Educational Benefit Cooperative

Procedure Manual

October 2025

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EBC

The Educational Benefit Cooperative (EBC) is a cooperative designed for school districts located primarily in the Chicago metro area. EBC began operations in July 1984. Through the cooperative, EBC members “pool” their resources to purchase medical, basic life, dental and stop loss coverage. A Board of Directors, consisting of one delegate from each member district, directs the EBC. The operations of the cooperative are governed by bylaws, also administered by the Board of Directors.

EBC PROCEDURE MANUAL

This manual is designed by Gallagher Benefit Services (GBS) for the EBC administrators as a guide to administer the EBC benefit programs. This a living document, which means that we will continue to update this manual as needs change.

Our goal at GBS is to give you clear, concise and accurate guidelines to follow and maintain. We appreciate your careful review of these procedures, and we thank you for your continued cooperation in following them.

The intent of this manual is to provide you with general information regarding the status of, and/or potential concerns related to the EBC benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

EBC OVERVIEW

Gallagher Benefit Services

Gallagher Benefit Services provides consulting services to the EBC Board. Their function is to assist in the following areas:

- Plan design
- Government compliance
- Benefit communications
- Employee meetings
- Underwriting benefits
- Marketing benefit programs

Businessolver

Benefitsolver by Businessolver is your online enrollment system. They are responsible for the following services:

- Enrollment and eligibility for all EBC lines of coverage (Medical, MetLife Dental and Basic Life)
- Enrollment and eligibility for additional lines of coverage where applicable
- COBRA administration
- Invoices for the EBC lines of coverage

Blue Cross Blue Shield

Blue Cross Blue Shield is the third party administrator for the EBC medical plans. They provide the following services:

- Medical claims processing
- Claim record maintenance
- Medical necessity determination
- Large claims management

Prime Therapeutics is the Pharmacy Benefit Manager

MetLife

MetLife is the dental third party administrator for the EBC member districts that participate in the dental pool. MetLife provides claim administration per the contracts of each respective district.

Empower Health

Empower Health is a wellness vendor providing a medical health screening and flu vaccination program for the EBC member districts. They are responsible for providing confidential preventive health evaluations and vaccinations to individuals eligible for their district's health insurance plans on an annual basis.

Reliance Matrix

Reliance Matrix Life Insurance Company provides the fully insured Life and AD&D coverage for all EBC member districts. They are responsible for paying benefits in accordance with each district's respective Life/AD&D contract, and providing employee certificates, summarizing those benefits.

Navigate Wellbeing Solutions

Navigate Wellbeing Solutions provides the EBC Wellbeing Portal. The comprehensive program highlights the EBC Value-Adds and is home to other resources and group challenges.

Teladoc

Teladoc provides telemedicine to EBC member districts' employees if enrolled in medical coverage. Through Teladoc, eligible individuals are given access to U.S. board-certified doctors and pediatricians via phone or online video consultations.

EBC MEMBER DISTRICTS

- A.E.R.O Special Education Cooperative
- Addison SD 4
- Alsip Hazelgreen SD 126
- Atwood Heights SD 125
- Avoca SD 37
- Beach Park SD 3
- Beecher CUSD 200U
- Bensenville SD 2
- Berkeley SD 87
- Brookfield SD 95
- Brookwood SD 167
- Burbank SD 111
- Burr Ridge SD 180
- Butler SD 53
- Byron CUSD 226
- Calumet SD 132
- Cary SD 26
- CASE
- Coal City CUSD 1
- CCSD 89 (Glen Ellyn)
- CCSD 46 (Grayslake)
- CHSD 94 (West Chicago)
- Crete Monee SD 201U
- CUSD 201
- Decatur SD 61
- Deerfield SD 109
- District 45 (Villa Park)
- Dolton SD 148
- Dolton SD 149
- DuPage HSD 88
- East Maine SD 63
- East Prairie SD 73
- ECHO Joint Agreement
- Edmund Lindop SD 92
- Eisenhower Cooperative
- Elmwood Park SD 401
- Evanston/Skokie SD 65
- Evergreen Park Elementary SD 124
- Fairview SD 72
- Fenton HS 100
- Forest Park SD 91
- Franklin Park SD 84
- Genoa Kingston SD 424
- Glen Ellyn SD 41
- Glencoe SD 35
- Golf SD 67
- Grayslake CHSD 127
- Herscher CUSD 2
- Hillside SD 93
- Itasca SD 10
- Kankakee SD 111
- Keeneyville SD 20
- Kenilworth SD 38
- LaGrange Highlands SD 106
- LaGrange SD 102
- Lake Park HS 108
- LaSalle Peru Township HSD 120
- Lemont-Bromberek CSD 113A
- Lincoln SD 156
- Lincolnwood SD 74
- Lisle SD 202
- Lombard SD 44
- Maercker SD 60
- Mannheim SD 83
- Manteno CUSD 5
- Marengo Union Elementary CSD 165
- Marquardt SD 15
- Matteson SD 159
- Medinah SD 11
- Midlothian SD 143
- Mount Prospect SD 57
- Mundelein SD 120
- NDSEC
- Niles SD 71
- Niles Spec Ed 807
- Norridge SD 80
- North Chicago SD 187
- North Palos SD 117
- Northbrook SD 28
- Northbrook/Glenview SD 30
- NSSEO
- Oak Lawn Hometown SD 123
- Oak Park SD 97
- Oswego CUSD 308
- PAEC
- Palos Heights SD 128
- Palos SD 118
- Park Forest Chicago Heights SD 163
- Pleasantdale SD 107
- Posen Robbins SD 143.5
- Prairie Grove CSD 46
- Prospect Heights SD 23
- Queen Bee SD 16
- Reavis HS 220
- Rhodes SD 84.5
- Rich Township SD 227
- Ridgeland SD 122
- River Forest SD 90
- River Trails SD 26
- Riverside Brookfield HSD 208
- Riverside SD 96
- Roselle SD 12
- Salt Creek SD 48
- SASED
- Sauk Village CCSD 168
- Seneca Grade School 170
- Seneca Township HS 160
- Skokie SD 68
- Skokie SD 69
- Skokie SD 73.5
- South Berwyn SD 100
- South Holland SD 150
- SPEED-SEJA
- Sterling CUSD 5
- Summit Hill SD 161
- Sunset Ridge SD 29
- SWCCCASE
- Thornton Fractional SD 215
- Thornton Township SD 205
- Tinley Park SD 146
- TrueNorth 804
- Union Ridge SD 86
- Warren Township HSD 121
- West Northfield SD 31
- Westchester Public SD 92.5
- Willow Springs 108
- Wilmington CUSD 209U
- Winnetka SD 36
- Wood Dale SD 7
- Woodland SD 50
- Woodridge SD 68
- Zion School District 6

GALLAGHER SERVICE TEAM

Gallagher Benefit Service Contacts	Role	Phone Number	Email Address
Mel Diaz Area Executive Vice President	Lead Account Management	630.285.4195	mel_diaz@ajg.com
Victoria Dowling Area Sr. Vice President	Lead Account Management	630.285.3604	victoria_dowling@ajg.com
Miriam Bates Benefit Consultant	Account Management	630.694.5350	miriam_bates@ajg.com
Nancy Bellosa Sr. Benefit Consultant	Account Management	630.285.3991	nancy_bellosa@ajg.com
Allison Evors Sr. Benefit Consultant	Account Management	630.228.6759	allison_evors@ajg.com
Erica Mendoza Sr. Benefit Consultant	Account Management	630.694.5020	erica_mendoza@ajg.com
Kelsey Smith Benefit Consultant	Account Management	630.647.3074	kelsey_smith@ajg.com
Dania Aviles Sr. Account Representative	Account Management	847.378.2921	dania_aviles@ajg.com
Alyssa De Long Sr. Account Representative	Account Management	630.282.2460	alyssa_delong@ajg.com
Brian Franz Account Representative	Account Management	847.378.5920	brian_franz@ajg.com
Lesley Pasillas Account Representative	Account Management	630.285.4240	lesley_pasillas@ajg.com
Amna Siddiqui Account Representative	Account Management	630.228.6770	amna_siddiqui@ajg.com

BLUE CROSS BLUE SHIELD OF ILLINOIS

All EBC districts' medical plans are self-funded and use BCBS for claims administration and access to their wide network. Information in BCBS is updated weekly by file feeds from Businessolver. District Admins are given access to Blue Access for Employers—the BCBS portal that allows you to view employees' profiles.

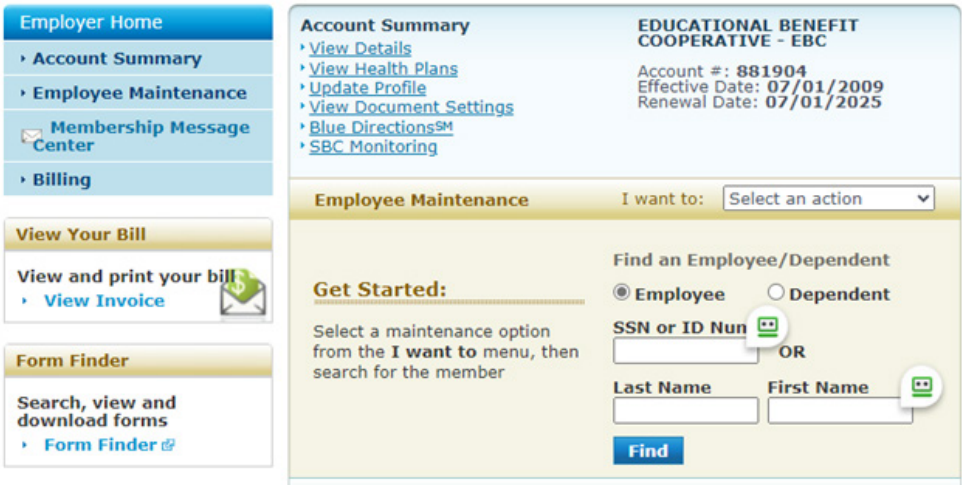
Blue Access for Employers (BAE)

Each EBC Primary and Secondary contact are sent login information for Blue Access for Employers (BAE) when he/she first joins the district. There is separate login information for PPO and HMO plans. You must make sure to enter the correct username based on the plan enrolled by the employee being searched. Employees enrolled in a HDHP will be found using your PPO login information.

TO ACCESS BAE, VISIT:
https://www.bcbsil.com/employer/index.html and enter your login credentials.

Once you have entered the site, you can search for an employee with his/her SSN, BCBS Member ID or, by Last Name and First Name.

You can confirm effective dates, term dates, and covered dependents.



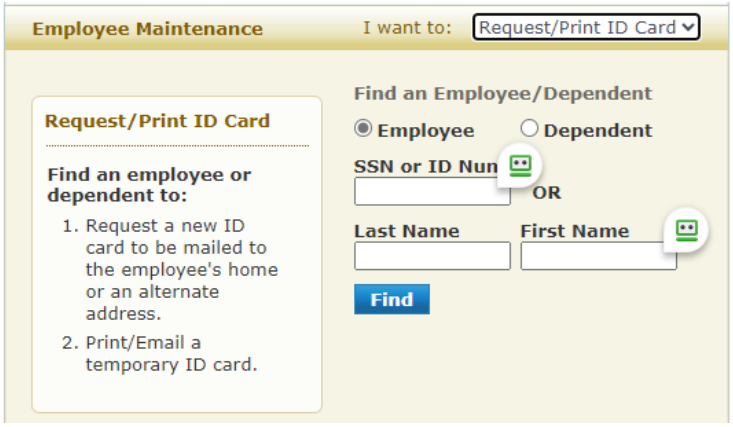
Steps to Request/Print ID Cards

Under the employee's name and member ID, select "Request/Print ID Card" from the "I want to" drop down box.

From the Request/Print ID Card page, you can:

- See when the last ID card was printed and mailed
- Verify the mailing address is correct
- Order new cards be mailed
- Print a temporary ID
- Email a temporary ID (you can enter your own email address for this purpose, should you not know the employee's address)

BlueCross BlueShield of Illinois



Blue Access for Members (BAM)

Employees who enroll under the district's medical plans have access to Blue Access for Members, online and through BCBSIL Mobile Application. In BAM, members can view their benefits, request new ID cards, and access BCBS tools and wellness resources.

STEPS FOR MEMBERS TO REQUEST NEW ID CARDS

Note: You can provide these steps directly to employees.

1. Log in to BAM (**www.bcbsil.com**). If you have not registered yet, you will need your group and ID number. You can find these on your BCBSIL ID card.
2. Once you have logged in, click on "Get a Temporary ID Card" under Quick Links on the home page. You are able to print a temporary ID card or email it to yourself.
3. If you need a new physical card, click the "order an ID card" link at the top of the page.
4. Confirm your address and click the orange button to request a new card. Your card(s) will be sent to you within two weeks. Regardless of how many people are covered on your policy, BAM will generate only one member ID card at a time. You will need to request multiple cards individually if you need more than one.

BCBS Phone Numbers – For Members

In the event an employee needs to contact BCBS and does not have access to his/her ID cards, the phone numbers are as follows:

- PPO Members **800.458.6024**
- HMO Members: **800.892.2803**
- For Prime Therapeutics: **800.423.1973**

BlueCross BlueShield of Illinois

It's now easier to find a provider and manage your health care expenses.

Provider Finder from Blue Cross and Blue Shield of Illinois is a fast, easy-to-use tool that improves your experience when you are looking for in-network health care providers. It can also help you manage your out-of-pocket costs.

The updated Provider Finder platform has undergone intensive testing. The result is a better experience that will help you be a smarter consumer of health care.

By going to **bcbsil.com**, you can login or create an account on Blue Access for Members℠ (BAM℠) and use Provider Finder to:

- Find in-network providers, clinics, hospitals and pharmacies.
- Search by specialty, ZIP code, language spoken, gender and more.
- See clinical certifications and recognitions.
- Compare quality awards for doctors, hospitals and more.
- Read or add reviews for providers.
- Estimate the out-of-pocket costs for more than 1,700 health care procedures, treatments and tests.*
- Find cost savings opportunities for prescription drugs using the Medication Finder tool.*

Stay Connected with BCBSIL

Even on the go you can manage your ID cards and stay on top of claims activity, coverage information and prescription refill reminders. It's easy: Log into or create a BAM account at **bcbsil.com**.

* Not all plans provide this information.

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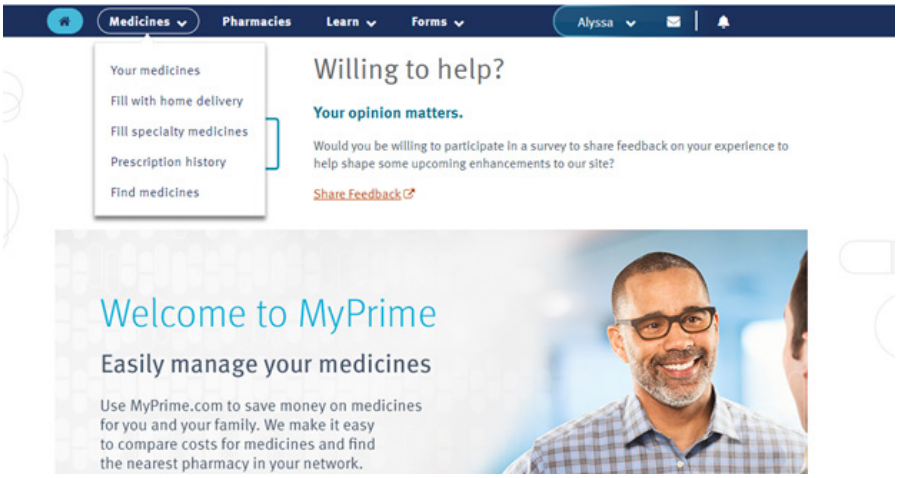
Prime Therapeutics

Prime Therapeutics is the Pharmacy Benefit Manager (PBM) for all EBC districts. The pharmacy benefit works in hand with your district's medical plans to provide cost-effective and high-quality pharmacy services to members. Based on your district's medical plan, members may be subject to a copay and a specific drug list. Members can also find information on their pharmacy benefits in their EBC Benefit Summary.

