible for COBRA);
(For these events, the maximum COBRA coverage is 36 months - employee's dependents may continue under COBRA for a maximum period of 36 months including the time they have already been on COBRA prior to the employee being eligible for Medicare

C) Employee's dependent child ceases to qualify as a Dependent under the State's Plan.
(For this event, the maximum COBRA coverage is 36 months)

As a result of the Supreme Court Decision of June 8, 1998 (*Geissal v. Moore*), an individual, who meets one of the qualifying events above, is also eligible for COBRA if he/she has other group health coverage or Medicare coverage in effect *as of the date of the qualifying event* or obtains other coverage *during the COBRA election period*. If the individual is covered by both COBRA and another group health coverage (as the active employee or the dependent of an active employee) or by COBRA and Medicare, then the Other Health Plan or Medicare is **primary** to COBRA.

*An employee who elects to continue the State's Group Plan coverage as a retiree (see page 24) **waives** COBRA coverage for themselves and their eligible dependents. However, if the dependents(s) subsequently experience a qualifying event under COBRA regulations, the dependent may elect COBRA coverage for the remainder of the 36 months of coverage allowed. The 36 months of coverage begins on the date of the first qualifying event (i.e., date of retirement), not the date of the subsequent qualifying event (i.e., divorce, etc.).

NOTICE REQUIREMENTS

If an employee and/or their covered Dependents wish to apply for COBRA coverage (upon meeting a qualifying event); the employee is considered to be a COBRA beneficiary. As a COBRA beneficiary, there are certain notice requirements that have to be met.

A. Notice of a divorce or a legal separation or a child who no longer qualifies as a Dependent – As a COBRA beneficiary, the Employee or the employee's eligible Dependent **must send written notice** to his/her Benefit Specialist or EGI immediately upon the later of:

- 1) The date on which the divorce becomes final or the date legal separation from the employee's spouse is granted; or
- 2) The date on which a Dependent child no longer qualifies as a Dependent under the State's Plan.

B. Notice of Disability – If the employee or one of the employee's Dependents is totally disabled on the date of the Qualifying Event or becomes disabled during the first 60 days of COBRA coverage, then the maximum period of COBRA coverage for all covered family members may be extended from 18 months to 29 months. To qualify for this extension, the employee or one of their covered dependents must be entitled to disability benefits under the Social Security Act. A copy of the letter that the employee or dependent received from the Social Security Administration confirming the disability benefit must be sent to EGI within 60 days from the date of entitlement, but before the end of 18 months of COBRA coverage. An employee or dependent that became totally disabled and eligible for disability benefits **after the first 60 days of COBRA coverage is not eligible for the extended benefits described above.**

COBRA BENEFITS

The employee or dependent is entitled to the same “health benefits” for which he/she was covered as an active employee or dependent when they became eligible for COBRA coverage. This includes preventive and optional dental coverage. The term “health benefits” does not include any Life Insurance or AD&D Benefits. The employee and/or dependent can elect the same deductible level or a higher deductible lever. An enrolling COBRA member cannot elect a smaller deductible. If the employee/dependent previously had optional dental (immediately prior to COBRA coverage), they may elect or not elect to continue the benefit as a COBRA participant. Cobra participants may also change their benefit elections (deductibles) during the month of November prior to the beginning of each new plan year (January 1).

If the employee was participating in the Medical Reimbursement Account (MRA) or the Dependent Care Day Account (DCA) of the Flexible Benefit Plan, then he/she must, upon termination of employment, be allowed to continue the contributions on an *after-tax* basis or to *terminate participation*. If the employee elects to terminate participation (when they leave State employment) then he/she **cannot** be reimbursed for expenses for services provided after the end of the month in which employment terminates. The terminating employee also has the option of paying their COBRA premiums and their MRA and DCA contributions through the remainder of the year on a pre-tax basis (if already pre-tax prior to termination) if they have sufficient earnings in their last paycheck to pay the entire amount for the remainder of the year. The employee must contact EGI at least 31 days prior to termination to make those arrangements.

COBRA PREMIUM

The COBRA beneficiary must pay the entire premium for the COBRA coverage to EGI. The amount of the premium is stated on the Notification form. The premium amount is 102% of the premium payable for an active employee. If the COBRA beneficiary is eligible for extended COBRA coverage (up to 29 months) because of disability benefits under the Social Security Act, then the premium for the COBRA coverage, beginning with the 19th month of coverage will be 150% of the premium payable for an active Employee.

Premiums quoted on the COBRA Notification Form are for one month of coverage. The coverage begins on the first of the month and ends on the last day of the month. A beneficiary **cannot** pay a partial premium for a partial month of coverage. The State’s insurance premiums are for a full month of coverage.

Period of COBRA Health Continuation Coverage

The period of COBRA coverage starts on the beginning of the month following the last day of the month that the employee or dependent is eligible for the State’s Group Plan (i.e., there is no break in coverage). Subject to payment of the premium and all other provisions of the State’s COBRA Plan, the period of coverage will continue until the earliest of the following dates:

- A) The date the COBRA beneficiary becomes covered under any other group health plan that does not contain any pre-existing condition exclusions or limitations;
- B) The date the COBRA beneficiary becomes entitled to Medicare;
- C) The date the State’s Plan terminates and is not replaced by any other plan;
- D) The date that is 18 months after the date that COBRA coverage began (or 29 months if the beneficiary is totally disabled as stated above); **OR** 36 months after the date that COBRA coverage began for a widowed spouse, the former spouse or legally separated spouse or a dependent child who became ineligible as a dependent under the State’s Group Plan.

Note: if the employee dies or becomes legally separated or divorced after the employee elected COBRA, or if the dependent child is no longer eligible as a dependent while on COBRA, then the maximum period of

continuation of coverage for the widowed spouse or the former spouse or the dependent child will be 36 months from the employee's first qualifying event (termination of employment or reduction in hours).

