Insurance Group Representative Guide

Introduction

Coverage in the Wood County Employee Health Benefit Plan is offered to eligible employees through an agreement between your Appointing Authority and the Wood County Commissioners (Trustees of the Plan). Individual Appointing Authorities may not alter the eligibility rules for coverage or other provisions of the Plan.

As part of the agreement, every department has an Insurance Group Representative (Group Rep) whose role is to submit information to the Plan on behalf of the Appointing Authority.

Monthly reporting is required to document eligibility & funding. Premiums are funded: Employer 85%; Employees 15% collected via payroll deductions. The process is documented monthly through resolution by the Commissioners.

About the Plan

The Wood County Employee Health Benefits Plan (Plan) is a self-funded, non-federal governmental plan that is not regulated by federal ERISA or state of Ohio Department of Insurance.

It is a Grandfathered Plan as defined by Affordable Care Act (ACA), of which several sections regulate the Plan.

The Plan uploads enrollment information to third party administrators who process claims for eligible members based on Plan design. The vision benefit is self-administered within the Commissioners' Office. Life insurance is fully insured and mandatory for all benefit-eligible employees.

Wellness Programs are offered but are not subject to HIPAA regulations. Confidential Wellness Screenings for new hires and spouses are required prior to enrollment in the Plan.

The Plan Document outlines how the plan is administered. Commissioners' Office staff oversee the administration of the Plan under the Commissioners' direction.

Your Role as an Insurance Group Representative

As a group rep you are an extension of the Plan. When you receive information, the Plan is receiving information. With that in mind, it is important to communicate with the Benefits Clerks on an on-going basis to ensure timely reporting of information.

In addition, some materials must be provided within set timeframes. Utilizing the established forms and checklists helps ensure these federal regulations are met. Submission dates and written sign-offs are required to show compliance.

A Benefits Line has been established to help you and employees with insurance-related matters. The number is 419.354.1373.

Group reps are responsible for the following:

- Information distribution & collection
- Monthly insurance reporting to report ongoing changes
    - Verification of hours for eligibility with payroll officer
    - Reporting funding
- Customer Service

Information Distribution & Collection

Insurance Orientations

One of the main roles of the group rep is to provide an insurance orientation for new employees.

Upon receipt of the ACA form, the Commissioners' Office will forward a new hire packet to you. This packet must be reviewed with the employee on the first day of employment in order to provide the employee the full election period.

The packet includes a checklist to review with the new employee.

A PowerPoint presentation has been created to assist with the review of material. This Employee Insurance Orientation is on the Employee Website under the Employee Health Benefits Page.

When reviewing the information with the employee, make sure the employee has initialed all of the sections and signed the document. Your signature will be needed as well.

Encourage employees to complete the insurance application from the writable pdf file on the employee website.

Return any certification forms received (spousal/dependent) to the Commissioner's Office upon receipt from the employee. These should be submitted prior to the insurance report to allow processing time.

Wellness Screenings

Part of the on-boarding process includes scheduling employees for their wellness screenings. It is recommended that the group rep schedule the appointments for the employee to avoid issues with the member's enrollment.

All employees and any spouses (primary or secondary) enrolling in the Plan must complete a wellness screening prior to enrollment. Employees may also elect to complete annual screenings.

- New Hires: Have 30 days from hire/change to FT status to complete.
- Annual Screenings: Employees may email wellness@woodcountyohio.gov to request a screening appointment.

If the wellness screening is not completed, the employee is not able to enroll except for Life insurance. The employee must wait until Open Election of Special Enrollment/Qualifying Event.

If the employee misses one or both of their scheduled appointments without providing 24 hours notice, the employee will be billed for the missed appointment.

Distribution of Insurance Cards

The Commissioners' Office will forward ID cards upon receipt from the third-party administrators. This may take up to three weeks after submission of the enrollment data to the administrators.

- Cards are printed for Medical, Prescription, and Dental coverage.
    - Vision coverage is administered within the Commissioners' Office as a reimbursement program. ID cards are not issued for vision coverage.
- Employees can also view ID cards on the third-party vendors' websites.
- A member can obtain services prior to receipt of their card by providing the group number printed on the Plan Administrator page of the Health Benefits Guide and their social security number.