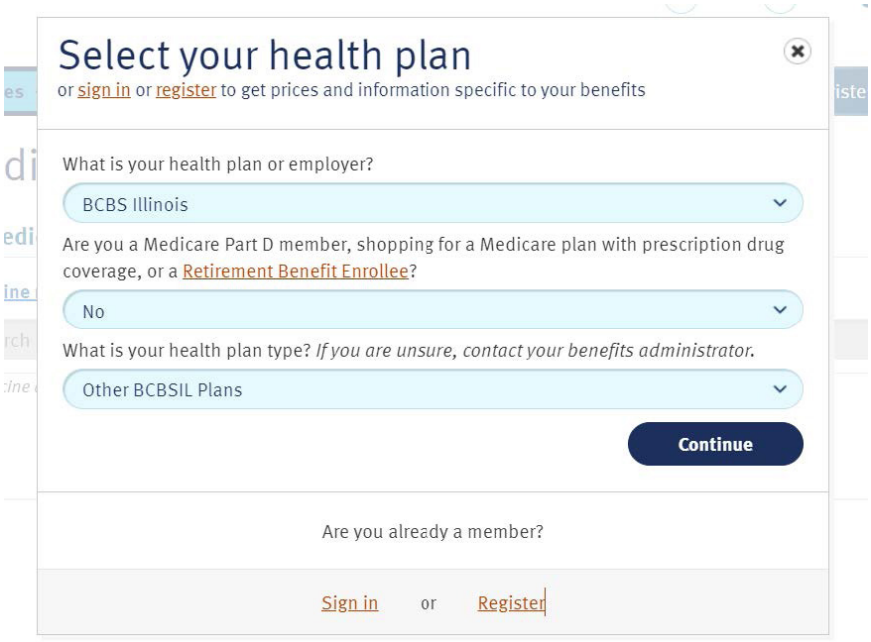
DRUG LISTS AND MYPRIME.COM

Admins and Members can access drug lists by visiting **myprime.com** and navigate the site as a guest. Registration is not required.

1. Visit **myprime.com**. Under Medicines, click **"Find medicines"**



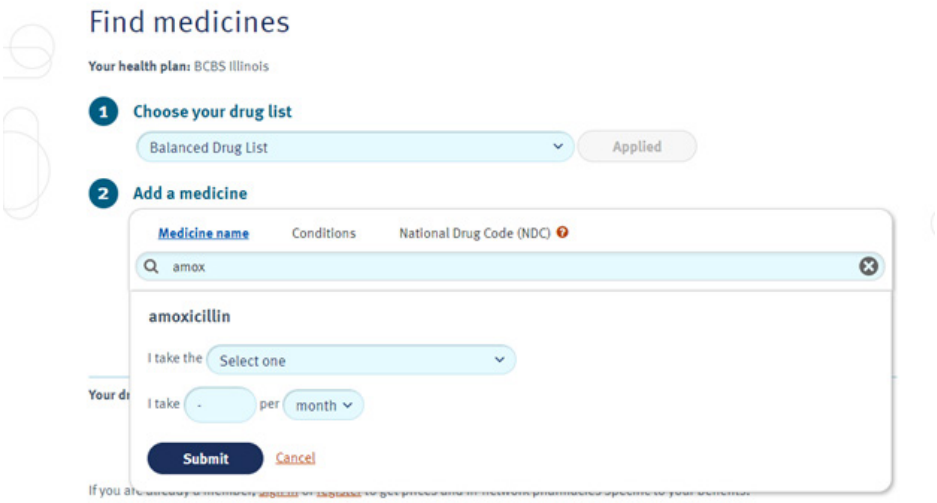
2. Select your health plan by selecting the options shown below.



BlueCross BlueShield of Illinois

3. Choose your drug list and enter the medicine name.
   Note: The drug list is based on the medical plan.
   PPO Medical Plan: Balanced Drug List
   HMO Medical Plan: Performance Drug List
   GF HMO Medical Plan: Basic Drug List

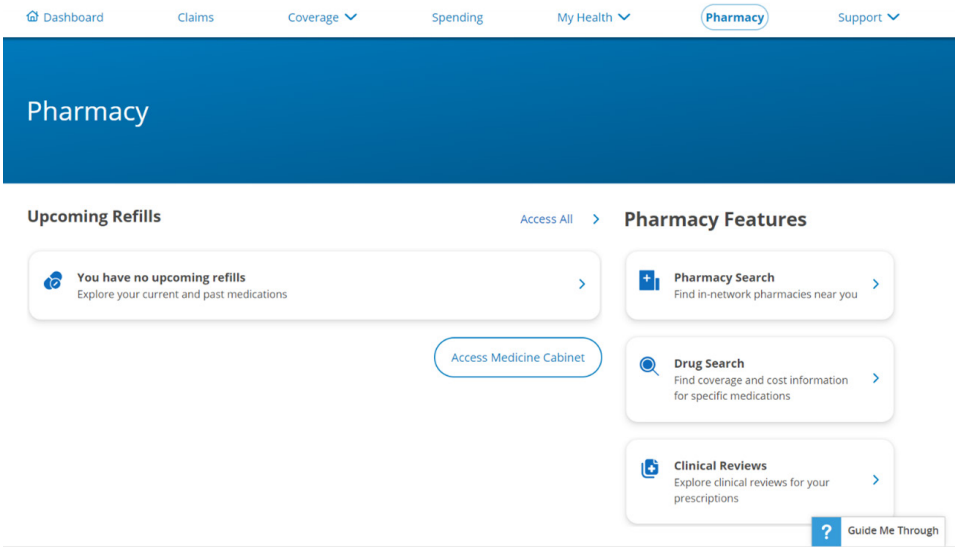
4. Based on the drug type listed from your search, you may refer to your district's benefit summary to view the copay correlated to the drug type.



BLUE ACCESS FOR MEMBERS

Members can access MyPrime with single sign-on from Blue Access for Members (BAM) by clicking Pharmacy on the top of the page. MyPrime allows members to access their personal prescription information. In MyPrime members can:

- Locate a pharmacy
- Find drugs/drug list
- View prescription claim history
- Create a personal drug list
- Learn about specific drugs Rx costs



BCBS and Medicare

BlueCross BlueShield of Illinois

The chart below explains how BCBS and Medicare will pay claims if a member is covered on the district's plan as an active employee or retiree.

Note: Retirees who remain covered on the district's plan should be aware the district's plan is **NOT** considered a Medicare Supplemental Plan. Gallagher does not advise on Medicare. When a retiree becomes eligible for Medicare and chooses not to enroll, the member's plan will pay as if they were enrolled in Medicare. Questions pertaining to Medicare should be directed to Medicare. Medicare is primary over the district plan for both domestic partners and civil unions, regardless of the employee's active or retiree enrollment status.

	District	Medicare
Active Employee		
Pre-65	Primary	N/A
Post—65	Primary	Secondary
Spouse of Active Employee		
Pre—65	Primary	N/A
Post—65	Primary	Secondary
Retiree Employee*		
Pre-65	Primary	N/A
Post –65	Secondary	Primary
Spouse of Retired Employee*		
Pre-65	Primary	N/A
Post-65	Secondary	Primary

*This will only apply if the district covers retired employees.

Blue Cross Blue Shield Programs - PPO/HDHP/HMO Members

BlueCross BlueShield of Illinois

BCBS BLUE365 DISCOUNT PROGRAM

BCBS offers a discount program to all their members. Members who sign up for Blue365 can save money on health and wellness products and services from top retailers that are not covered by insurance.

BCBS WELL ONTARGET

The Well onTarget Member Wellness Portal is designed to help employees reach their wellness goals. The interactive portal is user friendly, offering tools and trackers that allow members to earn Blue Points, which can be redeemed for a variety of gift cards.

FITNESS PROGRAM

The fitness program provides flexible gym packages which includes access to a number of facilities and virtual training options. The program costs $19 to sign up and members can choose between 8 different plan options. Members can view which gyms and facilities are included and sign up for the program by clicking the Wellness tab in Blue Access for Members.

QUESTIONS ABOUT THE PROGRAM?

Please contact your designated Gallagher Account Manager.

Blue Cross Blue Shield Programs - PPO/HDHP Members Only

BCBS MEMBER REWARDS PROGRAM

PPO or HDHP members and their covered dependents have access to BVA and Member Rewards through BCBS of Illinois, which is administered by Zelis. Members can call BVA or go online to BAM (Blue Access for Members) to shop for medical care procedures, save on out-of pocket costs and earn cash rewards when a lower-cost, quality provider is selected from several possibilities. Members who utilize the program will receive a check in the mail from Zelis sent to their home address.

BENEFITS VALUE ADVISOR

A Benefits Value Advisor (BVA) helps members navigate the world of healthcare. A BVA can help members answer any questions in regards to their copays, benefits, find a provider, and so much more. To contact a BVA, members may call the number found on the back of their ID card or start a Live Chat in Blue Access for Members.

LEARN TO LIVE: DIGITAL MENTAL HEALTH

PPO members, including dependents who are 13 years or older, have access to free digital mental health programs through Learn to Live. Participating members will complete an online assessment to help pinpoint what program is right for them. Members can also work with a coach who will provide additional support to help members reach their goals. Results, program process, and messages and communication that are shared with your coach are completely confidential. To get started with a mental health assessment, log in to Blue Access for Members and choose Wellness, then find Digital Mental Health.

24/7 NURSELINE

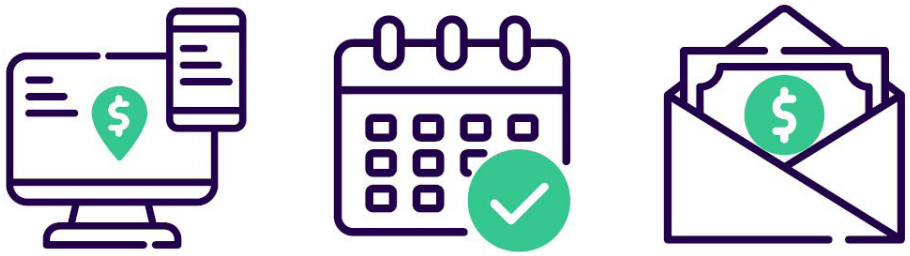
The 24/7 nurseline allows members to speak with a licensed nurse and seek wellness advise around the clock. Members can also listen to more than 1,000 health topics to learn more about a specific condition. The 24/7 Nurseline is available by calling **800.299.0274**.

DIABETES MANAGEMENT PROGRAM

Teladoc for Diabetes is a health benefit offered to all members enrolled in the PPO or HDHP medical plan. The program assists those diagnosed with diabetes manage their condition by sending the member test strips, a connected glucose meter, and personal support. Members diagnosed with Diabetes will be outreached to enroll in the program or can sign up online at **TeladocHealth.com/Smile/EBC** or calling **800.835.2362** and use registration code: **EBC**.

HYPERTENSION MANAGEMENT PROGRAM

Teladoc for Hypertension is a health benefit offered to all members enrolled in the PPO or HDHP medical plan. The program assists those diagnosed with hypertension manage and monitor their condition via wireless-connected blood pressure cuff, notifications of high blood pressure readings, and 24/7 coaching. Members diagnosed with Hypertension will be outreached to enroll in the program or can sign up online at **TeladocHealth.com/Smile/EBC** or calling **800.835.2362** and use registration code: **EBC**.



Blue Cross Blue Shield Programs - HMO Members Only

BlueCross BlueShield of Illinois

HMO BLUE CARD PROGRAM

The BlueCard Program* helps Blue Cross and Blue Shield of Illinois (BCBSIL) members who are traveling within or outside of the country. The program helps members find health care providers and receive the same benefits as their current BCBSIL plan when the member travels or is away from home for an extended period.

*BlueCard coverage varies for each BCBS Plan and depends on the provider. It is important that the member calls Customer Service at the number listed on the member ID card before travelling or visit Blue Access for Members. For more information visit **www.bcbsil.com/member/why-choose-us/blue-card**.

HOME AWAY FROM HOME

BCBSIL members enrolled in a HMO plan may become guests of an affiliated HMO group when they are away from home for at least 90 days. The Away From Home Care Program is available to members who have a dependent attending school out of state, family members who live in a different service area, or have long-term work in another state.

HMO members can log into Blue Access for Members or call the number on the back of their ID card to learn more about Away From Home Care and where it is available. For more information on the program, visit **www.bcbsil.com/member/why-choose-us/blue-card**.

MEDICAL GROUPS

Members enrolled in an HMO medical plan are required to choose a Medical Group and a PCP. The Medical Group is a 3-digit group number that can be found in ProviderFinder or by calling the provider's office. When a member selects their medical group, they can only visit providers within that same group. If an employee does not select their medical group at the time of enrollment, this will cause a delay in receiving their ID card.

Members are allowed to switch their medical group number once a month. To do so, the member will need to call the number found on the back of their ID card to request this. Once the request has been completed, the new medical group will go into effect the first of the following month.

BUSINESSOLVER OVERVIEW

benefitsolver

Businessolver is the online eligibility platform and COBRA vendor for all EBC districts. Businessolver also prints and transmits 1095-C Forms to the IRS for districts that wish to participate. To ensure accurate reporting, all insurance eligible employees should have a record in the system even if he/she currently waives coverage.

Weekly File Feeds

Each week, in the early hours of Wednesday morning, Businessolver sends an eligibility file to BCBS Medical and MetLife often referred to as a file feed. If changes have not been entered in the system before midnight, they will not be sent until the following week. Any changes made on Wednesday from 12:00 AM up until 11:59 PM the following Tuesday will be captured on the file feed and sent to BCBS and MetLife.

Annual Open Enrollment

Open enrollment occurs annually and is the time when plan participants, including those enrolled in COBRA, have an opportunity to make changes to their benefit elections. Each EBC district holds open enrollment at a different time, with the effective date for plan changes typically occurring July 1, coinciding with the EBC plan year.

Businessolver and your Gallagher team must be notified of your district open enrollment dates. Businessolver will then create an Open Enrollment BAR which can be found by clicking on the Enrollment BAR in the Edit/Term option of an employee's record. Benefit Access Rules (BARs) are viewable based on role, access level and window of time allowed to process each option. Each option requires a date to begin the process. During this time, districts are able to enter any changes in the system. For districts with a July 1 effective date and an open enrollment period that ends at the end of May, all changes must be in the system by the first Friday of June. For self-serve districts, employees are able to make changes to their elections during this time by logging into Businessolver and following the Open Enrollment prompts.

You must inform your employees and COBRA participants of the open enrollment period. Once your open enrollment period has ended, employees are not able to make any benefit changes unless he/she experiences a qualifying life event.

Ancillary Lines

Businessolver holds enrollment information for non-EBC sponsored plans for COBRA purposes. If Gallagher is the broker for a line of coverage, we will inform Businessolver of any changes to rates or plans. Districts must inform Businessolver directly (not through a Gallagher Account Manager) to update any plan information for lines of coverage Gallagher is NOT the broker for.

Districts should enter the enrollment for these plans timely, when the employee makes the election. Once you terminate an employee in the system, Businessolver will include all enrolled benefits on the COBRA notice.

Note: Unless there is a file feed to the carrier, districts are responsible for enrolling and terminating employees with the / within the carrier system(s).

In the event a terminated employee elects COBRA coverage for a non-EBC line of coverage, the district will continue to see the employee's name on the monthly carrier invoice. Each quarter, districts will receive a check from Baker Tilly (EBC Accountant) reimbursing them for the payment the district has made on behalf of the COBRA enrollee. To see who is enrolled in COBRA, districts can run a report in Businessolver, called an 'Employee Census Benefit.'

If a terminated employee elects COBRA for an EBC pooled line, such as a medical plan, the terminated employee will not be captured in the monthly EBC Invoice.

Businessolver Contact Information

Admin Support
(Member-specific benefit questions, administrator user setup, password resets, administrator support)
Admin Support Phone Number: 844.411.4784
Admin Support Email: ebc@businessolver.com

BUSINESSOLVER – MONTHLY EBC INVOICES

At the end of each month, the next month's invoice is generated in Benefitsolver for the district's EBC pooled lines of coverage (Basic Life and AD&D, Medical, and Dental). The invoice will reflect any changes made in the system prior to the 20th of each month. Any changes made after the 20th will appear as a credit or debit on the following month's invoice. Districts should pay the invoice as billed even if errors were made in the system. Adjustments will show at the bottom of the invoice and the bill should balance the following month.