TERMINATION OF COBRA

The health coverage under COBRA will terminate if the State Group Health Plan terminates and is not replaced; the Employee and/or Dependents fail to pay the premium; **or** Employee or Dependent become entitled to benefits under Medicare **after** COBRA is elected. As a result of the June 8, 1998 U.S. Supreme Court decision, COBRA coverage **cannot** be terminated if an individual is covered under Medicare or another group health plan **at the time** COBRA is elected (Note: Being "eligible" for other group coverage does not terminate coverage under COBRA). This means that a COBRA beneficiary can be covered under COBRA and another health plan (see page 28). Covered beneficiaries may also request cancellation of their COBRA coverage, at any time, by indicating so in writing and sending the request to EGI. The written request **must be** received by the last day of the month in order to cancel coverage for the next month.

CONVERSION BENEFITS

When the COBRA coverage period ends (after 18, 29 or 36 months depending upon the circumstances), the COBRA beneficiary is eligible to convert health coverage to a private plan with the current contractor for claims administration. The COBRA beneficiary will be notified by EGI of this entitlement to convert one month prior to the expiration of the COBRA coverage period.



COBRA PROCEDURES: Each agency must make an initial notification to all employees of their coverage rights under COBRA at the time of employment. This notification takes place when the Benefit Specialist provides a copy of the Group Health Plan Booklet to the newly hired employee (see the Health Benefit Book section on *Continuation of Medical Coverage under COBRA*).

When a covered employee (enrolled in the State's Group Health Plan) terminates employment with the State, or a covered eligible Dependent becomes ineligible for coverage under the State's Group Health Plan, the Benefit Specialist will provide EGI with either the Termination/Less than 80/Transfer checklist and/or an application dropping an ineligible dependent.

Upon notice from the Benefit Specialist, EGI will offer the beneficiary COBRA paperwork within 14 days from receiving that notice.

Note: The employee/dependent may change the deductible plan at the time they elect COBRA. Deductibles can still be changed in November (during the plan transfer period) prior to a new plan year. The change goes into effect on January 1 of the new plan year.

If the COBRA beneficiary elects COBRA coverage, he/she must return the COBRA Election Form to EGI **within 60** days of the later of:

The date the COBRA beneficiary would lose coverage under the State's Group Health Plan due to a qualifying event.

OR

The date of the notice.

The COBRA Election Form should be completed and signed by the COBRA beneficiary and returned to EGI *even if they are waiving COBRA rights*. If the COBRA beneficiary waives COBRA coverage and then decides

to reverse the waiver, they may do so **only if the subsequent election is before the end of the 60 day period**. COBRA coverage then begins on the first of the month following loss of coverage under the State's group plan.

The COBRA beneficiary must also send the premium amount owed to EGI **within 45 days** of the date on which he/she completes the COBRA Election Form. The premium amount due and the Flexible Benefit Plan contributions due (if applicable) must cover the number of full months from the date of the qualifying event to the time of the payment. Coverage will not be activated until premium is received.

The Employees' Group Insurance Department has mandated that all premiums for COBRA insurance coverage and contributions to MRA and DCA's be made through automatic deduction from the beneficiary's checking or savings account.

For employees and dependents to continue their COBRA coverage after making the initial payment to bring premium and contributions current, they must complete the Authorization Agreement for Direct Payments (ACH DEBITS) Form. This form is part of the COBRA package of information sent to each employee or dependent by EGI after notification from the agency. If the employee or dependent elects COBRA coverage, the Authorization Agreement must be completed and returned to EGI. Premium deductions will be taken from the individual's account on the 2nd to last banking day of each month. **If a beneficiary elects COBRA, their coverage will not be re-instated until payment is made. Coverage will show on Great West as terminated at the end of the month in which the most recent payment was received. With receipt of each payment their termination date will be extended. Therefore, coverage will only be good for months that have been paid.**

There are **no exceptions to the requirement for Direct Payment of COBRA premiums** except for beneficiaries who know they are going to elect COBRA coverage for three months or less. These individuals may send a check (payable to the STATE OF WYOMING) for the total premium (monthly premium x number of months of coverage), in advance, to EGI. Questions about premium amounts and/or direct pay procedures should be referred to EGI.

SECTION III

Administration of Flex Benefits & Employee Reimbursement Accounts

The Flexible Benefits Plan allows active employees to set aside pre-taxed money through payroll deductions to pay for eligible medical and dependent care expenses. Most importantly, it allows employees to save tax dollars through careful planning. Please refer to the Flexible Benefits Plan booklet for additional information on the Flexible Benefits Plan. *The following is a summary, **not** a complete guide with all of the regulatory requirements applicable to the Flexible Benefit Plans.*

The Flexible Benefits Plan is divided into four accounts:

Pre-tax Insurance Premiums- Insurance premiums for employee paid health; life and dental insurance are deducted prior to taxes. The employee must be enrolled in the State of Wyoming health/life/dental insurance to participate in this account. Insurance premiums for other health insurance plans (such as an employee's spouse's employer's plan) are not eligible for reimbursement from this account. Neither can dependent life insurance premiums be paid through this plan.

Dependent Day Care Account (DCA) – Day care, home care or child care expenses for care of dependent children under the age of 13, disabled children of any age, a disabled spouse, or disabled dependent parent may be reimbursed from this account. The employee must be eligible for benefits but does not have to be insured with the State in order to participate in this account.

Medical Reimbursement Account (MRA) – Co-insurance, deductibles and most medical expenses not covered by insurance, including dental and vision expenses and prescription drug co-payments may be reimbursed from this account. The employee must be eligible for benefits but does not have to be insured with the State in order to participate in this account.

Wrap Around Medical Reimbursement (WMRA) – Intended for individuals participating in the Health Savings Account (HSA). Only expenses not allowed under the health plan are eligible for reimbursement, i.e., vision or dental expenses.

HOW THE ACCOUNTS WORK

Dependent Day Care and Medical Reimbursement Account funds are maintained separately within the Flexible Benefit Plan. The amount the employee elects, in each account, may only be used for that purpose and not to supplement any other Account they may be enrolled in (i.e., an employee cannot be reimbursed from the DCA for medical expenses nor reimbursed from the MRA for dependent day care expenses).