Overage Dependents and OBRA Reports

Each month, the Benefit Clerk in the Commissioners' Office provides a list of dependents that will require one or both of the following forms:

- OBRA form (employee or dependent turning 65)
    - This form is used for members turning 65 or those who are disabled. The form identifies whether the member is electing our group health coverage or Medicare as primary coverage. If electing Medicare as primary, the member will also need to submit a Universal Application to terminate coverage under our Plan.
- Universal Application
    - To remove dependents who have reached the limiting age for coverage.

These forms should be identified on the next monthly insurance report and submitted with the report.

Enrollment Verifications

Enrollment reports are sent to the employee and department noting changes made following completion of the monthly cycle.

- Individual Enrollment Verifications (IEV) identify coverage elected by the employee and dependents covered under the Plan if applicable. Provide the IEV to the employee for their review of the information. Ask them to review the report carefully and report any needed corrections to you within three days.
- Enrollment Summary Reports lists all employees by coverage and whether they have a family or single plan. Keep this for your records.

Payments

Employee self-pay and COBRA premiums are due on the last day of the month prior to the next month's coverage.

- **COBRA** - 60-day enrollment period, enrollees have a 45-day grace period from date enrollment paperwork is signed. After that a 30-day grace period applies to pay monthly premiums.
- **FMLA without pay** - 30-day grace period to pay premiums.
- **Self-Pay** - No grace period.

Employee payments should be made payable to the Wood County Treasurer and forwarded to the Commissioners' Office for processing. Do not hold checks until the insurance report

due dates as pay-in at Treasurer's Office is required by next business day if over $1,000 or within 3 days if under.

Meet with Exiting Employees

When employees separate service, they should complete an Insurance Application to terminate coverage.

The ACA form should be submitted as soon as the separation is known. If it is an immediate termination, contact the Benefits Line to obtain the coverage termination date.

As the Group Rep, you can submit the application if the employee is not available. Just sign the form as the group rep.

You will also need to prepare the COBRA personnel action report to submit with insurance report.

Reminder Emails

It is encouraged that you email staff as a reminder to report changes that need to be included in the monthly reports. Provide examples of items that need reported. Many employees forget to report address changes and other required notifications.

Monthly Insurance Reporting

As the group rep you are responsible to report new enrollment and any changes to existing contracts to the Commissioners' Office on a monthly basis within the communicated timeframe.

Information on the Health Benefits Plan is posted on the Employee Website. A page is dedicated to information to assist group reps.

The Insurance Calendar identifies due dates and other insurance-related dates.

Templates for the required reports are also posted:

- Monthly Insurance Report – Summarizes changes to enrollment, coverage and funding
- Monthly Vision Report – Summarizes vision claims received from employees
- ACA Compliance Report – Summarizes the new hires, terminations, and other status changes that affect eligibility.

The Notification of Insufficient Wages for Payroll Deduction form helps communicate when employees must self-pay their premiums.

The FMLA Checklist identifies group rep responsibilities when invoking FMLA for an employee.

Preparing the Monthly Insurance Report

To prepare the monthly reports, you will need to review the following to identify any changes to report:

- Universal Applications received
- Contract changes – Single to Family; Family to Single
- Payroll Changes – unpaid leave of absence
- Prior month's report to identified continued leave of absence (paid or unpaid)
- Vision Claim Submission Forms received
- New hire, terminations or status changes (ACA reports should be submitted within 3 days of any changes)
- Returned sign-offs (Individual Enrollment Summary, annual sign-offs, etc.)
- Prior month's report for other items to report, e.g., missing SSN for new baby.

If you are not the payroll officer, you must check with the payroll officer to see if any employment status changes occurred since last report.

If you do not have any changes for the month, note "No Changes to Report", sign and submit the reports to the Commissioners' Office.

If you do have changes to report, complete the monthly insurance reports using the received applications from employees.

- List the employee's social security number, last name, first name, payroll number.
- If enrolling or terminating coverage, note the selected coverages under Types of Coverage.

Wood County Employee Health Benefits

MONTHLY INSURANCE REPORT

Department: _____ Group/Sub-Group No. _____ Coverage Month _____

Report changes to employee insurance coverage since the last Monthly Insurance Report. Information on part time employees is reported on the ACA Compliance Report.