If you do not terminate an employee and/or dependents in Benefitsolver and require a retro termination, you will only receive a credit for a maximum of 90 days of paid premium (if there are no outstanding claims).

Basic Life and AD&D—Reliance Standard Life Insurance Company

The following explains the information found on the monthly invoice:

Number covered—the total number of employees insured

Volume—equal to the sum of the life benefit amounts for all insured employees

For most districts, the Life and AD&D volume will be the same, although the monthly premium for each will be different. To calculate the premium for Life and AD&D, multiply the total volume by the specified rates, and divide by $1,000. If your district offers Supplemental Life through Reliance Standard, it may also appear on your EBC bill; however, the premium may be paid on a per unit, or a per $1,000 of coverage, basis depending on the life benefits offered by your district.

Medical—BCBS

The number covered reflects the total number of employees covered on your district's medical plan. The dependent number covered is the total number of employees who have elected dependent coverage.

Dental—MetLife

The number covered reflects the total number of employees covered on your district's dental plan. The dependent number covered is the total number of employees who have elected dependent coverage.

15 Day Rule

If a newly enrolled employee has an effective date of coverage from the 1st to the 15th of the month, the district will be charged premium for the month.

However, if the employee has an effective date from the 16th to the end of the month, the district will NOT be charged for the month's premium. Districts with termination rules that are date of event will also be billed, according to the date the employee terminates in the month.

The following are examples of how this will impact your invoice:

- District A has a new hire whose effective date of coverage is August 18th. As the employee's effective date of coverage is after the 15th of the month, the district will NOT be charged for the month of August.
- District B has a new hire with an effective date of coverage of September 2nd. As the employee's effective date is before the 15th of the month, the district will be charged for the month of September.
- District C has a new hire with an effective date of coverage of September 15th. As the employee's effective date is before/on the 15th of the month, the district will be charged for the month of September.
- District D has an employee terminating benefits on June 12th. The district will NOT be charged for the month of June as the employee terminated before the 15th of the month.
- District E has an employee terminating benefits on June 17th. The district will be charged for the month of June due to the benefits terminating after the 15th of the month.
- District F has an employee terminating benefits on June 15th. The district will not be charged for the month of June due to the benefits terminating between the 1st and 15th of the month.

Note: Districts with end of the month termination rules will be charged the entire month's premium regardless of date of termination, as the employee's benefits extend the whole month.

MONTHLY EBC PAYMENT INSTRUCTIONS

benefitsolver

Payment for EBC invoices is due by the first of every month; however, districts are given a 30 day grace period (or until the end of the month) to make the payment.

Delinquent payments will be subject to a penalty which shall be equal to the highest interest rate allowed by statute to be paid by an Illinois school district.

There are three different methods districts can choose from to pay the monthly invoice:

1. Mailing a check
2. ACH
3. Wire transfer

Mail

To facilitate prompt posting of the monthly payments, premium payment checks from each school district should be mailed directly to the bank for deposit. On a monthly basis, the EBC accounting firm, Baker Tilly, will be accessing a copy of each district's monthly invoice.

Send the monthly EBC premium payment by the first of every month to:

Educational Benefit Cooperative
36767 Treasury Center
Chicago, IL 60694-6700

ACH

If using the ACH option, fees may range from $1—$3 from the district's bank. Please note, if the district uses this method, a pre-note is recommended before the actual money is sent. ACH must have the exact information listed below or the money will not be received by the EBC and will be returned to the district.

INSTRUCTIONS FOR SENDING FUNDS VIA ACH TO ISDLAF:

Bank: Harris Bank, Chicago
ABA#: 071 000 288
Beneficiary: ISDLAF Account#: 2972503 SEC Code: Checking
Discretionary Data: Educational Benefit Co-op Acct. 10226-101

Wire Transfer

Wire transfer fees may range from $6 to $25 from the district's bank. PMA (administrator for ISDLAF) must be notified a wire is incoming and the wire must be done before 11 AM or EBC's account will not be credited until the following day.

INSTRUCTIONS FOR WIRING FUNDS TO ISDLAF:

Bank: Harris Bank, Chicago
ABA#: 071 000 288
Beneficiary: ISDLAF Account#: 2972503 SEC Code: Checking
OBI: Educational Benefit Coop Acct 10226-101

Any questions or problems related to ACH or wire transfers should be directed to Lisa Nusko at PMA.

Contact Information
Lisa Nusko
Phone Number: **630.657.6400 ext. 6527**
Email: **lnusko@pmanetwork.com**

COBRA

What is COBRA?

Under federal law, group health plans are required to offer certain employees and their dependents the opportunity to continue their health coverage upon termination of employment under certain conditions. COBRA or (Consolidated Omnibus Budget Reconciliation Act of 1985) offers employees opportunity to continue coverage for 18, 29, or 36 months from the point of the "qualifying event" depending on the reason for termination.

What is a COBRA Qualifying Event?

A qualifying event is an event which results in a loss of coverage such as:

- Voluntary or involuntary termination of coverage (except gross misconduct)
- Reduction of hours
- Death of an employee
- Medicare entitlement
- Divorce
- A dependent reaches the maximum age she/he is allowed to remain on the plan; or, loses full-time student status

What are the notice requirements?

A district has 30 days to enter the qualifying event in Benefitsolver, after which Businessolver (the online eligibility vendor) must notify the member and their enrolled dependents that they have a right to continue coverage within 14 days. Once the employee receives notification, they have 60 days to elect coverage. The member also has 45 days from the day he/she has made the election to continue coverage to make the first payment. This means an employee has up to 105 days they can float between coverages.

How long can someone continue on COBRA?

18 months - Employees and their dependents whose coverage ended due to termination of employment or a reduction in hours.

29 months - Employee and/or dependents who are disabled at the time of the qualifying event, or within 60 days of the qualifying event. In order to qualify for disability status, the member must be considered disabled by a determination from the Social Security Administration.

36 months - Qualified beneficiaries who have lost coverage due to death, divorce, legal separation, Medicare entitlement or loss of dependent status

When will COBRA coverage end?

COBRA coverage will discontinue under the following circumstances:

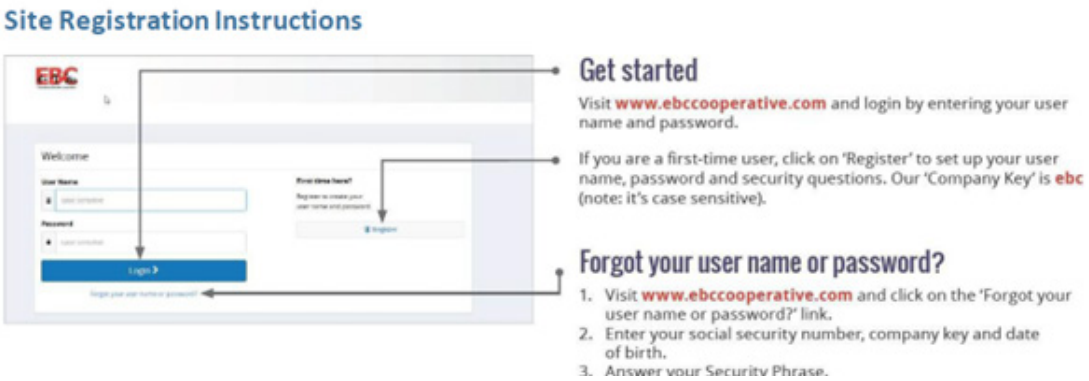
- The employee and/or dependent fails to make their payment in a timely fashion (members are given a 30 day grace period to pay premium)
- If the member becomes eligible for benefits under another group health plan
- If the member becomes entitled to Medicare
- Anytime the member wishes to cancel coverage

COBRA PARTICIPANT INFORMATION

COBRA enrollees can view their coverage and pay their monthly premiums via Businessolver's site: **www.ebccooperative.com**

Note: For first time users – the company key is: ebc

Site Registration Instructions



If a COBRA enrollee contacts the district with questions on their coverage, direct them to Businessolver's COBRA department.

Businessolver COBRA Department Contact Information

- **COBRA Phone#: 877.547.6257**
- **COBRA Fax#: 515.273.1545**
- **COBRA Email: clientcare@businessolver.com**
- **Businessolver COBRA Address:**
  Businessolver, Inc
  PO BOX 850512

Minneapolis, MN 55485-0512

TRAINING SOLVER

businessolver

Trainingsolver Experience

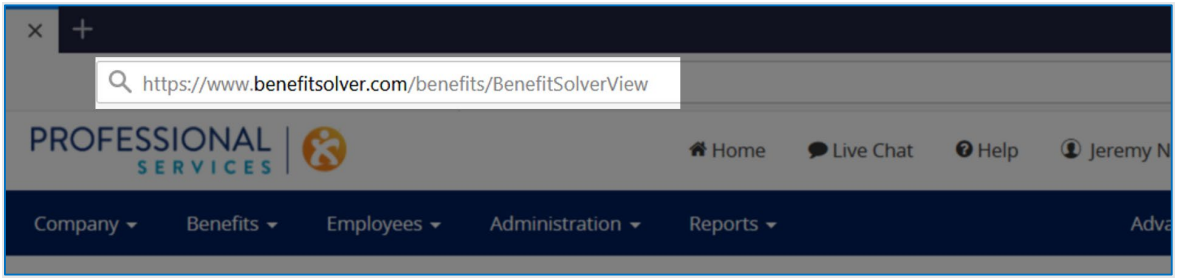
Trainingsolver eLearning Curriculum

Technology First – that is the approach you chose to take when you selected Businessolver. Every day, we deliver on providing industry-leading technology to support your business growth. We are equally committed to delivering industry-leading training to drive deep domain expertise with our technology to enable your success. We are excited for you to experience our Trainingsolver eLearning Curriculum and Learning Management System (LMS).

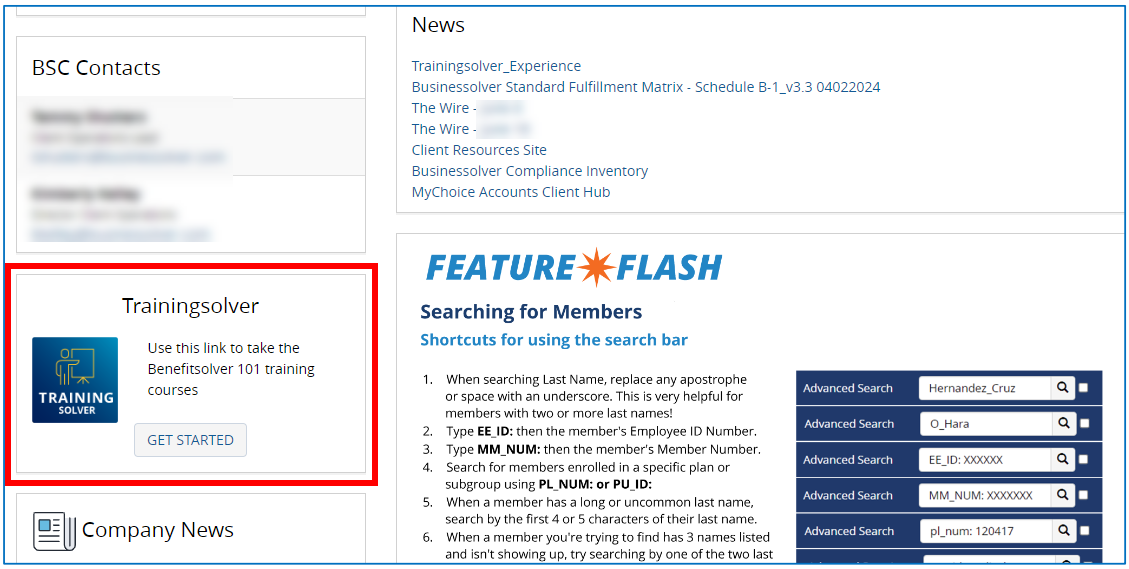
Delighting YOU – OUR CLIENT is at the core of our WHY. Here are just a few ways this training model delivers delight; courses featuring **the latest UI updates and system enhancements, automated progress tracking** to easily pause your learning and pick up where you left off, and access to **24/7 continuous learning** for just-in-time continued support.

Here's how you can access the Trainingsolver Experience.

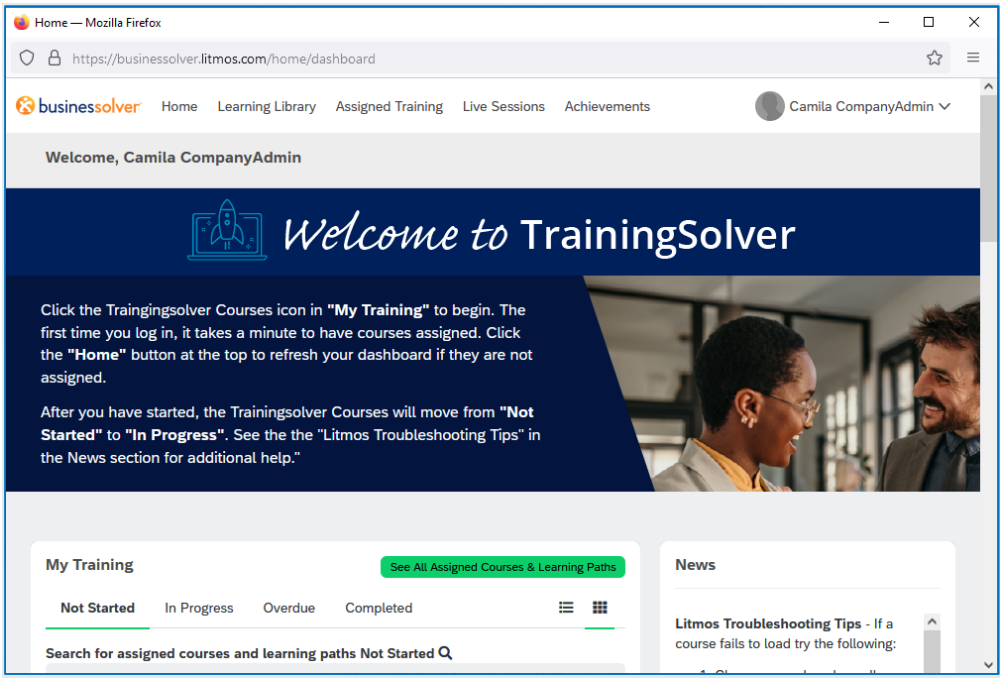
- Log in to Benefitsolver in Production, not a testing site such as the the UA or QA environments.



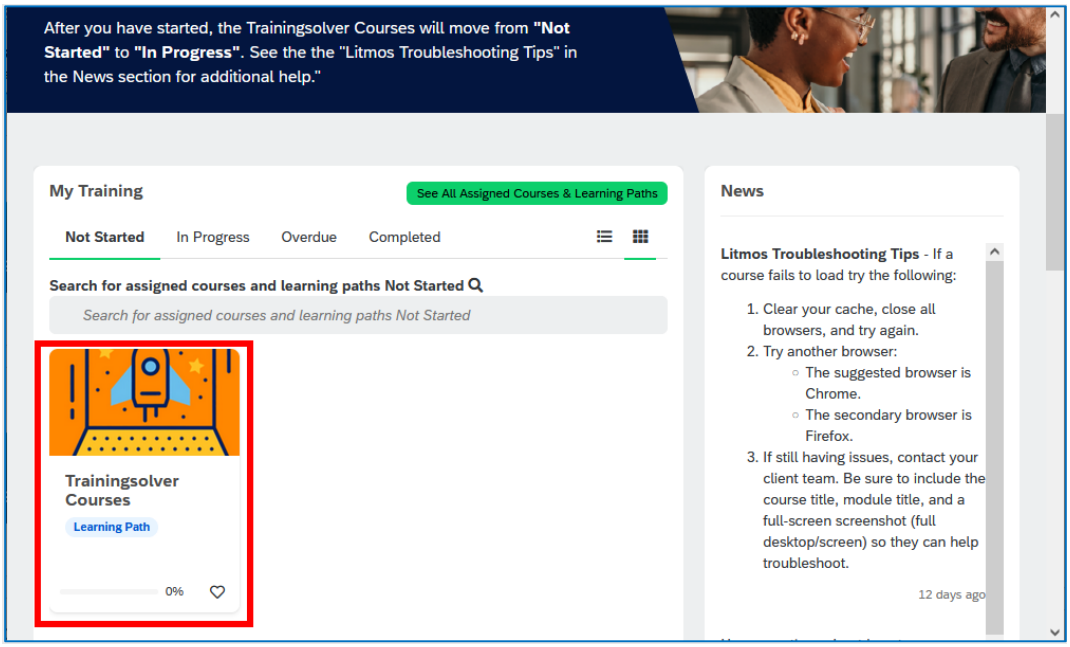
- Click the **Trainingsolver** widget from your admin home page.



