

GROUP INSURANCE BENEFITS ADMINISTRATION MANUAL

The Office of Group Insurance, Department of Administration as established in Idaho Code 67, Chapter 57, sponsors and is responsible for the administration of all medical, dental, and flexible spending account programs, insurance contracts and policies for State of Idaho employees, retirees, and their dependents.

This *Group Insurance Administration Manual* is organized by event, according to a variety of circumstances under which employees may enroll for benefits or make election changes as well as information for employers to remit premiums and enrollment registers to the OGI.

OTHER RESOURCES

The *Group Insurance Benefits Administration Manual* is designed to be used in conjunction with:

- **Office of Group Insurance website, ogi.idaho.gov.** The website includes comprehensive information about the group insurance benefits available to eligible employees and their dependents.
- **Office of Group Insurance Staff.** Our staff is available to answer any questions agencies, employees, retirees, or their dependents may have about the group insurance coverages or the administration of the plans.

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GROUP INSURANCE PLANS AT A GLANCE

Here is an overview of the State of Idaho employee group insurance plans discussed in this Group Insurance Administration Manual. For more information about plan benefits and provisions, refer to the Office of Group website.

PLANS	DESCRIPTION OF COVERAGE	HOW MONTHLY PREMIUMS ARE PAID
Premium Only Plan	<p>Employees who elect this plan can pay medical and dental premiums on a pre-tax basis. The majority of members elect this option.</p> <p>NOTE* If a district offers pre-tax deductions, they will need to maintain their own Section 125 document since the State is not responsible for the district's payroll.</p>	<p>Employee share of premiums is deducted before federal, or State income or FICA taxes are withheld.</p> <p>Employees can also choose to have premiums deducted post-tax.</p>
Medical	<p>Current options are:</p> <ul style="list-style-type: none"> • Blue Cross of Idaho Traditional Plan • Blue Cross of Idaho PPO Plan • Blue Cross of Idaho High Deductible Plan (HSA qualified but no funded HSA) • Decline coverage 	<p>Agencies and employees share the cost.</p>
EAP	<p>Included in each medical plan. Provides coverage for all benefit-eligible employees and dependents whether they are enrolled in the health plan or not. Blue Cross of Idaho contracts with ComPsych for claims management/preauthorization services.</p>	<p>Included in medical plan employer premium.</p>
Vision Benefits	<p>Included in each medical plan. Blue Cross of Idaho contracts with VSP (Vision Service Plan) for claims management.</p>	<p>Included in medical plan premium.</p>
Dental	<p>Blue Cross of Idaho is the Dental carrier.</p> <p>Employees are required to enroll for at least self-only Dental coverage when they enroll in the medical plan.</p> <p>Employees may elect/decline coverage for dependents at enrollment. <i>Dental enrollment for dependents can only be added at Open Enrollment if declined at initial enrollment without a qualifying life event.</i></p>	<p>Agencies and employees share the cost.</p>
Flexible Spending Accounts (FSAs) (OPTIONAL)	<p>Eligible employees can use either or both accounts to pay eligible expenses on a before-tax basis:</p> <ul style="list-style-type: none"> • Dependent Care Account • Health Care Flexible Spending Account 	<p>Employees make all FSA contributions and pay the monthly administrative fee for the account. Limits are dictated by the IRS.</p>

GROUP INSURANCE BENEFIT ADMINISTRATION IN GENERAL

ELIGIBILITY RULES

Eligibility is detailed in each plan contract posted on the OGI website.

Eligible Employees

Eligible Employees are officers or employees of state agencies, departments, school districts or institutions, including state officials, elected officials, or employees of other governmental entities which have contracted with the State of Idaho for healthcare coverage, and determined to be benefit-eligible. Benefit-eligible employees are then broken down into two tiers, Tier 1 – Full Time or Tier 2 – Part Time. Typical categories to help determine eligibility include:

1. Those working twenty (20) hours or more per week, where expected employment is more than five (5) consecutive months, and are not classified as a seasonal employee or a part-time temporary employee.
2. Seasonal Employee. An employee in a position for which the customary annual employment is six (6) months or less.
3. Part-Time Temporary Employee. An employee who is expected, at the time of hire, to work twenty (20) hours or more per week but less than thirty (30) hours per week, and whose term of employment is not expected to exceed five (5) consecutive months.