Check for the following: new hire/status changes/terms; contract changes: single to family/family to single; and payroll status changes (unpaid
Provide required 15-day termination notice for FMLA non-payment.
Attach signed Individual Enrollment Verifications from prior month enrollment.

Employee Demographic Information			Type of Coverage: + for additions - for deletions x for any other changes note reason in remarks							Funding: mark an x in appropriate box and note reason in remarks				Eligibility		REQUIRED -- Remarks/Reason for Change
			Health/H		Vision		Dental		Life	Code Change	Payroll Deduction Shortage		FMLA Self-Pay	Self-Pay	Event Date	Effective Date	
SS#	Last Name, First Name	Payroll #	S	F	S	F	S	F	S		1st Pay	2nd Pay					

- Use the noted symbols to report changes:

  + (plus) for additions - (minus) for deletions x for other changes

For example, if reporting a contract change from single to family, mark both the single (-) and family (+).

Report funding changes on the report including code changes, self-pays, and leave of absences. Place an 'X' in the appropriate box and include a reason in the remarks.

If an employee has a leave of absence, it is important to determine if the employee will have enough wages to cover the payroll deduction.

- Payroll deductions are taken the first and second pay of each month based on hours worked in a prior pay period.
- Deduction must be taken out of BOTH the first and second checks of the month.
    - Three pay months do not have insurance deductions taken on the third pay of the month.
- To determine if employee will have enough wages, look at the pay date to determine if wages will cover the premium.

Pay	Period Worked		Pay Date	Hours Worked
	From	To		
23	10/19/2025	11/1/2025	11/14/2025	80.00
24	11/2/2025	11/15/2025	11/28/2025	40.00
25	11/16/2025	11/29/2025	12/12/2025	7.50
26	11/30/2025	12/13/2025	12/26/2025	80.00

In this example, the employee has sufficient wages for the first pay in November and likely earns enough to cover the premium for the second pay.

However, the employee may not have sufficient wages the first pay in December, which means the employee will have to self-pay the premiums for the month of December.

Premiums are due by the last day of the month prior to the month of coverage. The employee would need to give five days notice if they want to continue coverage and also provide the payment by November 30.

Review Benefit Eligible Checklist

Ensure that all boxes are initialed by employee or flag for follow up.

The Checklist must be signed and completed within 30 days by the group rep and the employee. This is necessary to verify that the employee has received all the required information in a timely manner and that the application has been received within the 30-day election period for Special Enrollment/ Qualifying Event.

Ensure all checkboxes are initialed. If not, follow-up with the employee before submitting the checklist.

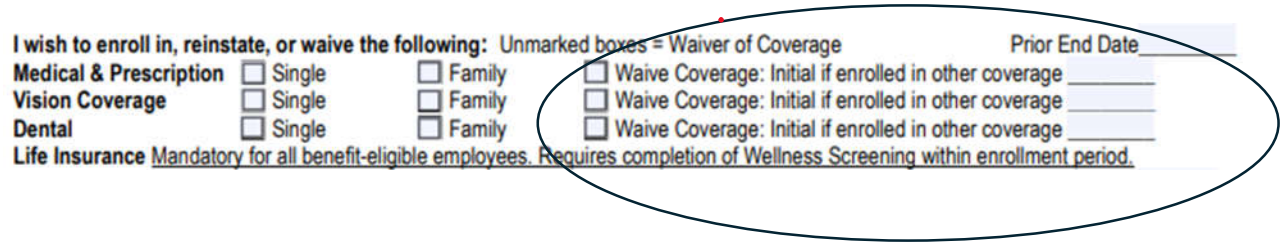
Make sure you also return the employee's signed Wellness Waiver form with the report.

Review Universal Applications

- Ensure a Universal Application is received for all enrollment, terminations, and requested changes.
    - To determine other forms needed refer to the Eligibly Guide: Q:INS/Eligibility/Eligibility Guide. This may include spousal/dependent certifications.
- Ensure all the information is complete on the insurance applications for the requested change. Compare social security numbers against form to identify discrepancies.
- All changes must be reported to the Plan within 30 days of the event; becoming eligible, Qualifying Event, termination, funding of premiums, etc. The Plan may request the employee provide paperwork to verify any information.
- Verify effective date for insurance.
- Ensure the employee's (or group rep's) signature is on the app and that the app is signed within 30 days of the event.