- The pop-up will log you into the Trainingsolver learning environment, powered by Litmos LMS. This is a 3rd party LMS and you may find references to Litmos throughout the platform.

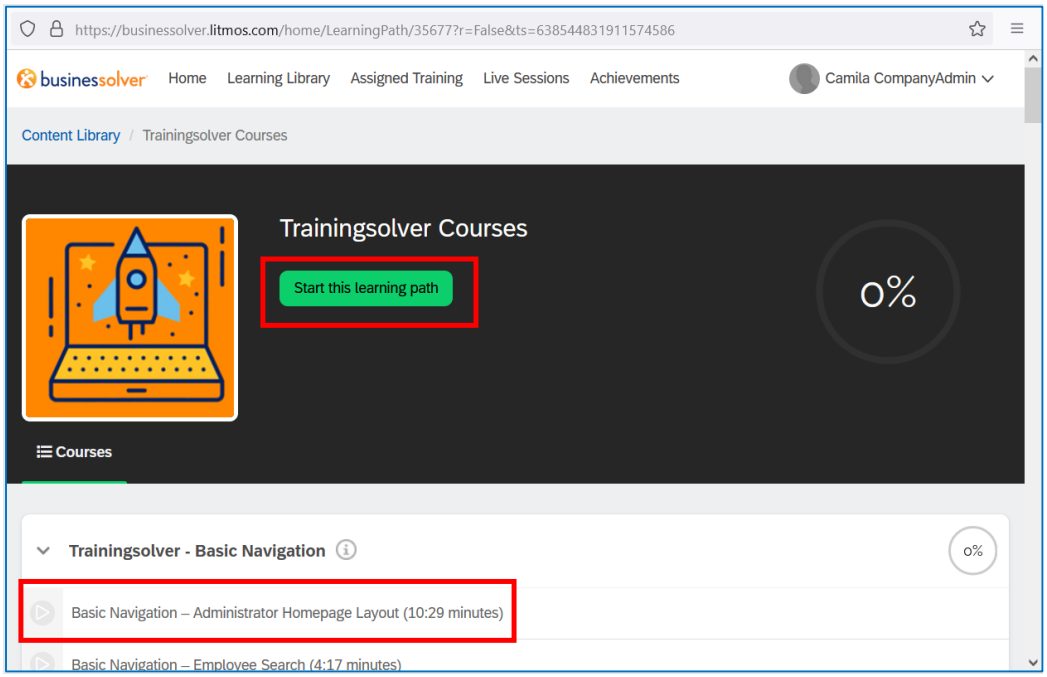


- Scroll down to **My Training** and click the **Trainingsolver Courses** icon to get started.



IMPORTANT NOTE: The first time you log in it may take a minute to assign the course. If they do not display right away, click the word **Home** at the top of the pop-up window to refresh the page.

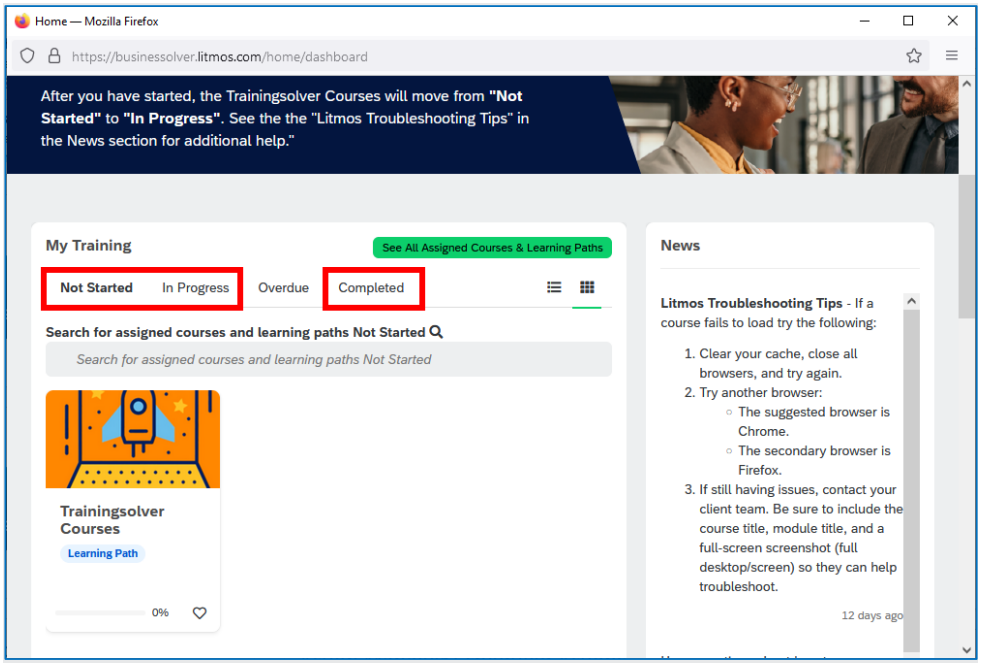
- Click the "**Start this learning path**" or scroll down to a specific course and click on the first module to begin.



- Complete a course by completing each module in order.

(scroll down to continue to next page)

- Once you have started a course, the Trainingsolver Courses icon will move from **Not Started** to **In Progress** within the **My Training** widget of the homepage. When all courses are complete, you can still access them under **Completed**.



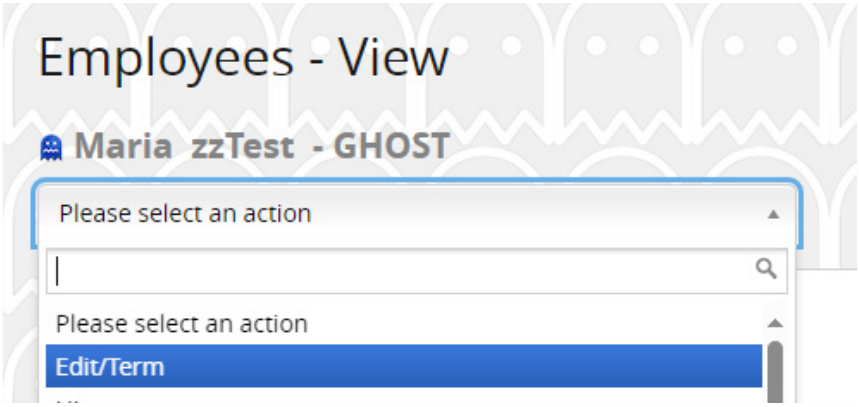
Trainingsolver Course List

- Trainingsolver - Basic Navigation
- Trainingsolver - Tools & Resources
- Trainingsolver - Basic Administrator Functions
- Trainingsolver - Advanced Administrator Functions
- Trainingsolver - Reporting
- Trainingsolver - Billing
- Trainingsolver - Payroll
- Trainingsolver - Layout Manager
- Trainingsolver - COBRA
- Trainingsolver - Data Flow
- Trainingsolver - MyChoice Accounts
- Trainingsolver - ACA
- Trainingsolver - Verification Services

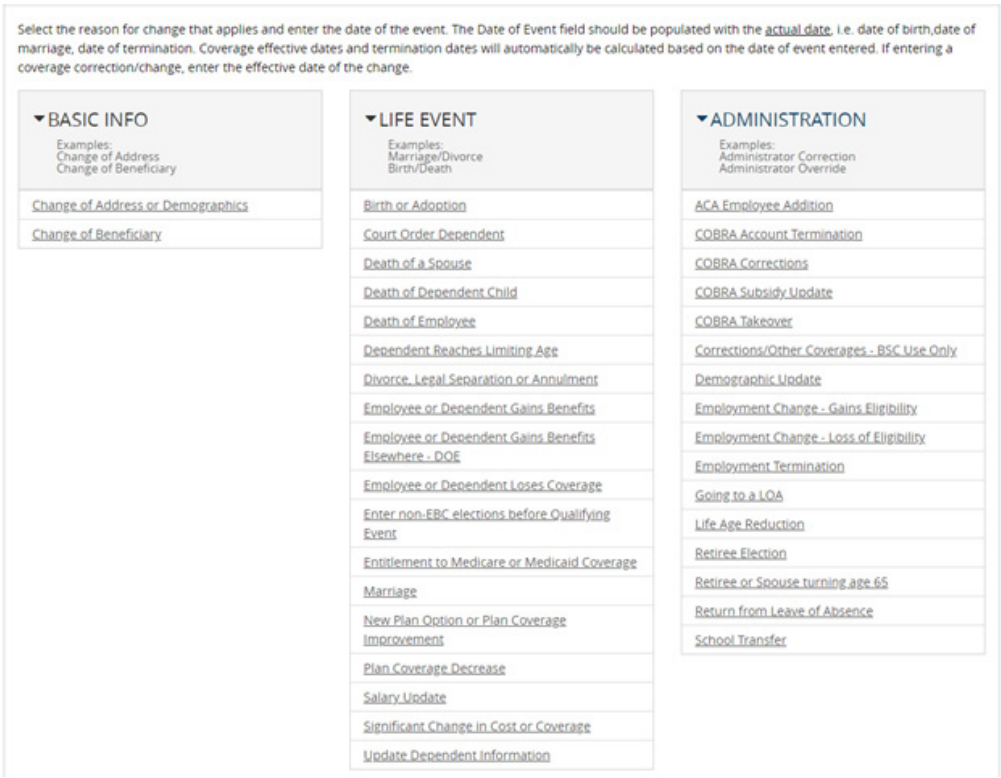
CULTURE. INNOVATION. FOCUS. QUALITY. We have your back. Enjoy your learning journey!

EDIT/TERM BARS

Edit/Term allows an administrator to update an employee's record using a variety of menu options referred to as Benefit Access Rules (BARs).



Benefit Access Rules (BARs) are viewable based on role, access level and window of time allowed to process each option. Each option requires a date to begin the process. This date will determine if the transaction is occurring in the appropriate timeframe and will also drive the effective date or termination date for the transactions (as determined by EBC and/or the district's eligibility rules).



BENEFIT ACCESS RULES

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Event	Days Prior to Event	Days as of Date of Event*
Birth or Adoption	0	31
Court Order Judgement Decree	0	31
Marriage	0	31
Divorce, Legal Separation or Annulment	0	31
Death of Employee	0	31
Death of Spouse	0	31
Death of a Dependent Child	0	31
Significant Change in Cost of Coverage	15	31
Employment Change - Loss of Eligibility	15	31
Unpaid Leave of Absence	15	31
Newly Eligible Enrollment	30	31
Enter non-EBC elections before Qualifying Event	30	Anytime
Dependent Reaches Limiting Age	30	60
Employee or Dependent Gains Benefits	30	31
Employee or Dependent Loses Benefits	30	31
Retiree or Spouse turning age 65	30	100
Entitlement to Medicare or Medicaid Coverage	30	60
School Transfer	30	60
New Plan Option or Plan Coverage Improvement	31	31
Life Age Reduction	31	60
Life After One Year	31	31
Plan Coverage Decrease	31	31
New Hire Enrollment	45	31
Rehire Enrollment	45	31
Employment Change - Gains Eligibility	60	31
Retiree Election	60	60
Return from Unpaid Leave of Absence	60	31
Employment Termination	90	31
Change of Address	Anytime	
Change of Beneficiary	Anytime	
Demographic Update	Anytime	

***Note:** The actual date of the event counts towards the 31/60/100 days.

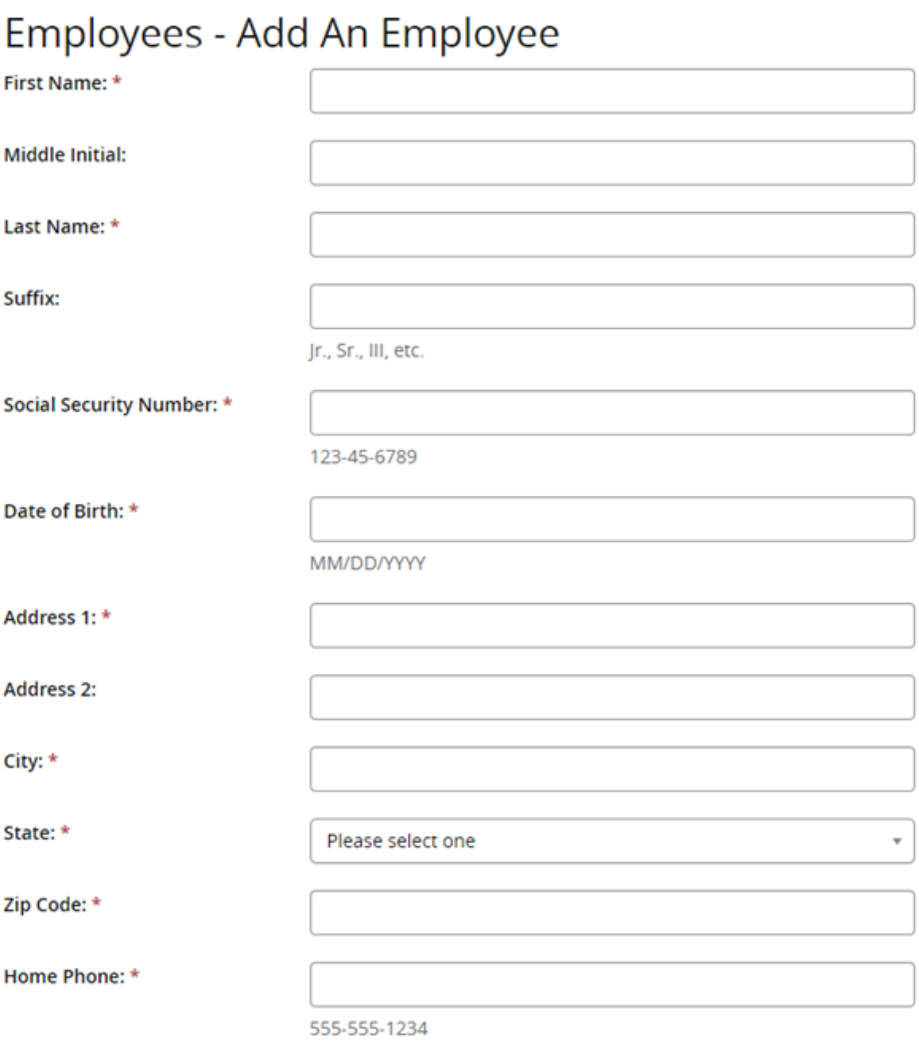
HOW TO ADD A NEW EMPLOYEE

Click on “Employees” menu and select “Add Employee”.

Note: All benefit eligible employees should be captured in BenefitSolver.

Complete the employee demographic information using information provided by the new employee.