In November, prior to the beginning of each new plan year (January 1st through December 31st) during a “plan transfer period”, employees are given the opportunity to enroll in the Flexible Benefit Plan. These elections become effective on January 1 of the new plan year. Medical and Dependent Day Care expenses must be incurred within the same plan year in order to request reimbursement in that plan year. *Any money an employee puts into an account and isn't used will be forfeited.* IRS regulations require some risk to employees involved with any Flexible Benefits Plan. Employees must estimate their expenses as carefully as possible so as not to put more money into the plan than they will spend during the plan year. **Any unused amounts will be forfeited.** Any forfeiture will be used to pay the cost of administration of the plan. Enrollment forms must be received to the agencies Benefit Specialist and date stamped no later than the 30th of November each year. Deductions for the plan year begin with the December payroll prior to January of the new plan year.

All active employees who are eligible for benefits are eligible to participate in the Flexible Benefit Plan. The most important way to ensure that this plan works is to ensure that every employee in the State is aware of the benefits and is encouraged to enroll. EGI has the new years flex election form distributed as a September payroll stuffer, generated by the SAO office. The Benefit Specialist should make available and/or distribute Flexible Benefit Plan enrollment forms (prior to the scheduled plan transfer period) to all employees who did not receive one as a payroll stuffer, answer questions and verify that the enrollment form has been signed and returned in the allotted time.

Employees Group Insurance (EGI) *must* have a signed enrollment form on file from each employee, whether they have decided to enroll in any part or parts of the Benefit Plan or decline to participate in any part of the plan. The signed form verifies that the employee was given the option to enroll or not enroll. If no election form is received then the employee is determined to have made a negative election (no participation). This documents the employee's intent to participate or not participate. The employee *does not* have to be enrolled in the State's Health Insurance Plan in order to participate in the Employee Reimbursement Accounts.



PROCEDURE: New employees should be offered the Flexible Benefits Plan on the first active working day. A copy of the Flexible Benefits Plan Booklet and an election form is given to the employee. The employee has 31 days, from the date **they are eligible**, in which to enroll. **Their election under the plan will be effective the 1st of the month following the date the signed form is received in the EGI office (or EGI sponsored employer (date stamped)).** The employee must complete a new election form each year to participate in the dependent daycare or medical reimbursement. The election of pre or post tax premiums will carry over from year to year until the employee changes it in any November for the next plan year.

Example: Suzanne was hired by a State agency on October 10th. She has elected to participate in the Pretax premiums and the Medical Reimbursement Account of the Flexible Benefit Plan. Her election was received in the Benefits Office on October 18th. Her flexible benefit elections become effective November 1st. The flexible benefit election form Suzanne submitted is for the current Plan Year only. In November (during the plan transfer enrollment period) she will submit another flexible benefit election form for the new plan year beginning in January if she wishes to participate in the medical reimbursement again.

Current employees should receive a copy of the Flexible Benefits Plan Booklet and an enrollment form prior to the enrollment period for each new plan year. Encourage employees to attend informational meetings when they are available in your area. The Benefit Specialist has the responsibility of notifying new employees about the Flexible Benefit Plan, including distribution of the Benefit Booklet and referring them to EGI for questions. Employees may call EGI at (307) 777-6835 or 1-800-891-9241.

Each employee should sign and complete a State of Wyoming Flexible Benefit Plan Enrollment Form. Benefit Specialists should review the form with the employee and answer any questions the employee might have (or refer the employee to EGI). The employee must understand, before the enrollment form is signed, that they are locked into their election until December 31st of the plan year unless a qualifying "family status change" occurs (please see the Flexible Benefit Plan Booklet). This means that, for employees with dependent insurance coverage who are paying premiums on a pre-tax basis, **they may NOT drop dependent coverage unless a qualifying family status change occurs.** If such a change does occur, *the employee has only 60 days from the date of the change in which to drop the coverage.* Family status changes are explained on pages 35-36 of this Section.

Make a copy of the enrollment form for your records, *a copy for the employee* and send the **original** to EGI, Emerson Building Room 106, Cheyenne, Wyoming 82002-0060.

If the employee works 80 hours or more, process the monthly election(s) as stated on the Flexible Benefit Enrollment Form for your payroll. If the employee works less than 80 hours or should go on “leave of absence” refer to #2 below.

College employees who work 9 months of the year but are paid over a 12-month period will have flexible benefit deductions taken from their pay over the period of time that they are receiving pay (i.e., 9 or 12 months). These employees are eligible to file claims through the end of the month that the last payroll deduction was taken or until they terminate employment, whichever is earlier. These employees may not elect to terminate flexible benefit deductions before these events unless they have a qualifying family status change. This means if the employee’s contract ends in May or June and they have elected to continue being paid through August, then they cannot terminate flexible benefit deductions prior to the last payroll date (August).

Salary Reduction Elections When Employee has Leaves of Absence – If the employee has elected to participate in the Employee Reimbursement Accounts (MRA and/or DCA) and begins or returns from an unpaid leave of absence it is considered to be a “change in status”. The employee may amend his or her salary reduction elections (monthly deductions) to be consistent with the change in status. This means a participant may make after-tax contributions to their MRA and/or DCA *during* an unpaid leave of absence; **or** make pre-tax contributions by increasing his/her deductions before taking the leave (but only for the portion of the leave that occurs during the Plan Year); **or** make pre-tax contributions after the leave by salary reduction.

The Employee may submit claims for eligible expenses incurred before participation ended, and will be reimbursed up to the balance remaining in their accounts when participation ended.

If the participating employee returns from Family Medical Leave (FMLA) or a qualified Military Leave under the Uniformed Services Employment and Re-employment Rights Act and begins employment again, the employee may choose to participate and salary reduction contributions will be increased to reflect any contributions for the Plan Year not yet paid or to amend the salary reduction election, as described above.

For other leaves of absence, if no coverage during leave is elected and the employee returns to active work during the *same Plan Year*, and the salary reduction election has not been amended, as described above, then the same election the employee had before the leave must be maintained upon return from the leave.