For school district teachers and staff on spread contracts, the 12-month contract qualifies as year-round full-time eligibility. Employees on shorter term contracts will have the opportunity to elect COBRA coverage for the medical, dental and FSA benefits during non-employment months.

Eligible Dependents

Eligible Dependents include (1) legal spouses and (2) children up to their 26th birthdays. The term "children" includes natural children, stepchildren, adopted children, or children in the process of adoption from time of placement. The term "children" also includes children legally dependent upon an employee or his/her spouse for support where a normal parent-child relationship exists with the expectation that the employee will continue to rear that child to adulthood; however, if one or both of that child's natural parents live in the same household with the employee, a parent-child relationship shall not be deemed to exist even though the employee provides support.

No Dual Coverage

No one may be simultaneously covered on this health plan as an insured employee and an insured dependent, or as more than one insured individual or insured dependent. For example, if both spouses are employed by a state agency or school district, they cannot both be enrolled as members and as dependent on their spouse's plan.

PAYING PREMIUMS

Premiums will be remitted from the school district to OGI monthly, not later than the 5th of the month. For districts who conduct payroll the 1st of the month, premiums will be collected and remitted in the month of coverage. For districts who conduct payroll other than the 1st of the month, premiums will be collected the month prior to coverage and remitted to OGI by the 5th of the month.

School Districts must submit payments either physically by check, or electronically by EFT, electronic funds transfer. The preferred method is EFT. The OGI and State Controller's Office (SCO) can provide instructions for setting up EFT. Premium registers (to detail the premiums received for each member) may be FAXED, mailed with the check, or emailed to the appropriate OGI staff member. Registers must be submitted either at the same time as a mailed check payment or emailed/FAXED to OGI prior to receiving payment. Initial premium templates will be sent to you to input employee information and monthly

premiums to be paid. At the turn of each fiscal year, OGI will work with you to change the template to match the new plan year premium amounts. The total from the registers should match exactly to the amount being paid. Any payments that do not match must be returned to the district for correction.

Medical and Dental Premiums & Registers

By the 5th day of each month OGI must receive premium registers and payment for that current month of coverage. If no premium is received, your enrolled employees are at risk of losing coverage. Premiums listed should reflect exact amount deducted from the employee's payroll, including any required premium adjustments. Adjustments may be required based on the employee's new enrollment into the plan, mischarged premium, plan change, or adding or removing a dependent from coverage.

OGI will provide the templates for submitting the registers for each plan type. One register per plan type is necessary for correct processing by OGI, which must include a total of all premiums paid and the headcount of employees.

Flexible Spending Contributions & Registers

By the 5th day of each month OGI must receive FSA contributions registers and payment for that current month of coverage. Contributions listed should reflect exact amount deducted from the employee's (bi-weekly/semi-monthly/monthly) payroll check, including any required contributions adjustments. Adjustments may be required based on the employee's new enrollment into the FSA, recent changes in FSA election amount due to qualifying event or return from leave. One register for each the DCFSA and HCFSA is necessary for correct processing by OGI, which must include a total of all contributions made.

Reconciling Premiums & Contributions

Medical/Dental: On the 15th of each month, OGI will email you a list of any necessary premium adjustments (e.g. an employee missed contributions). It is your responsibility to take the necessary payroll actions to respond to these reports and return them to OGI by the end of the month so they can be properly accounted for by the carrier. Extensive training will be provided to your agency on how to handle this process.

FSA: At least monthly, OGI will email you a list of any necessary FSA contribution adjustments. It is your responsibility to take the necessary payroll actions to respond to these reports and return them to OGI by the end of the month so they can be properly accounted for by the carrier. Extensive training will be provided to your agency on how to handle this process.

Sending Term Reports

On the first of each month, the agency will send OGI a report of any employees who terminated employment in the previous month. This report will be shared with the medical/dental carrier, and FSA carrier if applicable, to appropriately apply the termination of benefits

Submitting Address, Name, Date of Birth Change Requests

All requests to change an employee's address, name, or date of birth must be submitted to OGI who will forward them on to the carrier. This process ensures that HR also has received this information to update files. Employees can contact the medical/dental carrier directly to update their email address, phone number, dependent name or dependent date of birth.

Affordable Care Act (ACA) Reporting

Each non-State Controller's Office agency will be responsible for implementing, through internal or external resources, the measurement and lookback periods to monitor eligibility, documenting offers of coverage, and providing employees with the 1095-C documents (reported to the IRS under header 1094-C). The State's carrier will provide all enrollees with 1095-B reports upon request as Idaho no longer has mandatory mailing requirements for that document.