Waiver of Coverage:

- If not electing health, prescription, vision or dental coverage, that portion of the application must be marked as waiving coverage and initialed by the employee.
- Life insurance is mandatory and cannot be waived, therefore, employees must participate in the confidential mandatory wellness screening.


I wish to enroll in, reinstate, or waive the following: Unmarked boxes = Waiver of Coverage Prior End Date_____

Medical & Prescription	☐ Single	☐ Family	☐ Waive Coverage: Initial if enrolled in other coverage _____
Vision Coverage	☐ Single	☐ Family	☐ Waive Coverage: Initial if enrolled in other coverage _____
Dental	☐ Single	☐ Family	☐ Waive Coverage: Initial if enrolled in other coverage _____

Life Insurance Mandatory for all benefit-eligible employees. Requires completion of Wellness Screening within enrollment period.

Special Enrollment/Qualifying Events:

- Examples include e.g. marriage, divorce, birth, gain/loss of insurance. A qualifying event is an event that results in the gain or loss of other insurance coverage, loss = gain here; gain = loss here (no gain/gain or loss/loss.)
- Ensure the application is signed within 30 days of that life event. If beyond 30 days, employee must wait until Open Election or another Special Enrollment/Qualifying Event to make the requested change.
- For a divorce, the court paperwork is required and must have the file date stamped. (A certified copy is not required.)
- A gain/loss of insurance requires documentation, see Eligibility Guide.
- Check if change results in premium change from Single to Family or Family to Single and note on insurance report to change in benefits system.
- Note any spousal premiums on report.

Terminations:

- Employees cannot terminate their coverage mid-year without a special enrollment/qualifying event if enrolled in Section 125.
- If employee is terminating coverage due to the special enrollment/qualifying event, check if change results in premium change from Single to Family or Family to Single and note on insurance report to change in benefits system.
    - Life insurance also terminates if an employee is in an unpaid leave of absence that is not protected by FMLA. If a monthly measurement employee does not meet hours, life insurance also terminates.
- Prepare a COBRA Personnel Action Report for terminations.

OBRA Form:

- Employee/spouse/dependent eligible for Medicare due to age 65 and over or disabled must submit signed “Primary Coverage Selection Form”. This form is utilized to ensure Medicare eligible members sign off if they are requesting Medicare to be primary. Members may also select the Plan as primary with Medicare as secondary.
- If electing Medicare as primary, the employee would drop coverage under the Plan. These are Medicare rules.

Spouses:

- Verify spousal certification is complete to enroll spouse as primary.
  Tier 1 = no premium; Tier 2 = spousal premium applies; Tier 3 = no primary coverage.
- Note tier on insurance report to ensure added to benefit system.
- Spouses seeking secondary coverage must provide primary insurance information on the application and do not participate in the spousal certification. Secondary coverage is not available for vision, therefore if requesting vision coverage, the spouse must complete the spousal certification process.

Dependents:

- Ensure box is marked that they meet all eligibility rules.
  - If not, inquire as dependent may not be eligible for coverage.
- Medical/Prescription and Vision/Dental have different eligibility rules, see Health Benefits Guide/Plan Doc.
  - Medical/Rx to age 26 (end of the month in which dependent turns 26)
  - Vision & Dental to end of calendar year in which dependent turns 19 unless a full time student (then eligible to end of calendar year in which dependent turns 23).
    - Vision cannot be secondary.
- Confirm completion of dependent certification forms if over 19.
  - Verify reported ages by checking application and forms.
- If employee notes that National Medical Support Notice applies, add a remark on the report. (i.e., NMSN)
- If a dependent doesn't have a social security number when enrolling, make note to follow up until received.

Coordination of Benefits:

- If requesting secondary coverage, information regarding primary coverage must be provided. In most cases, the IRS does not permit the Plan to coordinate with High Deductible Plans (HDP) that are partnered with a Health Savings Account (HSA).
- Vision coverage cannot be secondary.

Section 125 election:

AUTHORIZATION FOR PRE-TAX INSURANCE PREMIUM AND/OR SPOUSAL PREMIUM (if applicable).
By signing this application I hereby give my authorization to have my monthly insurance premium and/or spousal premium (if applicable) deducted from my payroll check on a pre-taxed basis, through payroll deduction annually thereafter, if no new election form is filed during Open Election or based upon a Qualifying Event.