PROCEDURE: If the employee has a change in status that allows them to change their salary reductions for the MRA and/or DCA, they must complete a Flexible Benefit Change Form. Keep a copy for your files, give the employee one copy and send the **original** with documentation of the change in status to EGI.

Salary Reduction Elections For Employees Who Terminate - If a participating employee terminates employment from the State, the employee must be offered COBRA. If the employee elects to continue in the Flexible Benefits Plan as a COBRA participant (terminated employee does *not* have to enroll in the COBRA health and dental coverage), they will pay the amount of the salary reduction they had in effect as an active employee directly to EGI. The payment will be 2% more than the amount that the employee was having deducted from their monthly payroll check so that it will fulfill their original election amount for the Plan, however the payment will be made on an “after-tax” basis. Payments will be made on a monthly basis and the employee will be allowed to continue under the COBRA option in the Flexible Benefit Plan until the end of the current plan year.

Enrolled employees who terminate and do not elect to continue under the COBRA option may apply for reimbursement for dependent care and medical expenses incurred through the end of the month in which they terminate employment. A claim must be filed within 90 days of the end of the plan year for service provided during the plan year. This is referred to as the claims filing “grace period”.

*Example: John is a State employee who enrolled in the Medical Reimbursement Account of the Flexible Benefit Plan at the beginning of the plan year (January). In July, John resigns from State employment. He elects COBRA but does not elect to continue the Flexible Benefit Plan deduction for his MRA account. John has until 90 days after the end of the plan year (December 31) to file claims for medical services received from the beginning of the plan year (January 1) through the end of the month he resigned (July 31). Any medical services provided **after** July 31 (through the end of the plan year) **would not** be reimbursable through the MRA.*

If a terminated employee returns to eligible employment with the employer in the same plan year they may, under certain circumstances, elect to take the same benefit election for the remaining portion of the plan year as he/she had before termination. Participation will be effective the first of the month following election.

The terminating employee also has the option of paying their COBRA premiums and their MRA and DCA contributions through the remainder of the year on a pre-tax basis if they have sufficient earnings in their last paycheck to pay the entire amount for the remainder of the year. The employee must contact EGI at least 31 days prior to termination to make arrangements to do this.

FLEXIBLE BENEFITS PLAN CHANGES

At the beginning of each plan year, employees may elect to participate in the Pretax Insurance Premium and/or the Medical Reimbursement and/or Dependent Care Accounts. If participating in the MRA/DCA an employee elects an amount of money to be deducted from their pay as a contribution to a MRA and/or DCA. These elections may be changed during the plan year *only if the employee has a qualifying “Change in Family or Employment Status”*. Any change in election must be consistent with the change in status or it will not be allowed. This consistency requirement is met if it results in the Employee, Spouse or Dependent gaining or losing eligibility under the Plan’s health coverage or the health coverage of the Spouse’s or Dependent’s employer and the election change corresponds with that gain or loss of coverage. **The consistency requirement applies to the following family and employment status changes:**

- Change in the participant’s legal marital status, including marriage or divorce
- Legal separation/annulment
- Termination or commencement of employment by spouse or dependent
- Change in dependent eligibility (attainment of age, etc.)
- Death of spouse/dependent
- Birth/adoption /placement for adoption of a child
- Reduction/increase in hours of employment by employee, spouse or dependent (includes switch between part-time & full-time, strike and lock-out) that affects the eligibility of the individual.
- Commencement or return from an unpaid leave of absence by employee, spouse or dependent
- A change in the place of residence or work of the employee, spouse or dependent (i.e., moving out of an HMO service area – this is generally not applicable to State of Wyoming employees).
- A change affecting employment-related expenses for dependent care such as a dependent turning age 13 and no longer qualifying under the Internal Revenue Code.

Certain changes in cost or coverage may also permit you to change your annual election. These include:

- If the cost of dependent care automatically increase, the plan may make a prospective increase in employee contributions for the plan.
- If the cost of dependent care significantly increases, the employee may make a prospective increase in payments (this applies only if the dependent care provider is not a relative of the employee).
- If there is a significant change in coverage similar to a benefit package option becoming available, or if coverage under a dependent care assistance plan is significantly curtailed or ceases, you may revoke your election and make a new election that corresponds to the cost of the new child care provider.

The change in election amount for the MRA and/or DCA accounts must be made within sixty (60) days of the change in family status occurs. A copy of the appropriate documentation (marriage certificate, adoption certificate, divorce decree, letter of termination of employment, etc.) **MUST** be sent to EGI with the flexible benefits enrollment or change form.

*Example: Mary is a State employee enrolled in the Group Health Benefits Plan with single coverage but is **not** enrolled in any portion of the Flexible Benefits Plan. She adopts a child on June 15th (in the middle of the plan year). The adoption is considered to be a qualifying “family status change”. Therefore, Mary may elect family health and dental coverage within 60 days of the adoption and elect the pre-tax premium. She may also elect to participate in the Medical Reimbursement Account and Dependent Day Care Account as long as her election is made **within 60 days of the adoption.***



PROCEDURE: If the employee **is currently enrolled** in the Flexible Benefits Plan and has a qualifying family status change that allows them to change their election or drop participation in the plan, they should complete the Flexible Benefits Plan Change Form. This form and the required documentation must be sent to EGI **within 60 days of the change in family status.**

If the employee **is not currently enrolled** in the Flexible Benefits Plan and has a qualifying family status change that allows them to enroll, they should complete the Enrollment Form, State of Wyoming Flexible Benefit Plan. This form and the required documentation must be sent to EGI **within 60 days of the change in family status.** Flexible Benefit Plan election changes become effective the first of the month following receipt of the properly completed change form and appropriate documentation.

FILING CLAIMS FOR REIMBURSEMENT

Reimbursements will be made based on the plan year during which the service was provided. The Plan Year is the 12 month period beginning January 1st and ending on December 31st each year. Expenses cannot be carried over to the next Plan Year for reimbursement. For purposes of Medical Reimbursement, the service is provided on the date the employee or dependent actually goes to the doctor or purchases the prescription. For purposes of Dependent Care, the service is provided when the dependent goes to the day care facility, not when the employee pays the bill.