Required fields are denoted with a red asterisk. (*)



benefitsolver

The following describes the information needed for the mandatory elections:

Employment Status—Choose: Active Military—Overseas, Active Military—USA, Full-Time, LOA, Part-Time, Retired, or Terminated

Structure—This will vary for each district; with the minimum structures including Active and COBRA groups

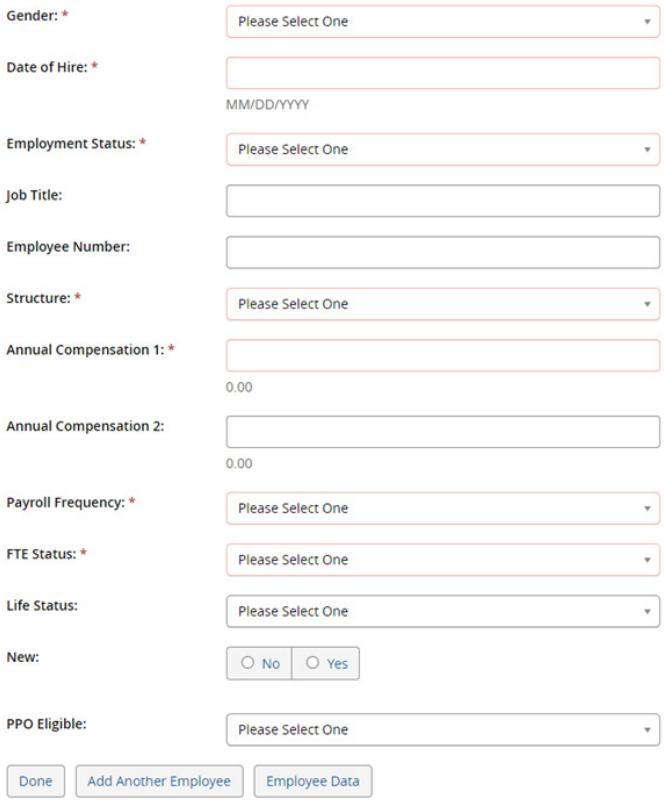
Annual Compensation—Enter the employee's annual salary.

Note: This should be updated in Businessolver at least once a year, especially for districts with a Basic Life Insurance benefit based on salary.

Payroll Frequency—Select the payroll cycle applicable to the employee. For districts that are self-serve (employees enter their own elections), it will accurately show what the deductions from his/her pay will be.

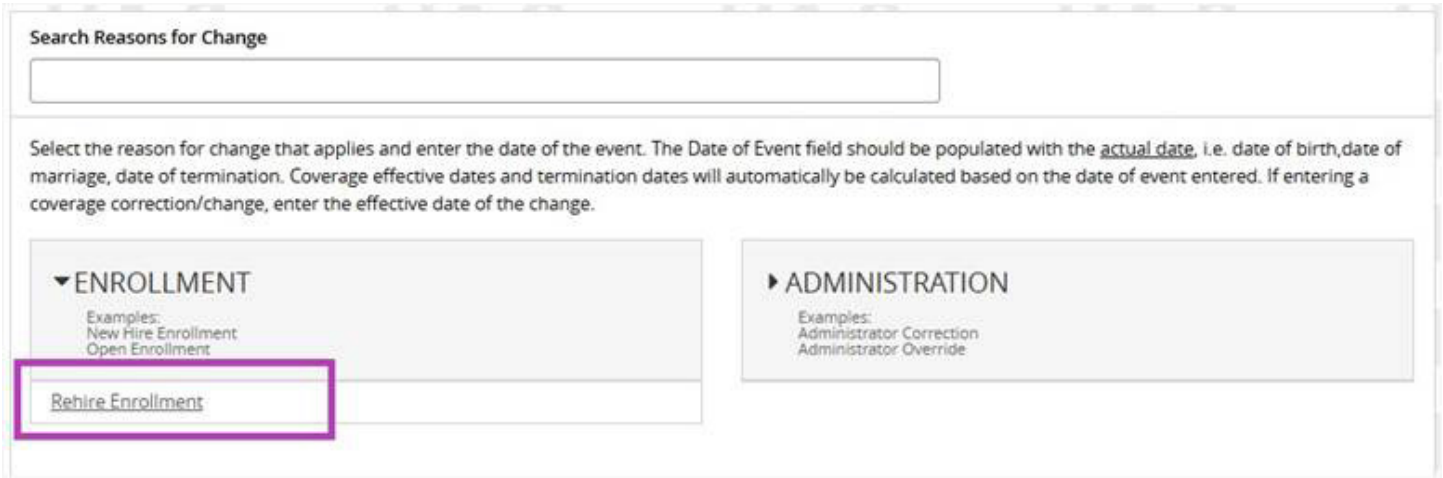
FTE Status—Select NONE

Click "Add another Employee" to add more employees or "Done" to save the new employee.



HOW TO REHIRE AN EMPLOYEE

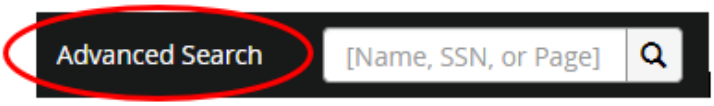
Please use the Rehire Enrollment event instead of the Demographic Update event when an employee is returning to work for the district (see screenshot below). Using the Rehire Enrollment event type will allow you to make the necessary record updates based on the employee's return (e.g., changing Structure Group, new annual salary, etc.), and will ensure the proper fields are updated to trigger the New Hire Enrollment event for the employee.



PENDING EOI REVIEW: HOW TO APPROVE/DENY FOR VOLUNTARY LIFE PRODUCTS (SELF-SERVE DISTRICTS)

Elections over the Guaranteed Issue (GI) amount and elections made after the newly eligible period has expired are automatically set to a Pending EOI status.

Note: You should NOT begin employee deductions for any amount over the GI until the approval/denial letter is received from the carrier.



How to Search for individuals pending EOI:

From the Admin Home page, go to the upper right hand corner and click on the words “Advanced Search”

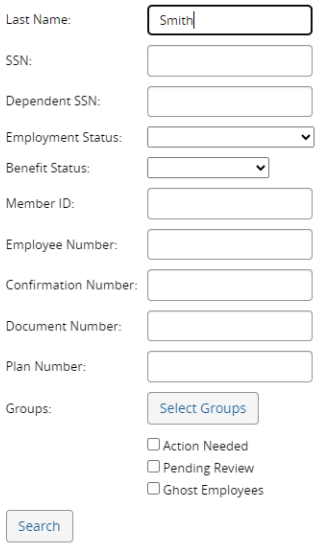
On the advanced search page, you have the option to search for an individual employee or search for ALL employees at the district who have pending EOI.

SEARCH FOR AN INDIVIDUAL EMPLOYEE:

- Type in the last name of your employee that you received the EOI Approval or Denial on.
- Once you’ve keyed in the last name, go to the bottom of the screen and place a checkmark in the box next to “Pending Review”.
- Click Search.
- On the next page the one employee searched will appear.

SEARCH FOR ALL EMPLOYEES PENDING EOI (RECOMMENDED FOLLOWING OE):

- Go to the bottom of the screen and place a checkmark in the box next to “Pending Review”.
- Click Search.
- On the next page all employees pending EOI will appear.



Note: If the member has multiple pending elections (i.e. pending Voluntary Life and Voluntary Spouse Life), you will see both benefits appear on the next screen after you’ve clicked Search.

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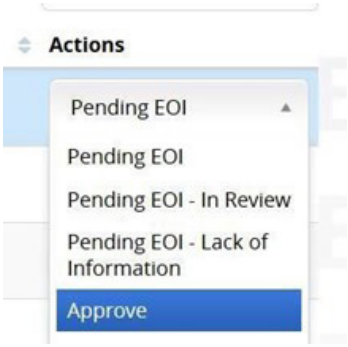
How to change the status of to Approve or Disapprove

- Locate the pending transaction line for the coverage you've received an Approval or Denial (Disapproval) on.
- Once you locate the pending transaction line, review the "Eff Date" to confirm it is correct (usually this is the 1st of the month following approval).
- If the effective date line is not correct, manually adjust/change it.
- Next review the Coverage/Elected amounts to confirm these match the letter you received from Reliance.
  - » If it matches, move over to the Actions drop down menu.
  - » If the Coverage/Elected amounts do not match your letter, please stop and go to the member's record. Create a case to the 4.1 Service Team at Businessolver to review and help adjust. Please attach the letter you received from the carrier so the team can assist.



Changing the status to expired:

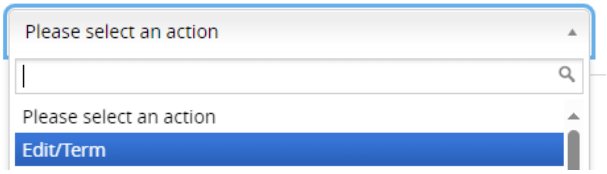
- If an employee has not completed their EOI application after 90 days from when they initially applied for coverage, the transaction status should be changed to Expired.

PROCESSING A LEAVE OF ABSENCE

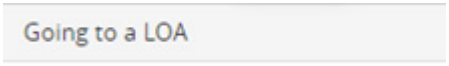
When an employee is not actively at work or receiving pay but it still employed by the district, it is important to process a "Going to a LOA" event in the Benefitsolver platform.

How to process a Leave of Absence

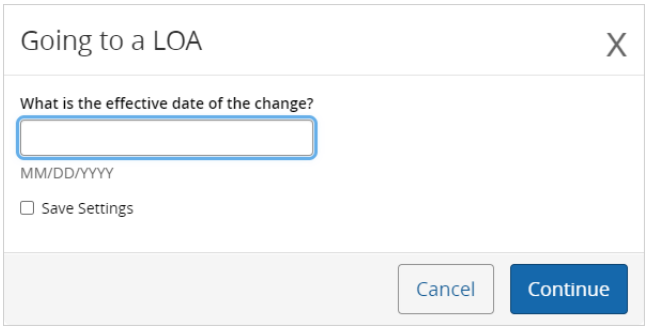
Step 1: From the employee's record, locate "Please select an action" and drop down to "Edit/Term".



Step 2: Next go to Administration, then click on the BAR titled "Going to an unpaid LOA".

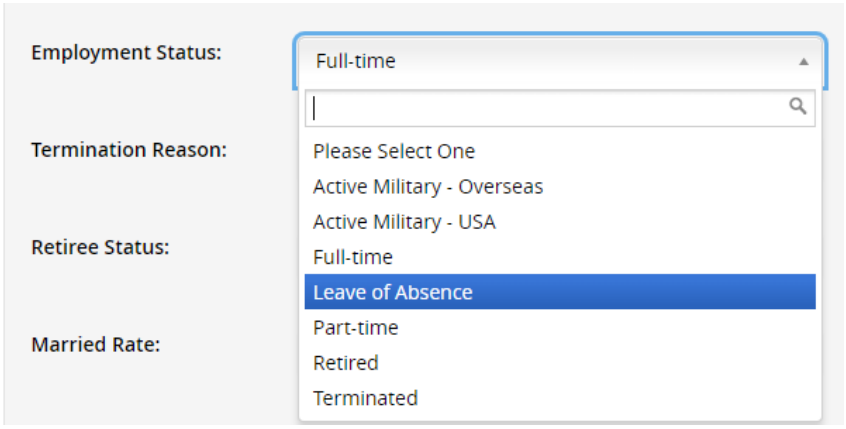


Step 3: In the next screen, enter the date the employee will go on unpaid LOA and click Continue.



Note: Your standard plan termination rules will apply.

Step 4: Go to Employment Information, click Edit. Drop down to the employee's employment status to change the status to Leave of Absence. Go to the bottom of the screen, click Next.



benefitsolver

Step 5: After your employee's employment status has been updated click "Edit" next to all benefits that the employee loses. Coverage will term once you waive the election(s).

Step 6: Finally click Approve.

Step 7: After you've approved complete the Cobra screen will appear.

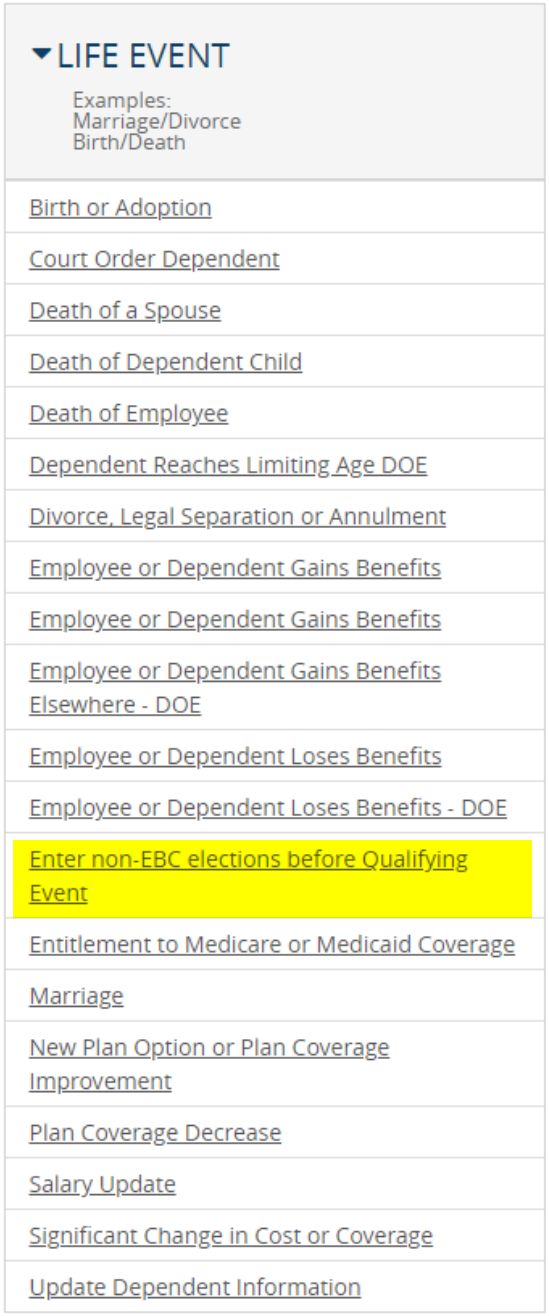
- Please select Reduction of Work Hours as the event
- Enter the date of event and then put a check mark next to all eligible recipients of the Cobra offer (any dependent that would have been covered on Medical, Dental or Vision).
- Click Next to complete the transaction.
  - » The employee should receive his/her Cobra QLE, if applicable, in the next 7-10 business days.

TERMINATING EMPLOYEES

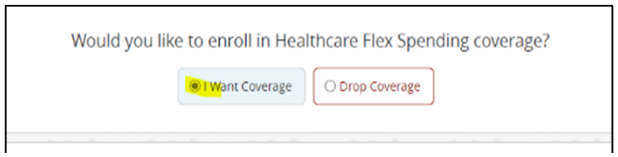
Note: Unless your district has implemented a file feed between Businessolver and the carriers for your Non-EBC pooled lines, you are responsible for terminating employees in both the carrier's enrollment site and in BenefitSolver.

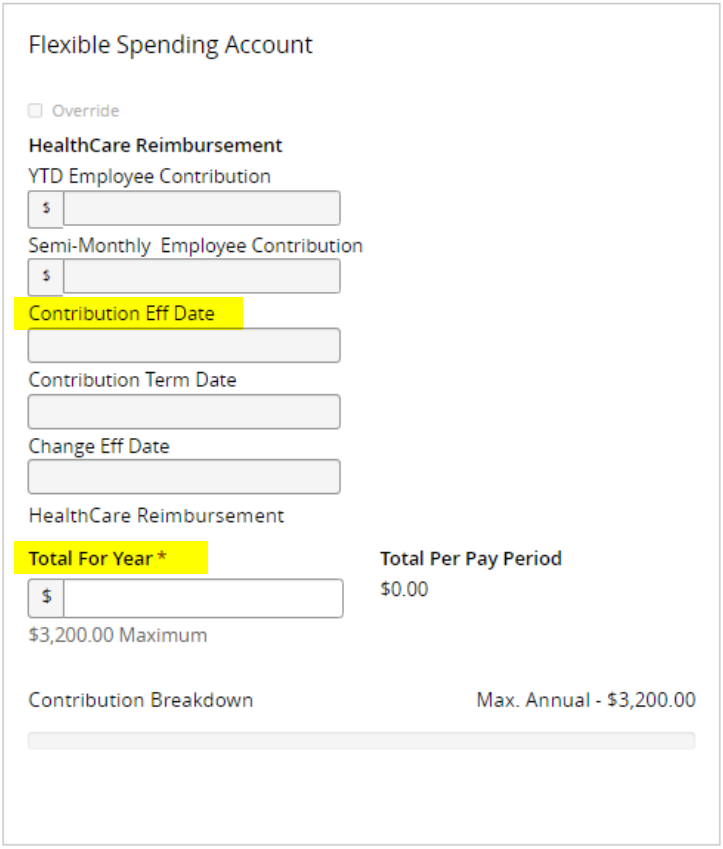
For districts with Healthcare FSA – If you have a termination and an FSA election was not entered through the OE BAR, you will need to add this to the member's record by processing it as a qualifying life event prior to completing the Employment Termination transaction. **If this does not apply to your district, you can move to the termination instructions on the next page.**

The process starts by selecting **"Enter non-EBC elections before Qualifying Event"** and electing the FSA plan, then the district can process the Employment Termination transaction.