☐ I choose **not** to elect my payroll deduction on a pre-taxed basis.

- If box is checked, verify with the employee that deductions should be taken after tax.
- Add note on insurance report (Post Tax election).

Review the reports prior to submission to ensure all information is reported correctly and all forms are received. You do not need to resubmit ACA forms with the monthly report as they should be logged as they as sent to the Commissioners' Office.

- Ensure the ACA Report notes all ACA forms received. ACA forms are only used to track employee eligibility; not all applications require the form.
- Be sure to include the timesheet for a monthly measured employee who separates with less than 130 hours of service for the month.
- Audit previous month's Individual Enrollment Statements (IEV) to ensure all have been returned.
- If any items are missing, follow up with the employee.
- The Benefits Clerk will contact you regarding issues with the report or missing documents. You may want to add notes to your copies of reports regarding discussions.
- Follow-up on any items needed from a prior report and record any information that must be included in the next report. (e.g., missing social security number, secondary coverage information, etc.).

Vision Report

This report summarizes vision claims received. Fill out the information for each claim submitted.

Wood County Employee Health Benefits

MONTHLY VISION REPORT

Department: Group/Sub-Group No. Coverage Month

Report monthly employee vision claim reimbursement.

SS#	Employee Last Name, First Name	Dependant Name (if applicable)	Amount of Claim

Group Rep Signature & Date

Be sure to review the claim and submitted receipts to make sure that the required information is included to process the claim.

- Patient Name
- Date of Service
- Proof of Payment (a credit card summary or WalMart cash register receipt is not sufficient on its own as they do not list what services were received.)
- Itemized List of Goods/Services
    - A copy of the prescription may be required to confirm who received services if patient name is not identified on the detailed invoice.

ACA Compliance Report Summary

The ACA Compliance Report Summary documents submitted ACA forms since the last monthly report.

The ACA Compliance Report identifies employment status to help determine eligibly for the Plan.

Wood County Employee Health Benefits

ACA Compliance Report Summary

Department: _____ Group/Sub-Group No. _____ Month _____

Report ACA Compliance Report forms submitted since last insurance report.

Employee Demographic Information			Effective Date		ACA Compliance Report Action					
SS#	Last Name, First Name	Payroll#	Hire Date	Date of Change	New Hire	Separation	Status Change		Unpaid LOA Report ALL unpaid FMLA/Military Report Other if greater than 8 hours	
					FT/PT	Term/Other	Less than 30 hr/wk	More than 30 hr/wk	FMLA Military Other	Dates of Leave

Document the ACA Compliance Report form on the summary page and send to the Commissioner's Office within three days of an appointment or status change. Do not hold forms to send with the monthly insurance report.

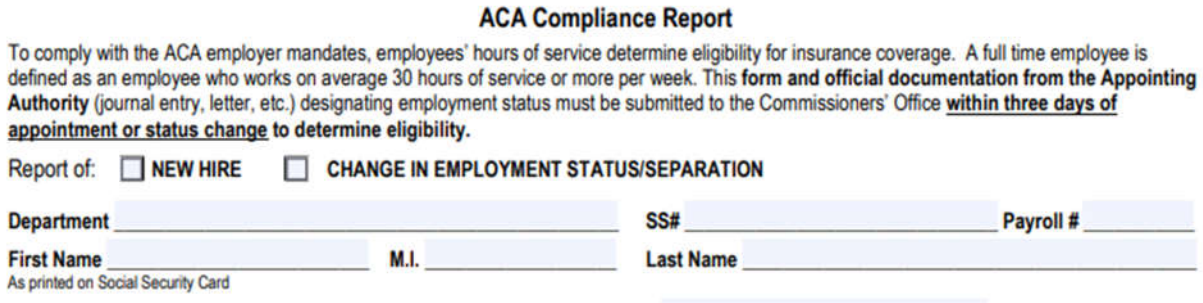
ACA Forms

A writable version of the ACA Compliance Report form is available on the employee website. Always report the date of the event. The Benefits Clerk will provide the effective date for coverage if applicable.

It is important to note if an employee is already employed by the County. Prior to hiring an employee, make sure they are not working somewhere else in the County.