The employee may obtain Reimbursement Claim Forms from the EGI website (<http://hr.state.wy.us./EGI/Index.htm>) or the agency Benefit Specialist.

Twice each month, checks will be distributed to reimburse employees for claims that have been submitted. If a claim is received after the deadline date, it will be paid in the following processing. An active employee must

file claims for reimbursement from their MRA and/or DCA **within 90 days of the end of the plan year** for service rendered during the plan year. *Any balances remaining in the MRA/DCA accounts after the 90 day “grace period” are forfeited.*



PROCEDURE: The employee completes the appropriate MRA/DCA claim form and sends it, along with an Explanation of Benefits (EOB) and/or itemized receipt or other required documentation to the Flexible Benefits Plan Section of Employees’ Group Insurance (EGI) Office for processing. The claim form must be completely filled out and if applicable and/or an EOB attached or the claim will be denied and a letter sent to the employee requesting the necessary information. Claims must be submitted with receipts taped to a 8 1/2 x 11 sheet or they will be returned to member to correct.

MEDICAL EXPENSES ELIGIBLE FOR REIMBURSEMENT

Medical care expenses include amounts paid for the diagnosis, cure, treatment, or prevention of disease, and for treatments affecting any part or function of the body. The expenses must be to alleviate or prevent a physical defect or illness. According to IRS guidelines, the following expenses are eligible for reimbursement under a Flexible Benefits Plan as long as they are not eligible for reimbursement from any other source:

- Abortion – obtained legally
- Acupuncture – performed by a licensed practitioner
- Ambulance
- Artificial limbs
- Birth Control Methods – prescribed by a physician
- Chiropractic care – services within the scope of license
- Contact lenses
- Deductibles and co-insurance – balances not paid by medical insurance
- Dental fees – x-rays, fillings, extractions, orthodontics, false teeth, etc.
- Diaper service – for handicapped or disabled child/adult
- Physician fees
- Eyeglasses – includes the cost of prescription lenses, frames, exams,
- Guide dog – cost of purchase, training and care
- Hearing aids – includes the cost of batteries and repair
- Learning disability – tutoring by a licensed school or therapist for a child with severe disability, as recommended by a physician
- Medical care – medical care for you and dependents in retirement and nursing homes is covered
- Medicines – prescribed and legally obtained
- Optometrist – services within the scope of license
- Psychologist – services within the scope of license
- Special Schools – to relieve a handicapped condition
- Therapy – physical or occupational therapy by a licensed therapist
- Treatment to stop smoking – cost of smoking cessation programs and prescription drugs designed to alleviate nicotine withdrawal
- Vaccinations & immunizations
- Vision care – including laser surgery to correct vision
- Weight-loss programs to treat a diagnosed disease, including obesity
- Wheelchairs, crutches – rental, purchase, operating costs for relief of sickness or disability

EXPENSES NOT ELIGIBLE FOR REIMBURSEMENT

Expenses for solely cosmetic reasons generally are not expenses for medical care. Also, expenses that are merely beneficial to one's general health (for example, vacations) are not expenses for medical care.

- Contact lenses/glasses insurance or maintenance agreements
- Cosmetic Services
- Cosmetic Surgery
- Dancing or swimming lessons, even if recommended by a physician
- Diaper Service – for non-handicapped or disabled child/adult
- Domestic help
- Expenses that are not substantiated
- Funeral Expenses
- General hygiene drug supplies (toothpaste, cosmetics, soap)
- Health Club dues
- Health Plan premiums – that are not paid by you through payroll deduction
- Practical nurse for well child care
- Tattooing or ear piercing
- Teeth bleaching
- Trips or vacations taken for general health, morale or change in Environment

****See the Flexible Benefits Plan Booklet for more detail on allowances and limitations****

SECTION IV

VOLUNTARY BENEFITS

Benefit eligible employees may also enroll in voluntary benefits; voluntary in that they are not subject to any state contributions and premiums are 100% employee paid. The benefits currently available include:

Vision (through VSP)
Short Term Disability (through Standard)
Long Term Disability (through Standard)
Long Term Care (through Genworth)

These benefits are fully insured and administered by their respective carriers. EGI will set up payroll deductions for the State of Wyoming Executive Branch, the University, community colleges, and applicable school districts will set up payroll deductions for their employees. These voluntary benefit premiums are only eligible for post tax status.

These benefits are subject to the same requirements for enrollment; newly eligible employees have 31 days from their date of eligibility to enroll in coverage. Please make sure to give information for each benefit to the employee to determine if they wish to enroll. There is no application to waive coverage, simply not submitting one will be considered waiving.

VISION

Has a two year waiting period to enroll if the employee does not enroll when originally eligible. There are no membership cards for the vision plan. The employee should inform the provider he or she has VSP through the State and they will look up the employee and if services are eligible, the employee will receive the discount and/or appropriate co-pay at the time of service. If the employee does not enroll in Vision when initially eligible, they must satisfy a two year waiting period.

Example: An employee was employed on 2/15/08, he/she will have met their two year waiting period in March 2010; however they can only enroll in November of the year they met the waiting period for a January 1 effective date of the next year. In this example the vision effective date would be January 1, 2011 if they completed their application in November 2010.

There is also a two year enrollment commitment when electing vision coverage. Therefore, if you do not elect vision coverage; you wait two years; if you elect vision; you commit to two years. Both scenarios are subject to qualifying events.

SHORT TERM DISABILITY

If the employee does not enroll when first eligible, they can enroll at a later date; however there is a penalty built into the plan by Standard. The employee who takes it when eligible will have a 14 day waiting period before the employee begins receiving pay; whereas the employee who enrolls later outside of their initial eligibility period, will have a 60 day waiting period before they receive pay. This 60 waiting period penalty stays for the first 12 months the employee is then enrolled. The employee must be capable of active work on the day before the scheduled effective date.

LONG TERM DISABILITY

If the employee does not enroll when first eligible, they can apply at a later date; however they will need to contact Standard directly to begin this process. The employee will have to go through a medical underwriting process to get approved or denied by Standard. Please forward the employee directly to Standard in this case.