WHEN AN EMPLOYEE IS NEW

New employees enroll for the coverage of their choice when they first come to work. As part of the new employee orientation process, you need to provide benefit eligible employees with an overview of the group insurance program (the enrollment process, effective dates of coverage, what benefits are available, etc.) including the location of the website.

As timing is critical to effective dates of coverage, this process needs to occur as close to the employee's date of hire as possible.

ENROLLMENT FORMS

Medical, Dental and FSA Coverages

Employees wishing to enroll must submit an application for medical, dental, FSA and pre- or post-tax withholding (Premium Only Plan) enrollment. The Premium Only Plan program is part of the medical/dental enrollment application which you will give to them as a part of their new employee orientation. Agencies are responsible for providing their employees with enrollment paperwork and instructions.

EFFECTIVE DATES OF COVERAGE

Effective dates of coverage are based on the date employees submit their enrollment forms. Detailed information can be found on the website.

When an employee leaves employment, we strongly encourage you to tell them to contact OGI for confirmation of when their coverage ends opposed to putting a date in their termination paperwork that could be incorrect. If an agency puts an incorrect date in the termination paperwork and an employee makes a claim against their insurance when they are not eligible for coverage, the agency will be responsible for paying that claim NOT the health plan.

THE ENROLLMENT PROCESS

Medical and Dental Coverages

To enroll themselves and their eligible dependents for coverage, employees must complete and submit to your HR office the appropriate enrollment form within 30 days of hire. Late enrollment will not be accepted, and employees will have to wait until the next Open Enrollment period (April/May) to enroll for coverage.

Once you have date stamped the form and confirmed that the required information is complete, you will forward the application to OGI via email or fax. We encourage employers to keep a copy of ALL enrollment forms in their personnel files as well as encourage employees to keep a copy.

To decline coverage, an employee must complete the "declination of coverage" portion of the enrollment form and submit it to their HR. This is important for the agency to log and track the count of eligible but not enrolled employees for their premium registers, if applicable to the premium model they have chosen.

Agencies are welcome to use systems like DocuSign to make the enrollment form accessible for electronic signature. OGI does not have a system to currently allow that. If some form of technology is used it must allow the form to be signed by the member, with a date stamp, then forwarded to the HR office to initial/sign and date stamp, and ultimately forward to OGI for processing.

Premium Only Plan

All employees must elect or decline participation as part of the medical/dental enrollment process. For employees who elect to participate, medical/dental premiums are withheld on a pre-tax basis.

FSA

Employees who want to enroll must complete and submit the appropriate enrollment form within thirty (30) days of hire. Those who do not enroll in the FSA's medical reimbursement account within the initial eligibility period cannot enroll until the following Open Enrollment. Employees may enroll in the FSA's dependent care account during the year if they experience a qualifying event.

WHEN AN EMPLOYEE MAKES CHANGES

Employees can change their current benefit elections for a variety of reasons. The rules for making those changes depend on the situation.

FORMS

Medical and Dental Coverages

Employees must submit an enrollment application for medical/dental and pre- or post-tax withholding (Premium Only Plan) enrollment program. The agency is responsible for providing their employees with enrollment paperwork and instructions.

EFFECTIVE DATES OF COVERAGE

Effective dates of coverage are based on the date employees submit their enrollment forms.

CHANGING MEDICAL AND DENTAL BENEFIT ELECTIONS

Open Enrollment

Annual open enrollment is the only time that employees may: (1) newly enroll or decline medical & dental coverage for themselves and/or dependents; (2) switch medical plans, (3) change their premiums from pre-tax to post-tax or vice versa, or (4) enroll in the Healthcare and/or Daycare FSA. Open enrollment is usually held the last week of April and first two weeks of May, with changes taking effect the following July 1. All employee elections must be submitted during the open enrollment period; forms submitted after the close of open enrollment cannot be accepted.

Each year OGI sends all agencies instructions in advance of the upcoming annual open enrollment. We include such details as the exact dates of the open enrollment period and employee deadlines for submitting election forms. We also post information for employees about available benefit options, upcoming changes, and how to enroll for the benefits of their choice on the Group Insurance website. **It is the responsibility of the individual district Human Resource/Payroll offices to provide the necessary Open Enrollment information/materials to their employees.**

Enrolling Newly Acquired Dependents

Employees have sixty (60) days to enroll new family members acquired through marriage, birth, or adoption. Coverage for a new spouse or stepchildren will begin the first of the month following the date of marriage. Newborns and newborn adoptive children have coverage on their date of birth; adoptive children older than sixty (60) days will have coverage effective on their date of placement with the employee.