- Overtime rules may apply for any hours worked over 40 in the workweek.
- Benefit eligibility may be extended as eligibility is based on hours paid.

You may be offering insurance and/or paying overtime when that was not your intent. Seek assistance from HR prior to hiring someone who is already employed by the County.



ACA Compliance Report

To comply with the ACA employer mandates, employees' hours of service determine eligibility for insurance coverage. A full time employee is defined as an employee who works on average 30 hours of service or more per week. This **form and official documentation from the Appointing Authority** (journal entry, letter, etc.) designating employment status must be submitted to the Commissioners' Office **within three days of appointment or status change to determine eligibility.**

Report of: ☐ **NEW HIRE** ☐ **CHANGE IN EMPLOYMENT STATUS/SEPARATION**

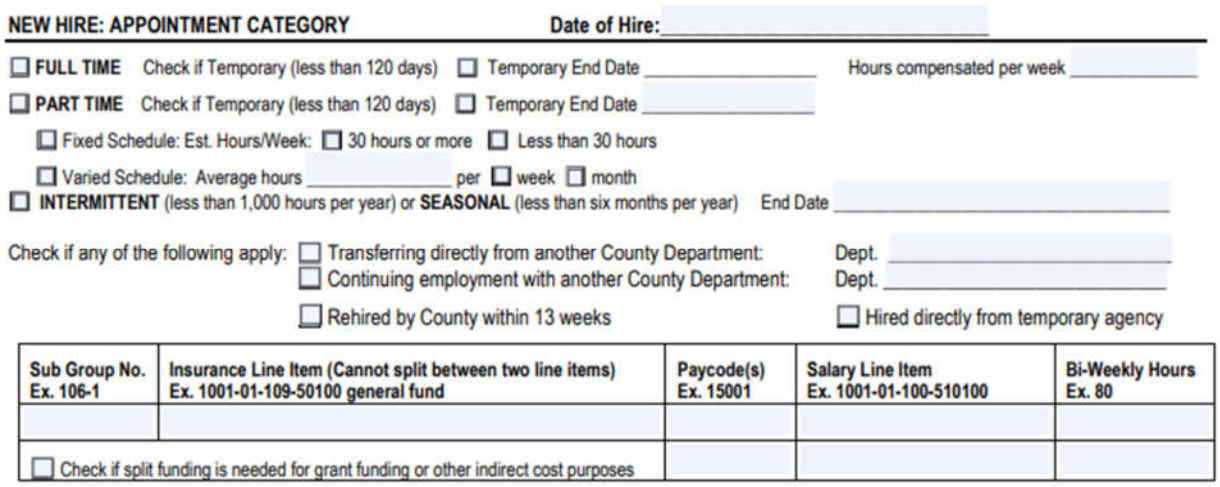
Department _____ **SS#** _____ **Payroll #** _____

First Name _____ **M.I.** _____ **Last Name** _____

As printed on Social Security Card

This section reports demographic the employee's demographic information.

- Be sure the employee's name is spelled correctly.
- The employee's Social Security number may not be known at this time which is okay.
    - Report the last four from the employment application.
    - Make a note on the Summary report to update the number prior to sending the monthly insurance report.



NEW HIRE: APPOINTMENT CATEGORY **Date of Hire:** _____

☐ **FULL TIME** Check if Temporary (less than 120 days) ☐ Temporary End Date _____ Hours compensated per week _____

☐ **PART TIME** Check if Temporary (less than 120 days) ☐ Temporary End Date _____

☐ Fixed Schedule: Est. Hours/Week: ☐ 30 hours or more ☐ Less than 30 hours

☐ Varied Schedule: Average hours _____ per ☐ week ☐ month

☐ **INTERMITTENT** (less than 1,000 hours per year) or **SEASONAL** (less than six months per year) End Date _____

Check if any of the following apply: ☐ Transferring directly from another County Department: Dept. _____

☐ Continuing employment with another County Department: Dept. _____

☐ Rehired by County within 13 weeks ☐ Hired directly from temporary agency

Sub Group No. Ex. 106-1	Insurance Line Item (Cannot split between two line items) Ex. 1001-01-109-50100 general fund	Paycode(s) Ex. 15001	Salary Line Item Ex. 1001-01-100-510100	Bi-Weekly Hours Ex. 80
☐ Check if split funding is needed for grant funding or other indirect cost purposes				

This is used for new hires: full time, part time, intermittent and seasonal.