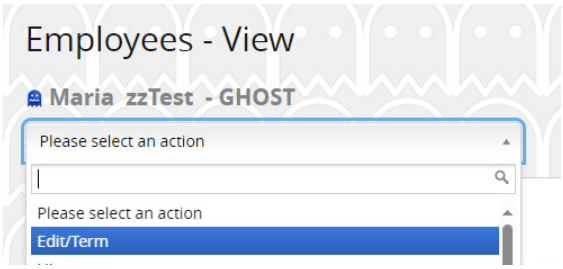


The recommendation is to enter the effective date of coverage based on the district's plan year (e.g. 1/1, 7/1, 9/1, etc.) then the participant's annual goal amount.





To begin the Employment Termination transaction, Select Edit/Term from the action dropdown menu on the employee record.

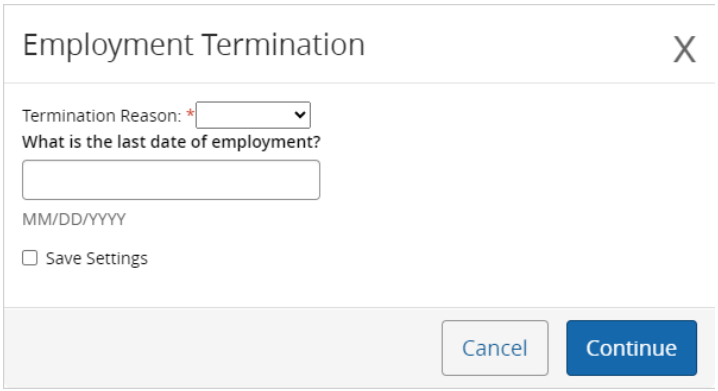


Select Employment Termination from the Administration menu.

Select the appropriate Termination Reason from the dropdown menu:

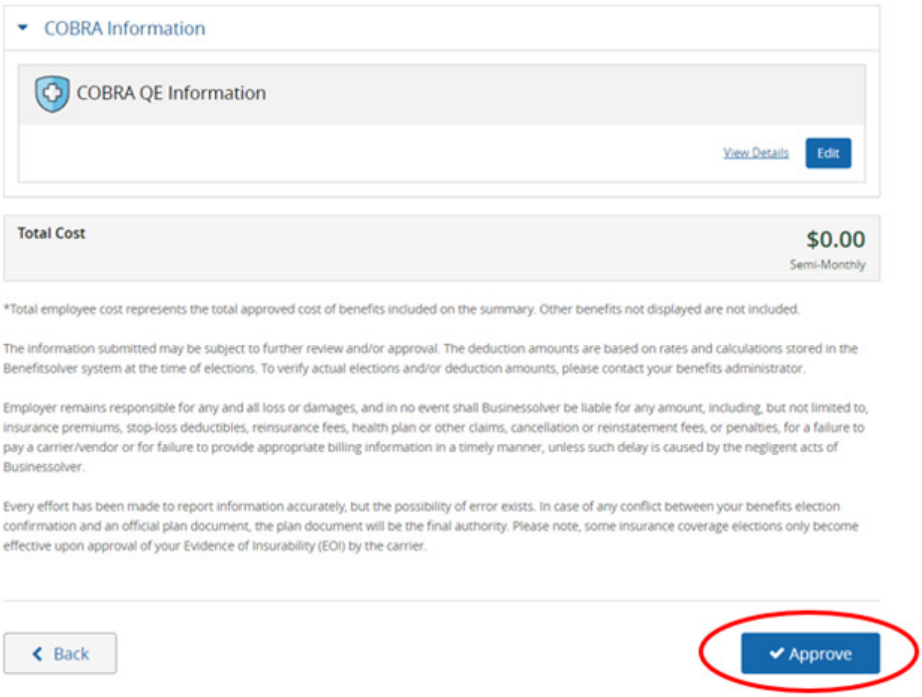
- **Voluntary:** Employee/member initiated termination process
- **Involuntary:** Employer initiated termination process

Enter the last date of employment. Benefits will terminate per your district's termination rules.

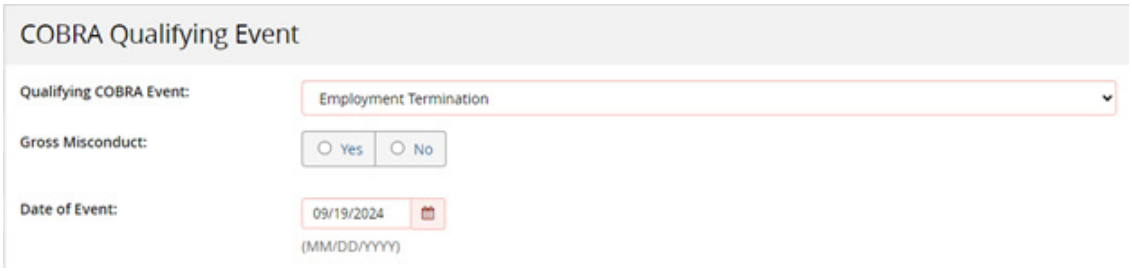


You will be directed to a Review Enrollment page. Confirm that the information in the Date of Termination and Employment Status fields are correct. If everything looks correct, click Approve.

Note: Do not click Edit under COBRA QE information.

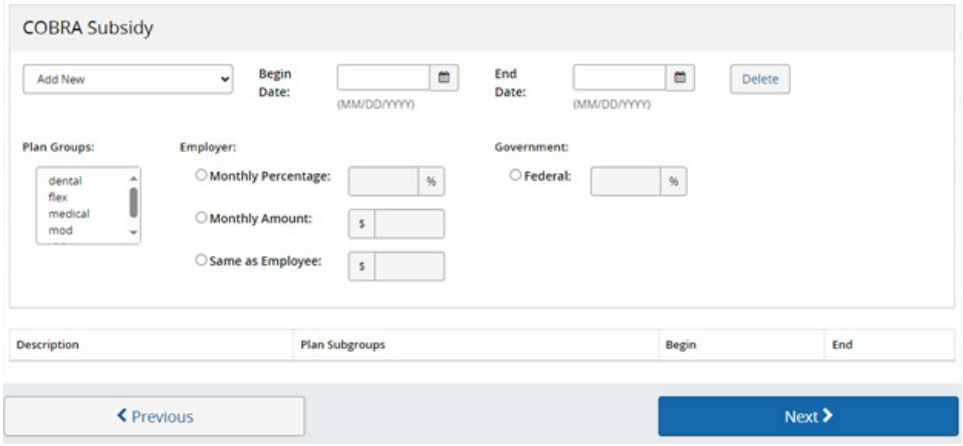


After you click Approve you will be redirected to the COBRA Qualifying Event Page



Review the information and click Next to complete the Employment Termination transaction.

Businessolver will send a COBRA Qualifying Event Letter to all COBRA eligible employees/members.



RETIREE PROCESS

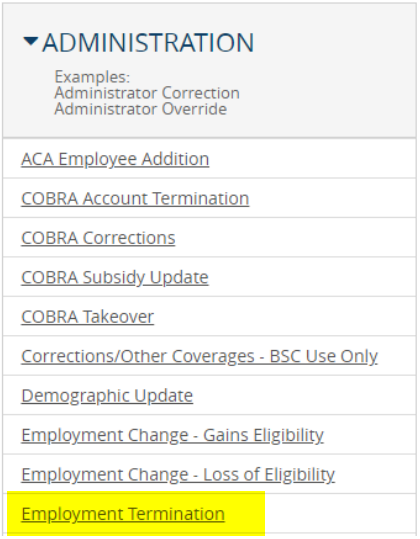
If an employee is **retiring and enrolling in coverage through the district** (not COBRA), the following steps MUST be taken to ensure the member is placed in the correct structure.

Note: This step only applies if continuation of coverage directly through the district is offered to Retirees. If the district does not offer a continuation of coverage directly with the district, this process does not apply.

Complete the Employment Termination Benefit Access Rule (BAR) by entering the last day of work and Benefitsolver will drop all the active benefits according to EBC rules.

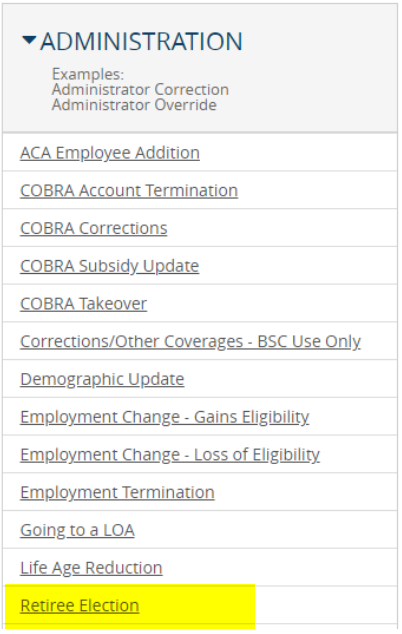
Click Approve.

Note: Benefitsolver will send a COBRA packet to the employee and affected dependents



Next, process the Retiree Elections Benefit Access Rule (BAR).

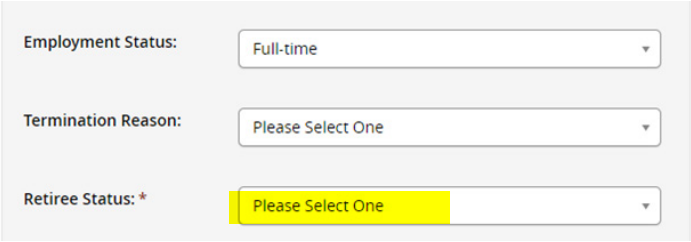
The Administrator may enter the same date as the employee's date of termination.



In Employment Information, edit the field for Retiree Status to reflect the age(s) of the retiree and/or spouse if covered on the plan. The drop down box options to choose from are:

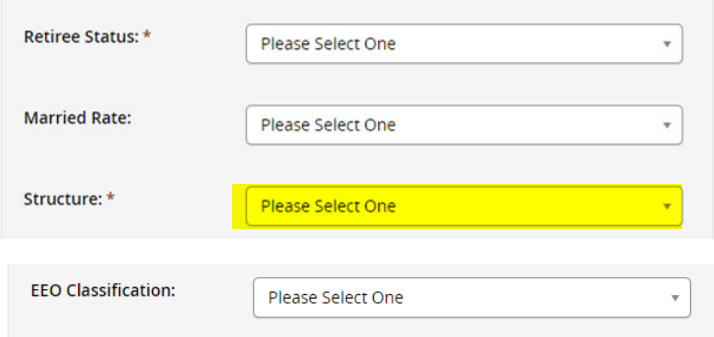
- Both Under
- Both Over
- EE Over/Spouse Under
- EE Under/Spouse Over

Note: This field MUST be populated correctly to drive the correct pricing.

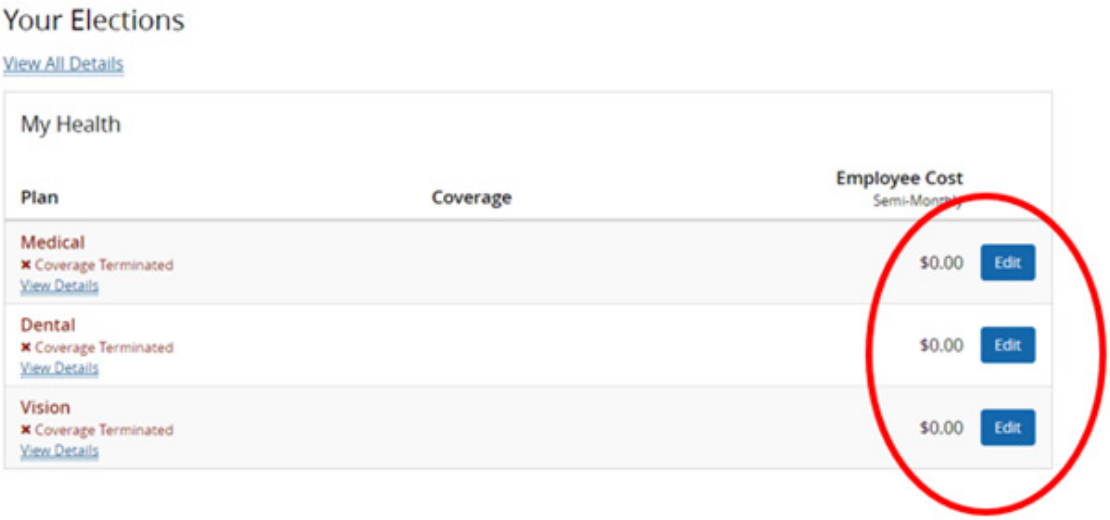


On the same **Employment Information** page, edit the Structure by using the drop down and selecting the structure that the employee belongs.

Then, select the applicable FTE status before hitting 'Next' at the bottom of the page.



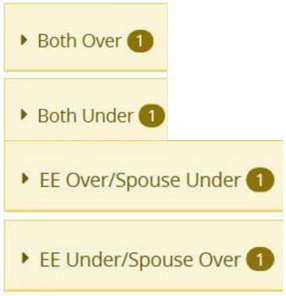
Under **Election Information**, click Edit to add the line(s) of coverage the retiree is electing. Districts are responsible for collecting the money from the retiree to pay for benefits. If there are any changes to the plan or increases in premium, districts should contact the retiree to let them know.



Retiree Rates

Retiree rates can be located in the plan info section of Benefitsolver.

- To locate the rates click on Benefits on the menu bar, then select **Plan Info** from the drop down menu.
- Once in **Plan Info**, select the plan for which you would like to review the rates.
- Select the retiree plan by locating (Plan Name) – Retiree.
- Once in the Retiree plan the different rates for that specific plan will be located under the appropriate header in respect to the age of the members (Are they over or under 65 years?) Both Over, Both Under, Employee Over/ Spouse Under or Employee Under/Spouse Over.



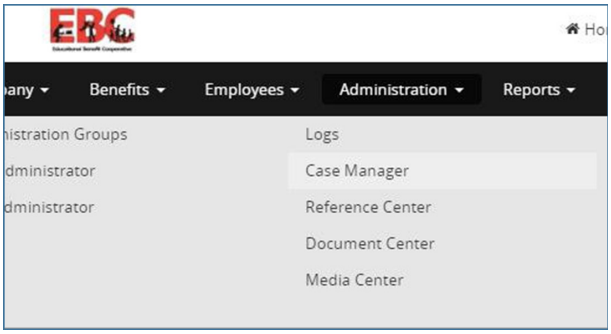
CASE MANAGER

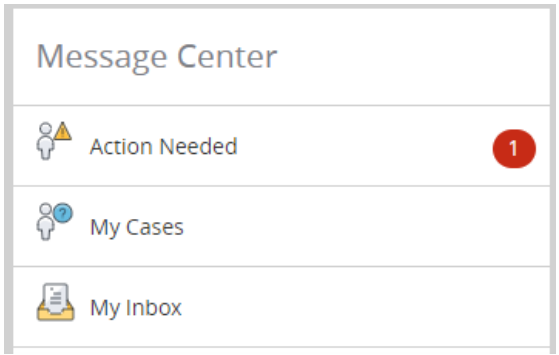
If you require Businessolver to update an employee's record (because you are unable to); or, if you have any questions about the record, you can use Cases as a secure and safe way to contact Businessolver.

Cases are also a way to add notes to a member's record as well as to upload related documents or links.