Late Enrollees

All enrollment changes are limited to the Open Enrollment timeframe without a qualifying life event. Qualifying live events include marriage, divorce, birth, adoption, loss of other coverage, etc.

Dental coverage is required for employees who are enrolled in the medical plan; employees may elect dental coverage for their dependents being enrolled in a medical plan.

Declining Dependent Dental Coverage

Once dependent dental coverage has been declined, it can only be added during Open Enrollment without a qualifying event.

CHANGING FSA ELECTIONS

Employees may only change elections mid-year in the event of a qualifying family status change. No other mid-year changes are allowed by the IRS. To change contributions, the employee submits a revised FSA Election form indicating the new contribution amount. Employees may increase, decrease, or initiate dependent care elections, but may only increase existing medical reimbursement account elections. All changes must be submitted within thirty-one (31) days of the qualifying event.

OGI must review and approve any mid-year changes in FSA contributions.

WHEN AN EMPLOYEE GOES ON LEAVE

Employees who go on authorized leaves of absence may continue group insurance coverages for a period of time. The rules differ depending on the kind of leave. You may need assistance from OGI to determine eligibility for an employee to self-pay.

LEAVE WITHOUT PAY (LWOP)

The plan contracts allow for employees to continue coverage for a period of time when they are on Leave Without Pay. To continue coverage, employees must self-pay the total monthly premium, including the state contribution, for each continued plan. If an agency has an employee in this situation, they should call OGI for specific instructions and guidance.

Employees self-pay by sending their HR office monthly checks or money orders made payable to the Office of Group Insurance. Cash payments are not accepted. You in turn will need to complete the appropriate Self-Pay Reporting Form and send it to our office along with all self-pay checks attached, no later than the fifth (5th) of the month for which the payment applies.

After reaching the maximum LWOP self-pay period, employees may continue medical and/or dental for a period of time under COBRA.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

While on approved FMLA leave, employees may continue medical and dental coverages.

To continue coverage, employees must pay their share of the monthly premiums and your agency must continue to pay all employer premiums. Employees who continue to receive paychecks while on FMLA pay their share of the premiums through payroll deductions. Employees who are not receiving paychecks while on FMLA must self-pay their share of premiums by sending monthly checks or money orders to their agency HR, made payable to the Office of Group Insurance. Cash payments are not accepted. Agency HR in turn will need to complete the appropriate Self-Pay Reporting Form and send it to OGI along with all self-pay checks attached, no later than the fifth (5th) of the month for which the payment applies.

After reaching the maximum FMLA self-pay period, employees may continue medical and/or dental for a period of time under COBRA.

Medical and Dental Coverages

While employees are on active status, they continue to have their share of monthly premiums payroll deducted, and your agency will pay the employer's share as usual.

If an employee ends up in a situation where they are still actively employed but not receiving a paycheck, you will need to complete the appropriate Self-Pay Reporting Form and send it to our office along with all self-pay checks attached, no later than the fifth (5th) of the month for which the payment applies.

When eligibility for active employee coverages ends, Blue Cross provides the individual with information regarding options for continuing coverage under COBRA provisions.

Flexible Spending Accounts (FSA)

If an employee is on leave AND not receiving a paycheck, the HR office should communicate with OGI whether the employee wants to pause their FSA contributions for a period of time, thus reducing their overall annual election, or if they want to make up the contributions when they return to work.

WHEN AN EMPLOYEE RETURNS FROM LEAVE

If employees continue their group insurance coverages while on leave of absence, those coverages will resume when they return to work **but re-enrollment may be required**. If coverage lapsed during the leave, employees may have the option to resume participation when they return. The rules for resuming coverage differ depending on the kind of leave.

RESUMING COVERAGE AFTER LEAVE

Medical and Dental Coverages

To resume coverage, returning employees can re-enroll themselves and eligible family members in the same plans in which they were enrolled before they went on leave. Please contact OGI for re-enrollment instructions specific to employees returning from military leave.

Employer-paid coverage is effective the first (1st) of the month following the date the new enrollment form is submitted (or immediately when returning from military leave, provided the new enrollment form is completed within thirty [30] days).