- Temporary appointments cannot exceed 120 days and should include an end date.
- Intermittent appointments and seasonal employees should also have identified end dates.

Unlike payroll, insurance funding cannot be split between two codes. If split funding is needed for any reason, check the box. Additional follow-up will be provided to determine total insurance costs.

CHANGE IN EMPLOYMENT STATUS - Includes Transfers to Another Department and Separations

If employee is a monthly measurement, verify that employee will meet 130 hours of service during month(s) of reported event.
If under 130 hours for the month, coverage will terminate retroactive to the last day of the prior month. Forward timesheet(s) for the month with insurance report.

Effective Date of Change/Separation_____

☐ Part Time to Full Time Hours compensated per week _____ *If benefit eligible, note Sub Group & Insurance Line Item above.*
☐ Part Time Hours Change Estimated Scheduled Hours/Week: ☐ 30 hours or more ☐ Less than 30 hours
☐ Full Time to Part Time Estimated Scheduled Hours/Week: ☐ 30 hours or more ☐ Less than 30 hours
☐ Unpaid Leave of Absence ☐ FMLA ☐ Military ☐ Other: _____
Unpaid Leave: Start Date: _____ End Date: _____
Check Wages for Premium Collection: Month: _____ 1st payroll deduction ☐ Yes ☐ No / 2nd payroll deduction ☐ Yes ☐ No
☐ Self Pay Required for Month(s) _____ ☐ Not enrolled in benefits
☐ **TRANSFER TO ANOTHER DEPARTMENT**: New Department _____
☐ **SEPARATION OF EMPLOYMENT** Last Day in Active Pay Status_____
☐ Benefit Eligible at Separation: ☐ Ongoing ☐ Monthly: Hours of Service for Month _____ *(If less than 130, not eligible for month.)*
☐ Not Benefit Eligible/Enrolled

This section reports changes in status including unpaid leave of absence. A Notification of Insufficient Wages for Pay Deduction form is available on the employee website to help communicate self-pay amounts and due dates.

This will also provide a "heads up" for employees who may be short wages for payroll deduction.

If an employee is transferring from one County department to another County department:

- The department the employee is leaving from should note the "Transfer to Another Department" and note the department name.
    - The employee must submit a Universal Application to transfer departments.
- The department that the employee is transferring to should use the New Hire section at the top of the form and check the "Transferring from another Department" box and list the prior department.

New hire packets will be sent based on eligibility. Measurement periods will be identified.

DETERMINATION OF BENEFIT ELIGIBILITY -- For Commissioners' Office Use _____

☐ **New Hire:** ☐ Benefit-Eligible Insurance Checklist attached - Monthly Measurement through _____

Effective Date for Coverage _____

☐ Non-Benefit Eligible Insurance Checklist attached – Variable Hour: IMP End Date _____

☐ **Status Change/Separation:** Current Measurement: ☐ Ongoing ☐ Monthly ☐ Variable Hour

☐ Change to Monthly through _____ ☐ Insurance Checklist Attached *See New Hire noted above*

☐ Term: Coverage Termination Eff. Date _____ ☐ No Change

Note: _____

Termination dates of coverage and other notes will be provided to assist you with reporting items on the Monthly Insurance report.

Customer Service

Employees are directed to see their group rep when they have questions regarding the Plan.

Plan information is available on the Employee Website.

See the Health Benefits Guide for contact information, who to call when. Direct any eligibility questions to the Benefits Line. The third-party administrators do not handle eligibility or address changes. These are all completed through an Insurance Application.

Claims questions can be directed to the third-party administrator customer service line.

If you are not certain about a situation, reach out to the Benefits Line for assistance.