PROCEDURE: When enrolling a new hire in either short or long term disability, the bottom of the enrollment form has a section for the agency Benefit Specialist to complete, this includes: Date of hire, hours worked per week, and the employee's earnings. This information is necessary to determine the employee's premium for both benefits. Also, the employee's premium for these benefits will increase as the employee ages or their pay increases.

HOW TO FILE A DISABILITY CLAIM

On the EGI website is a link to Standard. There you will find claim forms for both STD and LTD. Forms include an employer section for the Benefit Specialist to complete and forward to Standard. The Benefit Specialist completes the employer section and forwards the physician section to have filled out and forwarded to Standard.

Customer Service for Short Term Disability 800-368-2859

Customer Service for Long Term Disability 800-368-1135

LONG TERM CARE

If the employee does not enroll when first eligible, they can enroll at any time later, however they will need to contact Genworth directly to begin this process. The employee will have to go through a medical underwriting process to get either approved or denied by Genworth. Please forward the employee directly to Genworth in this case.

PROCEDURE: When enrolling a new hire in long term care, the employee needs to preferably enroll online, within 31 days of eligibility, (see EGI website for the Genworth link). EGI will be notified of the premium to charge from payroll if applicable. The employee will receive their policy in the mail indicating the effective date of coverage. The employee is the person guaranteed coverage, spouses will need to go through underwriting and they may be contacted at their home if further information is needed.

Section V

Glossary of Terms

Active Participant – An individual who is a participant in an employer sponsored plan.

Actuary – A person professionally trained in the technical and mathematical aspects of insurance. The actuary estimates how much money must be contributed to a fund each year in order to support the benefits. Actuaries determine policy rates, reserves as well as conducts various other statistical studies.

Administrative Services Only (ASO) – An arrangement in which a plan hires a third party to handle administrative services such as claims processing while the plan bears the risk for the claims. Great West HealthCare is contracted under an Administrative Services Only contract for the State of Wyoming.

Adverse Selection – The tendency of an individual to recognize his or her health status in selecting the insurance plan that tends to be the most favorable to him or her (and more costly to the plan). Adverse selection revolves around participants who, because of the premium costs they incur, choose to buy coverage elsewhere for their young and/or healthy dependents. This leads to an older or higher utilizer pool of people who participate in the program which raises the average costs to the plan.

Allowed Charges – Charges for services rendered or supplies furnished by a health provider that would qualify as covered expenses for which the program will pay in whole or in part, subject to any deductible, coinsurance or table of allowance included in the program.

Amendment – A formal document changing the provisions of a insurance plan.

Assignment of Benefits – The signed transfer of payment by the insured person to a health care provider such as a physician or hospital.

Balance Billing – The practice of charging full fees in excess of the covered amounts and then billing the patient for that portion of the bill that the insurance does not cover.

Beneficiary – A person named by the insured participant to receive any benefits provided the the plan if the participant dies. The Beneficiary(ies) for the State’s life insurance program may be changed by the participant at any time.

Benefit Fund – The monies set aside the plan sponsor for payment of benefits.

Birthday Rule – Coordination-of-benefits rule whereby, if both spouses are working and carry dependent coverage, the responsibility for primary coverage falls to the parent having the earlier birthday in the calendar year, regardless of which parent is older.

Business Associate – Under HIPAA privacy legislation, an individual who, on behalf of a covered entity, performs or assists with a function or activity involving protected health information. Examples include lawyers, consultants, third-party administrators, doctors an health care clearinghouses.

Case Management – A utilization management system focusing on coordinating the health care services needed by a patient. It includes a standardized, objective assessment of patient needs and the development of an

individualized care plan that is based on the needs assessment. Case management is often used for patients with certain medical conditions who need extensive medical services; usually overseen by an individual or team of medical practitioners.

Certificate of Creditable Coverage – A document provided by a health program which documents the amount of previous qualified health coverage. Certificates are used to provide coverage credit for health insurance pre-existing condition clauses.

Claim – An itemized statement of services rendered by a health care provider for a given patient. The claims is submitted to a health benefits plan for payment. Monthly billing statements are not itemized statements and cannot be used for claim submissions.

Claim Administrator – Any entity that reviews and determines whether to pay claims to enrollees or physicians on behalf of the health benefit plan. Great West Healthcare is the claims administrator for the State's health benefit program.

Claim form – The form used to file for benefits under a health plan.

Claimant – Plan participant who files a claim for benefits.

Claims Experience – The frequency, cost and types of claims insured employees file to receive benefits. Claims experience is one of the primary factors used in calculating insurance premiums.

COBRA – Consolidated Omnibus Budget Reconciliation Act of 1985. The main provision of this legislation with respect to health care coverage is that most group health plans must provide each participant and qualified beneficiaries under the plan the option to pay for continued coverage for a specified period of time under the plan in the event coverage would otherwise have ceased as a result of one of a number of “qualifying events.”

Coinsurance – A policy provision by which the insured person and the insurer share the hospital and medical expenses resulting from an illness or injury in a specified ratio (e.g., 80%:20%), after the deductible is met.

Comprehensive Major Medical Coverage – This coverage provides protection characterized by a deductible, less than 100% reimbursement and a high maximum benefits. A typical type of comprehensive plan provides that most types of medical expenses are covered, usually after the satisfaction of a deductible (such as \$350). After covered expenses exceed this initial deductible, the plan typically pays a percentage, such as 80%, of all other covered medical expenses subject to plan provisions. An annual out-of-pocket maximum (such as \$2,000) is a common feature of these plans.

Coordination of Benefits (COB) – A group health insurance policy provision designed to eliminate duplicate payments and provide the sequence in which coverage will apply (primary and secondary) when a person is insured under two contracts.

Cost Containment (Medical) – Methods and programs designed to contain costs by ensuring appropriateness, medical necessity and relatedness of treatment and procedures. Examples include utilization review and bill review.

Cost Sharing – Arrangements whereby consumers pay a portion of the cost of health services, sharing costs with employers. Deductibles, co-payments, co-insurance and payroll deductions are forms of cost sharing.