For employees returning from military leave, participation will resume at the same status in which they left. This means, for example, if the employee returns within the same plan year as the leave began, any amounts he or she paid for covered expenses before the leave will still count toward satisfying that year's medical or dental plan deductibles or out-of-pocket maximums or dental waiting periods.

For employees who previously declined dependent dental coverage, the declinations remain in effect when they return from leave.

Flexible Spending Account Participation

Employees who go on leave and subsequently return within the same plan year must resume participation in the FSA. You will need to ensure that payroll deductions are activated when employees return to active status, and if the employee has chosen to make up any missed contributions while on leave will need to be applied to future paychecks.

Typically, employees who go on leave and do not return to work until a different plan year cannot re-enroll in the FSA unless they were on military leave. Please contact OGI for re-enrollment instructions specific to employees returning from military leave.

WHEN AN EMPLOYEE TRANSFERS FROM ONE AGENCY TO ANOTHER

MEDICAL, DENTAL AND PREMIUM ONLY PLAN ELECTIONS

If an employee transfers from one entity that participates in the State's plan to another, please have them contact our office for instructions. For example, going from a school district to the Department of Education.

WHEN AN EMPLOYEE FILES A CLAIM FOR BENEFITS

Employees handle their own medical, dental and FSA claims.

MEDICAL, VISION AND DENTAL CLAIMS

In general, employees simply show their plan identification cards to providers at the time of services. The providers then bill the plans directly.

When employees are required to file claims (for example, if services are provided by a non-participating provider who will not bill insurance), they send their itemized receipts and claim forms (downloadable from the carriers' websites) directly to the applicable carrier.

FSA CLAIMS

Employees who elect to participate in the FSA receive claim reimbursement information from the plan administrator, Navia Benefit Solutions. Employees may elect to use an Electronic Payment Card (debit card), submit claims electronically, in their smartphone, or via hardcopy.

WHEN AN INDIVIDUAL LOSES ELIGIBILITY FOR GROUP COVERAGE

LOSS OF ELIGIBILITY

Employees lose eligibility when they no longer meet the plans' definition of an eligible employee or stop paying premiums. This may happen, for example, because they terminate employment, or they may become temporarily ineligible due to a reduction in hours. Family members lose eligibility when they cease to meet the plans' definition of an eligible dependent.

WHEN COVERAGE ENDS

For employees whose active status ends before the fifteenth (15th) of a month, coverage will continue through the end of that month.

For employees whose active status ends on or after the fifteenth (15th) of a month, coverage extends through the end of the following month.

For enrolled dependents, coverage ends when the employee's coverage ends or at the end of the month in which he/she ceases to meet the definition of an eligible dependent, whichever occurs first.

CONTINUING COVERAGE AFTER LOSS OF ELIGIBILITY

After active employee coverage ends, employees have options for continuing most coverages on an individual basis for a period of time. Eligible retirees may also purchase retiree group medical coverage for themselves and their dependents; there is no retiree group dental plan.

Active Employee Medical, Dental and FSA Coverages

After eligibility for group coverage ends, employees may be able to purchase continued medical and/or dental coverages for a period of time under COBRA. Employees may be eligible to continue their FSA medical reimbursement account on a post-tax contribution COBRA basis if their account balance exceeds their contributions when their employment ends. Please refer employees with COBRA questions to our office.

RETIREE SICK LEAVE

PERSI requires that the retiree be drawing a retirement benefit to be able to access their sick leave funds. There is no expiration date on the funds and school districts sick leave balances will not be capped like State employee sick leave is.

Approved Carriers & Sick Leave Options

School district employees can use sick leave funds to pay premiums for any of the coverages provided by the list of OGI approved carriers.

Keep in mind, some programs may have age restrictions (over or under age 65). Retirees can work with more than one carrier as well.

A list of approved carriers is posted on the OGI website, <https://ogi.idaho.gov/retiree/using-sick-leave/>. This list is subject to change as additional carriers are added.

OPEN ENROLLMENT

Open Enrollment is held at roughly the same time each year, the last week of April and first two weeks of May. This is the only time each year that employees can change elections without a qualifying life event. Communications and forms will be sent to all HR offices well in advance of Open Enrollment.

Information about Open Enrollment, premiums, qualifying life events, and all applicable plan updates will be posted on the OGI website starting in March ahead of Open Enrollment.