There are three ways to view cases:

1. **Case Manager:** Click on Case Manager from the Administration menu in the Basic Navigation Toolbar within Benefitsolver. This will take Administrators to all open cases assigned to "you" or that "you" have assigned to others. Once a case has closed, it will drop off of this list. The Administrator will be able to filter for all closed cases, if needed.
2. **Message Center Widget (homepage):** Administrators can view all open cases in the Message Center/Action Needed section located on the homepage in Benefitsolver. While cases may be created directly in an employee's record (View Creating Employee Cases for more information), the administrator may view assigned cases in Case Manager.
3. **Individual Employee Records:** (View Creating Employee Cases page for more information)





Reviewing Cases that are Assigned to You

If you are assigned a case in BenefitSolver, please review the case and respond with any missing information and respond as necessary.

Note: Benefit Administrators will receive an email notification when a new case is assigned to them.

To view the notes in a case that was assigned to you, click the post-it note icon on the right side of the case.

- Review Notes and add additional details (if needed)

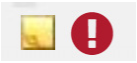
If you need to respond to a case:

- Click "Add a Note" to update the following fields
  - » Status
  - » Due Date
  - » Assigned To
  - » Originating Source
  - » Description
  - » Attach a File URL (Optional)

Note: Assign the case to the person or team who initially issued the case to you.

Creating Employee Cases

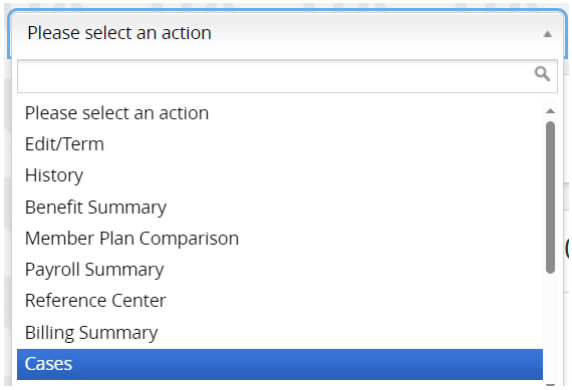
Cases are safe locations to house employee/member level data, forms, authorizations, as well as secure communication routes between administrators, Businessolver personnel and brokers. Members/employees do not have access to view these notes from the employee/member search function. Note, employee/member with open cases will have the envelope with the red exclamation and members with resolved cases will only display the envelope icon. All cases will remain on the employee/member's record.

 Member Case Needs Action

 Member Case(s) are resolved

HOW TO CREATE A CASE

1. Access the Member's Record
2. Click the drop down menu and click Cases
3. Click **Create Case**
4. Complete any field that has a red asterisk (*)



- Reason/Disposition
- Status
  - » **Status Options**
    Action Needed - For assignor when opening & assigning a case
    Working - For assignee when actively working on the case
    Waiting Client - For assignee when pending client
    Waiting Vendor - For assignee when pending vendor
    Resolved - Note the case is Closed/Completed
    Resolved - 1st Call - For service center representatives to store phone call notes
    Resolved - Approval - For administrators to note when a case is Closed & decision was Approved
    Resolved - Denial - For administrators to note when a case is Closed and decision was Denied
- Due Date
- Assigned To
  - » **Note: Assign Cases to 5.1 Service Team**
- Originating Source
- Description –
  - » **Note:** The Description option of the case allows the person creating the case to utilize free form text to explain the case as detailed as possible. This function may also be utilized to fill in any necessary information that cannot be fully explained in the drop down menus as well as to give any special instructions to the assigned administrator.

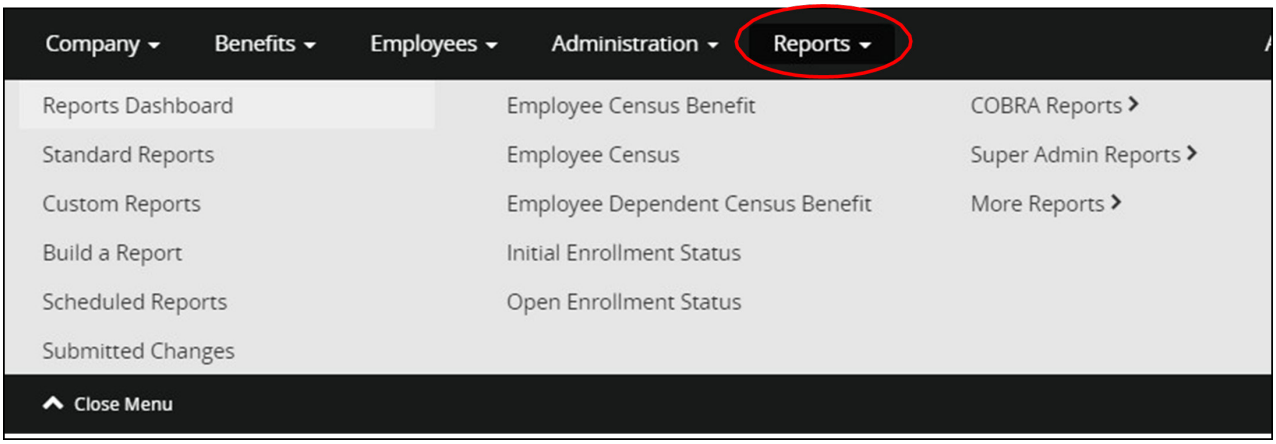
5. **CLICK SUBMIT**

benefitsolver

REPORTS

Businessolver gives Administrators access to numerous reports that can assist with the administration of benefits. Administrators can generate standard reports and also build custom reports with specific information.

The different reporting options are accessible through the toolbar under the **Reports** tab.



Frequently Used Standard Reports

EMPLOYEE CENSUS BENEFIT

All active/terminated employees with an election record of one or more benefits will display in the report. Employees in Benefitsolver with no benefit elections will not display. An employee that has a DOH after the "To" date will not be included in the report. Click on the "Advanced" link to modify which fields to include in the report.

EMPLOYEE DEPENDENT CENSUS BENEFIT

All active/terminated employees and their dependents with an election record of one or more benefits will display in the report. Employees in Benefitsolver with no benefit elections will not display. Anemployee that has a DOH after the "To" date will not be included in the report. Click on the "Advanced" link to modify which fields to include in the report.

OPEN ENROLLMENT STATUS

Review the Annual/Open Enrollment status for each employee.

PAYROLL DEDUCTION CHANGES (HELPFUL AFTER OPEN ENROLLMENT)

Enter date range to review any changes on employee records that affect coverage effective dates, cancellations, and tier changes.

PAYROLL DEDUCTION AUDIT AND PAYROLL DEDUCTION AUDIT (FUTURES)

Enter date range to review payroll deductions for elected benefits. When running the report prior to the open enrollment effective date, use the Payroll Deduction Audit (Futures) report and enter the effective date in the "To:" field. When running the report after open enrollment, use the Payroll Deduction Audit report enter the effective date in the "From:" field.

MAXIMUM STUDENT AGE (IDENTIFY MAX AGED DEPENDENTS)

Enter date range to display over-age dependents enrolled in coverage.

COBRA ACTIVITY REPORT (IDENTIFY COBRA ENROLLEES)

DEPENDENT OVER AGE 26

Military Dependents over the Age of 26

Military Dependents can qualify to remain on the plan to age 30 if each of the following criteria are met:

1. Be unmarried.
2. Live within the state of Illinois.
3. Have served as an active or reserve member of any branch of the Armed Forces in the U.S.
4. Have received a release or discharge other than a dishonorable discharge.

The process of adding or maintaining coverage for a military dependent that is over the age of 26 is as follows:

1. Obtain a copy of the military dependents DD 214.
2. Create a case on the member's (parent) record in Benefitsolver, attached the DD 214, and assign to your Gallagher Account Manager.
3. Gallagher will work with your carriers for approval, then notify Businessolver of the eligibility change.

Disabled Dependents over the Age of 26

Disabled Dependents can qualify to continue coverage past the age of 26 if enrolled in the plan prior to their 26th birthday.

To cover a disabled dependent the employee must notify the district of the disabled dependent *prior to the dependent's 26th birthday*.

The process is as follows to request coverage for a disabled dependent:

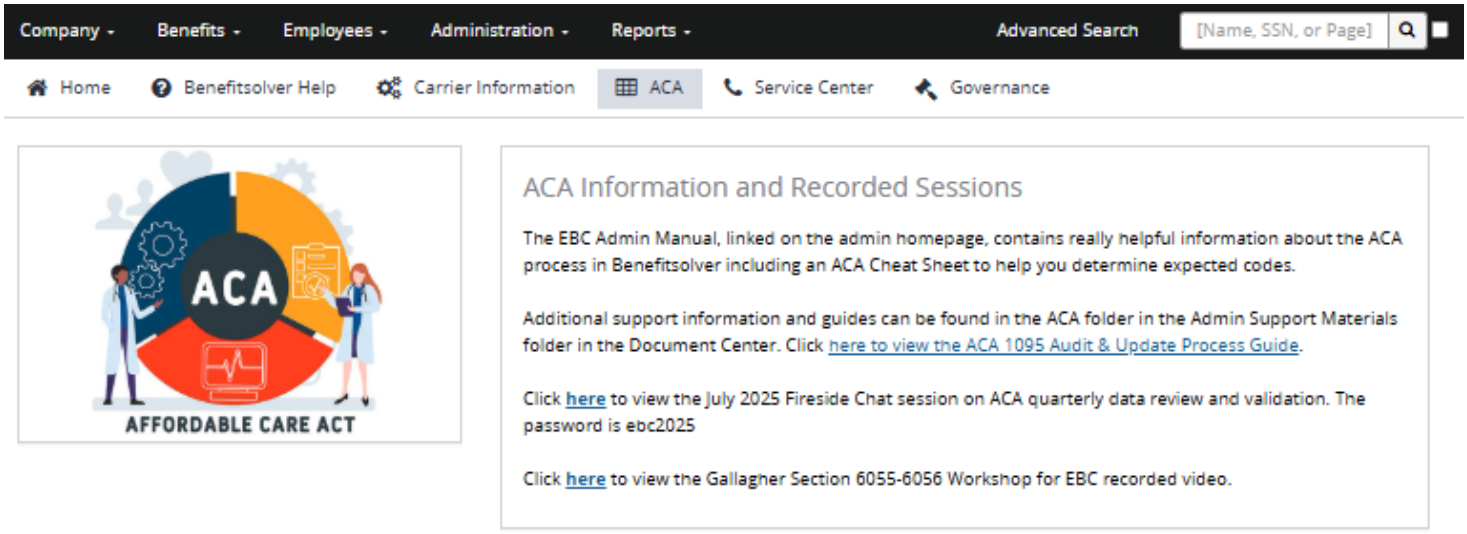
1. District request BCBSIL Disabled Dependent Certification form from Gallagher Account Manager.
2. District provides form to employee.
3. Employee and Dependent's doctor complete form and submit it back to district.
4. District sends completed form to Gallagher Account Manager via a case in Businessolver.
5. Gallagher Account Manager sends the form to BCBSIL for approval.
6. If approved, Gallagher will notify Businessolver to change the dependent's status.
7. The employee will receive a letter at their home regarding the request as well.

If you have any questions, please contact your designated Gallagher Account Manager.

ACA OVERVIEW

ACA Reporting Training

Training on ACA reporting is available in BenefitSolver. Administrators can be view recorded sessions that will guide them through the ACA data review process and ACA coding.



ACA Reports

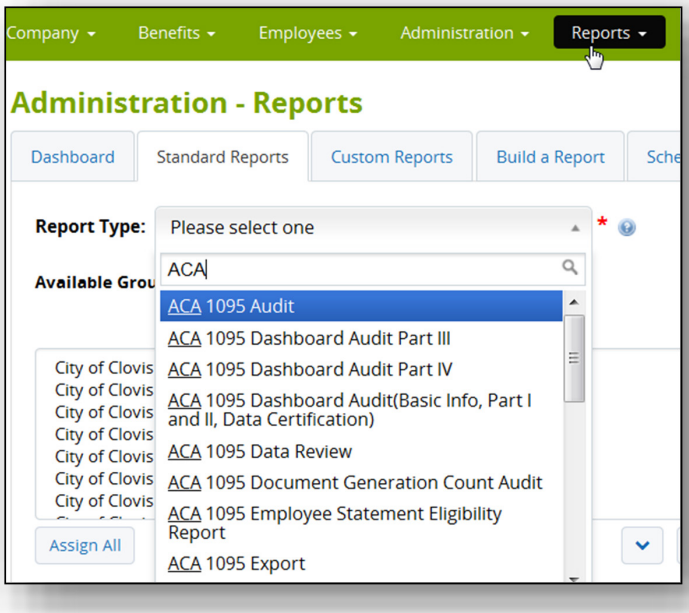
The ACA Suite of Reports is extensive in Benefitsolver. With the nature of the IRS regulations, the reporting functionality may increase. To assist with essential reports, listed below are applicable ACA-driven reports EBC administrators may prefer to review.

Note: Some reports may be focused on the 1095-C Form transmissions with coding.

Under Reports > Standard Reports > Report Type box: Type in ACA to find a list of available ACA reports.

EBC REPORTS

- ACA 1095 Audit
- ACA 1095 Export



Updating Employees' ACA Data

OPTION 1: ACA 1095 EXPORT REPORT

Administrators can make edits directly in the 1095 Export report and request that Businessolver import the corrections utilizing the 1095 Export report. Districts that utilize the 1095 Export report to make edits to their ACA data are required to submit the report to Businessolver by the due date provided by Businessolver.

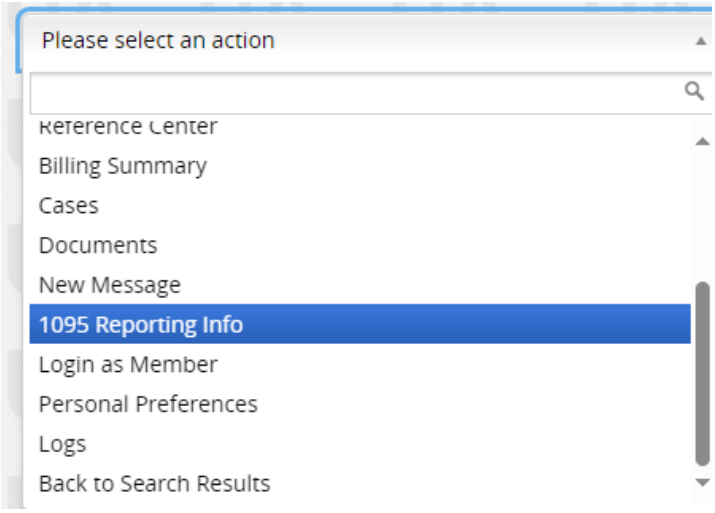
To access the 1095 ACA Export report, complete the following steps:

1. Click on "Reports" from the Menu bar and then select "Standard Reports".
2. Under "Report Type", select "ACA 1095 Export"
3. Next, bring down or assign your structure groups/locations.
4. At the bottom of the screen, enter the date range you are auditing. For example, the From Date is entered as 01/01/2018 and the To Date can be entered as 03/31/2018 to audit the 2018 1st quarter data.
5. After the above steps are completed, click Generate Report at the bottom.
6. Your report will queue and finish up in the "Report Dashboard" Click on the "Report Dashboard" tab, the status will update to Completed as soon as the report is available for you to download.

OPTION 2: EMPLOYEE 1095-C EDIT FEATURE

Administrators can edit an employee's ACA data by utilizing the Edit feature found in every employee's account. Employee ACA data is located in the employee record.