CPT (Current Procedural Terminology) Codes – A five-digit coding system developed by the American Medical Association to categorize medical procedures for billing purposes.

Credentialing – Obtaining and reviewing the documentation of professional providers. Such documentation includes licensure, certifications, insurance, evidence of malpractice insurance, malpractice history and so forth.

Death Benefit – The payment made to the designated beneficiaries upon the death of a participating employee in the Life insurance program.

Deductible – The amount of out-of-pocket expenses that must be paid for health services by the insured before becoming payable by the health plan.

Defensive Medicine – The practice by physicians of authorizing medically unnecessary tests and procedures, increasing hospital admissions and extending lengths of stay in an attempt to limit their exposure to malpractice suits.

Dependent – Generally the spouse or child of a covered individual, as defined in a contract.

Dependent Care Flexible Spending Account – Employer-sponsored flexible benefits plan feature that permits employees to use pre-tax (tax-free) dollars from their paychecks to pay the cost of care for children or elderly dependents up to a certain limits and within very specific guidelines.

Disease Management – A proactive, integrated systems approach targeting individuals who are or may become at risk for chronic health conditions. Often uses educational and prevention initiatives, careful monitoring techniques, patient self-care and evidence based clinical practice guidelines to improve health outcomes and reduce health care costs for chronic disease patients. Disease management uses a team approach to managing chronic diseases. Through collaboration with physicians and other health professionals, participants are educated on ways to manage their chronic conditions, taught to recognize and report signs and symptoms, and encouraged to follow their prescribed treatment regimens.

Eligibility Period – A period of time when potential members may enroll in a medical, dental or life program outside of open enrollment or evidence of insurability.

Eligibility Requirements – Conditions that an employee must satisfy to participate in a plan.

Employee Contributions – The amount an employee is required to pay to participate in a plan.

Employer Contributions – The amount an employer contributes on behalf of an eligible participant of a plan.

Enrollment – The process by which an eligible individual and/or dependents become subscribers to a plan.

Evidence of Insurability – A statement or proof of a person's physical condition or other factors affecting his or her acceptance for insurance. Usually used for application for life insurance for late enrollees.

Expected Claims – The claims forecast for a group of covered persons for a future period. The expected claims forecast is used to develop premiums for medical and dental programs.

Experience Rating – The process of determining the premium rates for a group risk, wholly or partially on the basis of that group's claims experience.

Experimental Medical Procedures – Health care services or treatments that are not widely accepted as effective by entities such as the Health Care Financing Administration, the American Medical Association, National Institutes of Health or have not been scientifically proven to be effective. Such services are excluded from our health plan.

Family Deductible – A deductible that is satisfied by the combined expenses of all covered family members. For example, a program with a \$350 deductible may limit its application to a maximum of two deductibles (\$700) for the family, regardless of the number of family members. An aggregate family deductible may be met by several family members.

Fiduciary Responsibility – Under ERISA, a fiduciary must discharge his or her duties solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits, while defraying reasonable expenses of the plan. The conduct of a fiduciary will be governed by the “prudent man” or “prudent person” standard: that is, a fiduciary must act with the same care as a prudent person dealing with similar situation would exercise.

First Dollar Coverage – A benefit plan that provides reimbursement for incurred health care costs “from the first dollar,” with no deductible.

Flexible Spending Accounts (FSAs) – Many flexible benefit programs include flexible spending accounts, which give employees the opportunity to set aside pretax funds for the reimbursement of eligible tax-favored welfare benefits. FSAs are funded through salary reduction. Employees can pay health insurance deductibles and co-payments, or pay for child-care benefits with FSAs.

Fully Insured – A group insurance plan in which an insurer pays all claims and assumes all risks for an employer in exchange for payment of a regular premium.

Generic Equivalent Drugs – Prescription drugs that are equal in therapeutic power to the brand-name originals because they contain identical active ingredients at the same doses.

Grievance Procedure – A formal process for the resolution of member or provider complaints.

Health Care Flexible Spending Account – Allows employees to set aside pretax funds for eligible health care benefits such as physical exams, vision care, dental care, general health care, including deductibles and co-payments.

Health Care Fraud – As defined by the National Health Care Anti-Fraud Association, a deception or misrepresentation that is intentionally made by an individual, knowing that the misrepresentation could result in some unauthorized benefit to the individual or to some other party.

Health Care Provider – An individual or institution that provides medical services (e.g., physician, hospital, laboratory, etc.).

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – Federal legislation that improves access to health insurance when changing jobs by restricting certain preexisting condition limitations, and guarantees availability and renewability of health insurance coverage for all employers regardless of claims experience or business size.

Health Risk Assessment – A wellness program instrument that can evaluate the health status of an individual and the relative risk of disease, injury or death associated with a specific set of lifestyle behaviors when combined with specific information about the individual involved.

Health Savings Accounts (HSAs) – These are tax-exempt trusts or custodial accounts created for employees, retirees and the self-employed who are covered under qualified high-deductible health plans. Funds can be used for medical expenses, including prescription drugs, qualified long-term care insurance premiums and COBRA coverage. Amounts not distributed can be carried forward. Like an IRA, the individual who is the account beneficiary owns the HSA, making the plan portable.

High-Deductible Health Plans – Health benefit plans that have a minimum deductible of \$1,000 for individuals and \$2,000 for families, which applies to all health care benefits except preventive care. Out-of-pocket expenses requirement cannot be more than \$4,000 for single coverage or \$10,000 for family coverage. The plans may be offered in conjunction with an HSA.

High-Risk Pools – State-created insurance pools of individuals with extensive current or anticipated health care needs. These pools spread the risk of those individuals among the health insurance companies doing business in that state. These pools have been used by a number of states in an attempt to extend coverage to their medically uninsurable citizens. People with a chronic disease or illness, such as diabetes or multiple sclerosis, can purchase health care insurance. Additional funds for these high-risk pools are typically taxes on health insurance premiums.

Incurred but Not Reported (IBNR) – Claims that have been incurred (services rendered) but have not been reported to the insurer as of some specific date. Plans must estimate this liability for accounting purposes based on their experience with claims lags.