Who do I contact with questions about my medical coverage?	
Inquiring About:	**Who To Contact:**
Covered Benefits/Predetermination of Benefits	Meritain Health 1.800.925.2272
Deductible/Out-of-Pocket Maximums	Meritain Health 1.800.925.2272
Eligibility/Adding a Dependent or other changes	Commissioners' Office Benefits Line 419.354.1373
Precertification for Required Services	Meritain's Medical Manager 1.800.242.1199
Finding an In-Network Provider	FrontPath Health Coalition 419.891.5206
Claim Payment/Denial	Meritain Health 1.800.925.2272
Explanation of Benefits (EOB)	Meritain Health 1.800.925.2272
New ID cards	Meritain Health 1.800.925.2272

Who do I contact with questions about my prescription coverage?	
Inquiring About:	**Who To Contact:**
Covered Benefits	MedBen Rx 1.888.633.2366
Eligibility/Adding a Dependent or other changes	Commissioners' Office Benefits Line 419.354.1373
Medical Necessity Review/Precertification	MedBen Rx 1.888.633.2366
Claim Payment/Denial	MedBen Rx 1.888.633.2366
New ID cards	MedBen Rx 1.888.633.2366

Common Claim Issues/Questions

Eligible Medical Expenses:

- Services listed in the Medical Schedule of Benefits will be considered eligible only if they are medically necessary due to illness or injury. Limitations may apply.

Predetermination of Benefits:

- If unsure if a service will be covered under the Plan, the member may request a Predetermination of Benefits through Meritain's customer service. The process may take 15 to 30 business days to complete. This is also separate from any precertification requirements.

Precertification Requirements:

- Certain medical and prescription services require Precertification as outlined on the back of the medical ID card.

  Prior to receiving services, members should verify that precertification is complete.

  Outpatient surgeries do not require precertification unless they overnight stay extends beyond 23 hours. Then Precertification would be required for an inpatient stay.

Explanation of Benefits (EOB):

- Encourage employees to review the EOB upon receipt. Some claims are denied for being sent to the wrong address, previously submitted claim, submitted after one year, etc.

Denied claim due to claim being sent to the wrong address:

- Employees should contact their provider to ask for the claim to be resubmitted to the address on the back of the medical ID card.

Denied claim for late submission by the Provider:

- Employees should write a letter to the provider and explain in detail that the claim was submitted after the deadline.
- Attach a copy of the EOB with the submission date and date of service highlighted.
- The member can also request that the provider cease any aggressive phone calls and collection activity as insurance information was properly provided and that the member cannot be balance billed when it was submitted improperly.

- Sending the letter to both the provider and the billing address may prove helpful. Members are welcome to copy FrontPath and Meritain on the letter as well.

Requesting Change in Coverage

A consistency requirement must be satisfied, i.e., the new election must be on account of and correspond with the change in status. Because the spouse/dependent is not electing dental or vision coverage through the new employer, it would be inconsistent to allow the employee to drop the spouse/dependent from those coverages.

Requesting Reimbursement – Paper Claims

Should a new member seek services prior to being added to the Third-Party Administrator's system, the member will need to submit a paper claim form.

Paper claim forms are available on the employee website under the applicable coverage.

- Medical claims can often be resubmitted by the provider. Paper claims are usually only submitted when using a non-participating provider who does not file claims on the member's behalf.

- Paper claims are more common with pharmacy charges since they are billed at point of sale.

The member will send the paper claim form directly to the Plan's Third-Party Administrator (i.e., FrontPath, MedBen Rx).

Upon receipt of the claim, the Third-Party Administrator will re-adjudicate the claim and forward any reimbursement due directly to the member.

Health Insurance Portability and Accountability Act (HIPAA)

The Federal Government through its Health Insurance Portability Act, commonly referred to as HIPAA, requires all persons who deal with personal health information to protect such information from public disclosure.

A person's health information, including their plan(s), pre-existing conditions, health conditions, treatment and utilization data or other information that is personal and private to them is protected under the "Protected Health Information" elements of the HIPAA laws. The laws are broadly interpreted to include the following:

Health care claims or equivalent encounter information;

- Eligibility for a health plan;
- Referral certification and authorization;
- Health care claim status;
- Health plan premium payments;
- Coordination of benefits; and,
- Enrollment and dis-enrollment in a health plan.

As a group rep you must sign off on the HIPAA Confidentially Certification prior to receiving protected health information.

If others in your department have access to the protected health information, they must also sign the certification. Contact the Benefits Line to schedule a HIPAA review for the employee.

Before discussing a spouse's (or adult child's) situation with an employee, make sure you have a HIPAA sign-off permitting you to discuss matter with the employee. Unless the member is with the employee or you have written authorization, you cannot discuss the matter with the employee.