Incurred Claims – Claims where services have been rendered to a plan participant.

Lag – The period of time between the incurring of a claim and the payment of that claim.

Length of Stay (LOS) – The number of days that elapse between admission and discharge from a hospital or health care facility.

Loss Ratio – The ratio of paid and incurred claims plus expenses to premium.

Mandated Benefits – A specific set of benefits required by law to be provided by all insurance carriers and reimbursed under all insurance policies.

Maximum Allowable Cost - The allowable expense is the amount that the majority of providers in the geographical region charge for a procedure. All medical procedures have an allowable expense. Great West Life Insurance is able to access the allowable expense for all procedures and limit the payment based on that amount. The plan is not able to pay whatever the provider chooses to charge. It is necessary to administer these allowances in order to help keep health care costs down and to keep the health plan viable.

Maximum Out-of-Pocket Payment – The maximum amount of money a person will pay under a plan. The out-of-pocket payment is usually the sum of the deductible and coinsurance payments.

Medically Necessary – Describes services provided to a patient as judged against generally accepted standards of medical practice. The term is usually used to determine whether or not a procedure or services is covered by

insurance. The reasonable and appropriate diagnosis, treatment and follow up care as determined and prescribe by qualified, appropriate health care providers in treating any condition, illness, disease or injury.

Newborns' and Mothers' health Protection Act of 1996 – Federal law that mandates that group health plans (as defined in HIPAA) may not restrict the length of any hospital stay in connection with childbirth for either the mother or the newborn child to less than 48 hours for a normal vaginal delivery or 96 hours for a Caesarean delivery. Plans may not offer incentives to mothers to accept less time, nor may they penalize providers for adherence to the law.

Open Enrollment – A period during which uninsured eligible employees and their dependents may enroll in coverage. The State of Wyoming Health program open enrollment happen in November of odd number years which provide the opportunity to enroll if you or your dependents are not currently participating in the health insurance program.

Prescription Drug Formulary – A listing of prescription medications that will be covered by a health plan that often fosters substitution of generic or therapeutic equivalents on a cost effective basis. This is usually done through tiered co-payment levels that provide lower co-payments for generic or preferred name brand drugs.

Outpatient – A person who visits a clinic, emergency room or health facility and receives health care without being admitted as an overnight patient.

Outpatient Surgery – Same day surgery without anticipation of the overnight stay of patients. Often performed at an ambulatory surgery center.

Paid Claims – The dollar value of all claims paid (e.g., hospital, medical, surgical) during the plan year, regardless of the date that the services were rendered.

Plan Sponsor – The party that establishes and maintains the plan, which is the State of Wyoming for the Employees' and Officials' Group Insurance Program.

Precertification – The process of obtaining authorization from the health plan for hospital admissions or for surgery, based on the judgment of medically appropriate care by a qualified peer. Failure to obtain precertification results in a financial penalty to either the provider or the subscriber.

Preexisting Condition – A physical and/or mental condition of an insured person that existed prior to the issuance of his or her policy.

Prescription Drug Formulary – A listing of prescription medications that will be covered by a plan or insurance contract designed to foster substitution of generic or therapeutic equivalents on a cost effective basis. Prescription drugs are generally tiered with lower payments for lower cost medications.

Preventive Care – Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examinations and immunizations.

Qualifying Event – An occurrence that may entitle a person to make changes to their benefit elections. Examples include termination of employment, reduction in hours, death of employee, divorce, a dependent child's loss of dependent status, etc..

Rating – The process that determines how much a particular package of benefits will cost and what will be charged (premium) to cover those expected costs for a specific group of people.

Reserves – Funds set aside by a self-funded plan to assure the fulfillment of commitments for future claims. These funds are designed pay for the estimated liability for unpaid insurance claims (losses) that have occurred as of a given date. The estimated liability includes losses incurred but not reported (IBNR), claims being adjusted and amounts know to be payable in the future. Reserves also protect a Plan from fluctuations in claims payments where higher than anticipated claims are incurred and paid.

Risk Pool – The population of individuals (or groups) across which costs for insured expenses are spread through premiums or other mechanisms.

Secondary Payer – The insurance carrier that is second in responsibility under coordination of benefits. Often mention in the contexts of efforts to recoup payments made as primary payer when other primary, duplicate coverage exists.

Self-Insurance – A self insured plan is where the employer is acting is acting as an insurance company. The employer pays claims with the money ordinarily earmarked for premiums. The State of Wyoming health program is a self funded medical plan which means that the State is the “insurance company” for our healthcare. This allows the state to minimize our costs while maximizing the money available to pay your medical claims which lowers our medical premium rates.

Significant Break in Coverage – Under HIPAA, a period of 63 consecutive days during which and individual does not have any creditable health care.

Solvency – The ability of a plan to meet its present and future obligations; the adequacy of provisions for funding.

Step Therapy – In the context of pharmacy benefits the practice of utilizing the most cost-efficient method to treat a patient according to protocol that calls for using one drug therapy before proceeding to another drug therapy that is more expensive or difficult to use.

Stop-Loss Provision – A health insurance policy provision. A stop-loss provision is determined in two ways: either after a certain amount of benefits are paid from the plan or after a certain amount of out-of-pocket expenses are paid by the individual or family unity. When the dollar amount specified is reached, the coinsurance factor is raised to 100% generally for the rest of the calendar year.

Tertiary Care – Specialized health care, needed by relatively few people, such as select rehabilitation services, highly technical medical procedures, burn centers and so on. The highest level of care.

Third-Party Administrator (TPA) – The party to an employee benefit plan that may pay claims and/or provide administrative services. Usually and out-of-house professional firm proving administrative services for employee benefit plans.

Total Compensation – The sum of all financial and non-financial elements in the employment package, including base salary, incentives, benefits, bonuses and any other reward of employment the employee values.

Unbundling – Charging separately for procedures normally covered as one billing unit so the total exceeds what should be charged.

Underwriting – The process of identifying and classifying the potential degree of risk represented by a proposed insured.