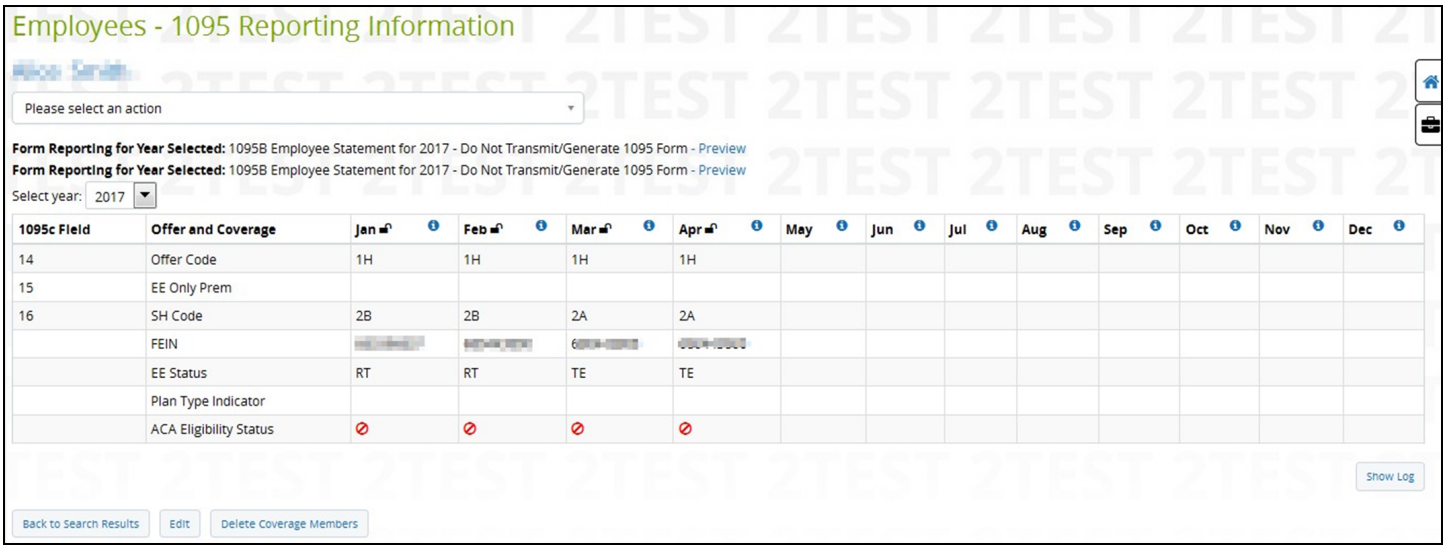
To get to an employee's ACA data, click on the drop down menu that states "Please select an action" drop then go to the **1095 Reporting Info**.



The Employee's 1095 Reporting Information will list all reporting data month by month for the identified year.

Administrators may edit the monthly data by utilizing a drop down box with eligible options for each of the below fields:

- Offer of Coverage Code
- Minimum Premium
- Safe Harbor Code
- Location FEIN association
- Employee's Status



Note: The system is currently setup to default to a 1E Offer of Coverage code (unless you are a self-serve district) and 2C as the safe harbor code if an employee accepts coverage. The employee only premium listed in line 15 is the lowest "Employee only" monthly premium of all the plans your district offers.

Important: The premium amount will have to be edited to reflect the actual lowest monthly offer the employee would pay after Board contributions are taken out. Businessolver can import the monthly premium if your district identifies the groups of employees that have the same contribution amount.

Sample test scenarios that should be reviewed:

- Look for a current eligible employee with medical benefits and one who waived medical benefits. Are the codes reporting as you would expect?
- Look for any "UN" codes reporting under the Offer of Coverage and Safe Harbor column. These codes will need to be corrected/fixed before mailing forms.
- Review a terminated employee's codes.
- Cobra Medical enrollee – Please review a Cobra participant that is enrolled in Medical. Are the codes reporting as you would expect?
- Do your employees have the correct employment status listed for each month? For example, if someone termed in October 2017 are you seeing their status reporting as TE? Or, are you seeing their status as FT?
- Do we have your employees' correct SSNs listed?
- Are there any errors on dependents' SSNs on our site? For example, do you have any employees listing their dependents' SSN as 999999999?
- Is the correct FEIN showing for your district?
- Please review the Offer of Coverage, Minimum Premium and Safe Harbor codes for all employees. Are these reporting as you would expect?

ACA CHEAT SHEETS

When reviewing and editing codes for a month an employee only partially worked, be careful about fine distinctions. Keep in mind the following examples:

- **Line 14 Codes:** You can only enter an offer code (such as 1E) for the whole month if you provide coverage for every day of that calendar month. Even if an employee is starting on the second of the month, you cannot use an offer code for that month.
- **Line 16 Codes:**
  - » Code 2A: This code is only used if the employee is NOT employed on any day of the month.
  - » Code 2B: Use this code if a full time employee's coverage is ending because of a mid-month termination.
  - » Code 2C: An employee must be enrolled for each day of the month.
  - » Code 2D: This code is only used if the first day of employment is NOT the first day of the calendar month.
- **Part III, Column (e):** When reviewing an employee's record, ensure the boxes that are checked (signifying the employee and/or dependent had coverage) are for the periods of time the member had coverage for at least one day in the month.

Leave of Absence

Districts can no longer use 1H (No Offer) for the months an employee is on a Leave Of Absence (non FMLA) or becomes ineligible for benefits due to a reduction in hours. This only applies if the individual is still considered to be an employee of the district. When the event occurs and benefits are terminated in Businessolver, a COBRA notice is sent.

- When the employee goes on LOA or becomes ineligible for benefit the offer codes (line 14) should be:
- 1B (member had Employee Only coverage when active)
- 1C (member had Employee and Children coverage when active)
- 1D (member had Employee plus Spouse coverage when active)
- 1E (member had Family Coverage when active)

Line 16 should be:

- 2B (member declined COBRA)
- 2C (member enrolled in COBRA)

HRA Funds in Lieu of Coverage

If your employees are given HRA funds when they waive the district's coverage due to being enrolled on a spouse's or parent's plan, you MUST request proof of other coverage. See below for codes.

- Line 14 and 16 will remain as 1E (offer) and 2F or 2H (depending on how your district determines affordability)
- Part III of the 1095C Form will show as the employee having coverage for the months the employee is enrolled in a spouse's plan. This will have to be manually updated in Businessolver.

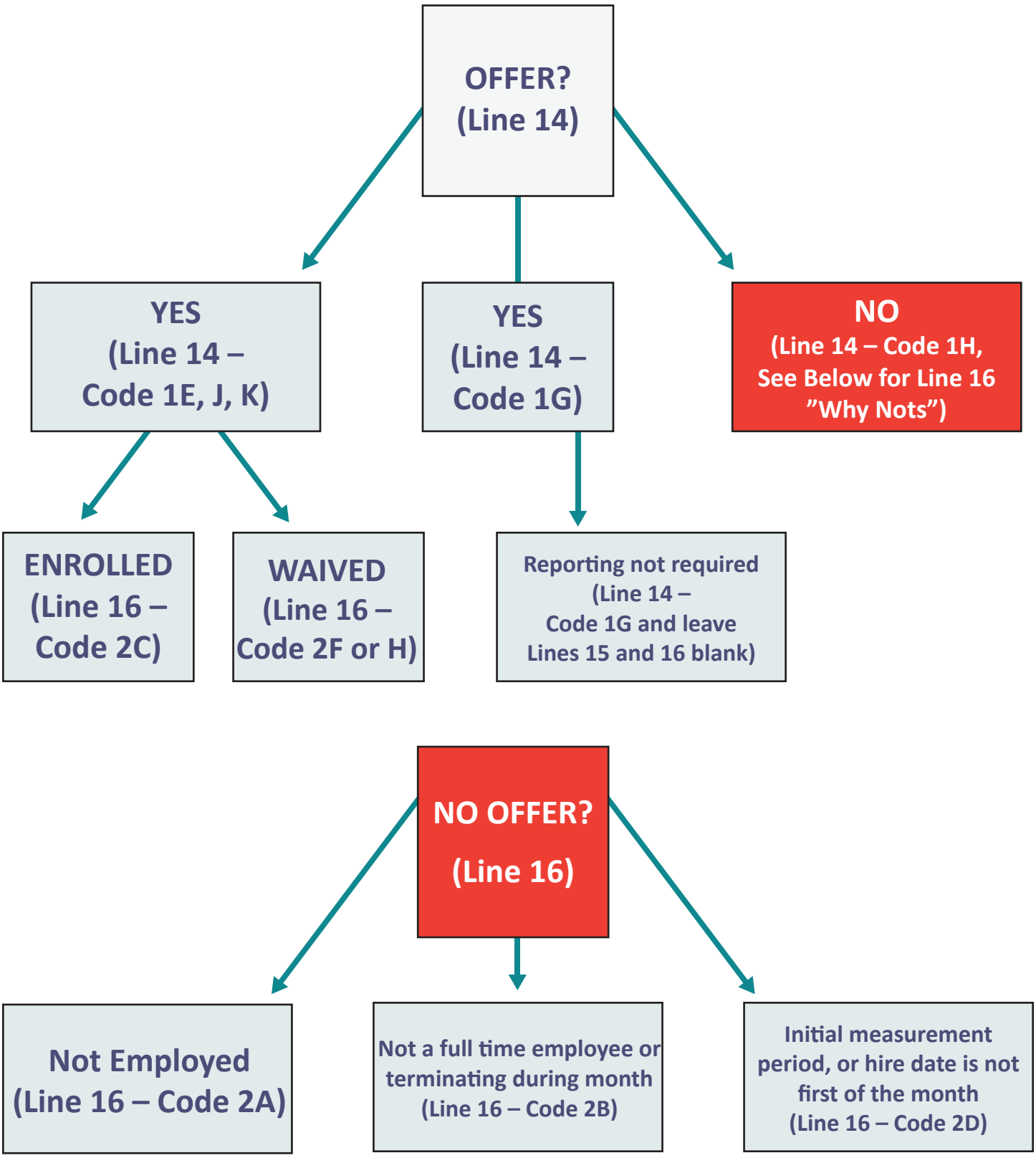
To fully understand the recommended codes you should use, please refer to the tables below. All "1" codes are for Line 14 (offer codes). Codes that start with 2 are for Line 16.

benefitsolver

Line 14 = OFFER	**1 E**	**Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to dependent(s) and spouse.**
	1 G	Offer of self-insured coverage to an employee who was full-time for any month of the calendar year. **USED FOR PART TIME, FULL YEAR RETIREE AND COBRA.**
	1 H	No offer of coverage (employee not offered any health coverage or employee offered coverage that is not minimum essential coverage). **ALSO USED FOR PARTIAL YEAR RETIREE AND COBRA.**
	1 J	Minimum essential coverage providing minimum value was offered to employee for the full month, as well as conditional MEC to spouse; however, did not provide coverage to the dependents of the employee. ***CONDITIONAL OFFER CODE***
	1 K	Minimum essential coverage providing minimum vavlue was offered to employee and the dependents of the employee for the full month; however the offer of coverage to the spouse was conditional. ***CONDITIONAL OFFER CODE***

Line 16 = Why Not?	**2 A**	**Employee was not employed during the month (the employee is not yet hired or, is no longer employed.** **ALSO USED FOR PARTIAL YEAR COBRA AND RETIREE ENROLLED.**
	2 B	The employee was not full-time for this month – the employee was either part-time, seasonal or variable hour, or the employee is in a measurement period and his/her full time status is not yet established. **ALSO USED FOR EMPLOYEES TERMINATING MID-MONTH.**
	2 C	Employee accepts the offer and enrolled in coverage for the FULL month. If you have an option of coverage between 2C and another code, always use 2C.
	2 D	Employee was in a section 490H9(b) Limited Non-Assessment Period. This includes initial measurement period, 90 day or less waiting period, or a first calendar month of employent if the first day of employment is not the first day of the calendar month. **USED FOR WAITING PERIOD AND DURING THE MEASUREMENT PERIOD.**
	2 F	Section 4980H affordability Form W-2 safe harbor. Using this code indicates overage is affordable for the employee based on the W-2 safe harbor method. The W-2 safe harbor code must be used for every month that the employee is offered coverage. **USED IF EMPLOYEE WAIVES COVERAGE.**
	2 H	Section 4980H afforabiliy rate of pay safe harbor. Using this code indicates coverage is afforabale based on the rate of pay safe harbor method. **USED IF EMPLOYEE WAIVES COVERAGE.**

Together, lines 14 and 16 tell a story, and have a limited number of pairings. Some examples include:



METLIFE DENTAL

MetLife

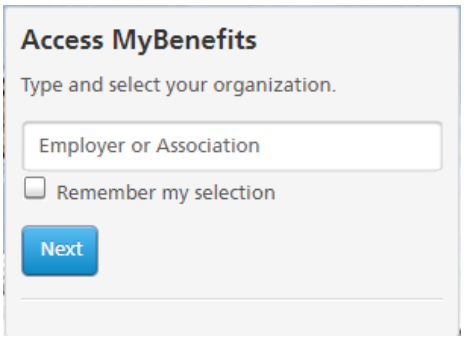
MetLife provides dental benefits to districts that are part of the EBC dental pool. Members that enroll in coverage will NOT receive an ID card. Employees and dependents will be identified as having coverage by the subscriber's (employee) name and SSN.

If you have questions regarding your district's plan, contact your Gallagher Benefits Consultant or Account Manager.

MetLink

Administrators have access to MetLink. Once an administrator has registered for MetLink, they will have access to review enrollments, employees' demographic and benefit information.

If you would like to obtain access to MetLink, please contact your designated Gallagher Account Manager as you will need a username and temporary password that will be provided by MetLife.



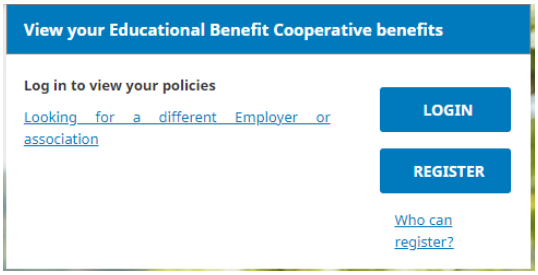
Member Resources

If your employees have questions about a recent claim, they should call **800.942.0854**.

Members can view their dental explanation of benefits all in one place, by visiting **www.metlife.com/mybenefits**.

Member should enter their district's name in the Access MyBenefits box.

They will then be directed to the Log In/Registration page. First time users will have to create a new profile by clicking on "Register".



Once a member has registered and created an account in MetLife's portal, they will have access to:

- Claim status
- Eligibility information
- Summary of dental benefits
- View ID card
- Find In-Network Providers who are part of the PDP Plus Network

RELIANCE STANDARD

Reliance Standard is the Basic Life and AD&D carrier for the EBC pool.

Filing a Claim with Reliance

PAPER FORM

Reliance will need to receive a completed Life Claim form with proof of loss and beneficiary's information. If you do not have the Life Claim Application form stored, you can locate it on the Reliance website or contact your respective Gallagher Account Manager for assistance.

To submit a life claim you will need the claim form to be completed, section A, B, & C and the authorization form.

- Section A is for you/ the district to complete. Please realize that some questions may not seem relevant. Feel free to answer N/A if it is not applicable.
- Section B, C, and the authorization form should be completed by the beneficiary.
- All completed sections must be submitted together along with a certified copy of the death certificate and beneficiary designation form. The submission instructions are on the top of the first page of the claim form.

ONLINE

The district or the beneficiaries can initiate the claim online by visiting **RSLClaims.com**.

In order to submit a claim online, you will need a valid email address and general information to get started. You will not need the policy number to submit a claim online, nor will you need to create an account login or password.

If you have any questions about submitting the claim online, you can contact customer care at **1.800.351.7500**. Customer care representatives are available Monday – Friday from 8:00 AM to 7:00 PM EST.

Waiver of Premium

This is not an automatic benefit. A Waiver of Premium Claim Form must be completed.

If an employee becomes disabled and no longer able to be active at work, he/she may have the ability to continue their Life coverage, and qualify for Waiver of Premium. Waiver of premium provides an extension of group life insurance coverage (Basic and Voluntary) while an insured employee remains totally disabled*, without the district or member having to pay premium.

To be eligible for the benefit, total disability must exist for 6 months. A claim form showing satisfactory proof of an insured employee's total disability should be submitted to Reliance Standard after the fourth month, but no later than 12 months from the date of disability*. The submission of proof is required annually in order to remain eligible for the benefit.

A district/employee must continue to make premium payments until Reliance Standard approves the waiver of premium application. However, if a determination has not been made after twelve months from the date the employee ceased to be active at work, he/she should be advised of the option to exercise the Conversion Privilege provision, allowing individuals to continue their insurance coverage.

If the Waiver of Premium is approved, the premium paid through the Total Disability period will be refunded.

In the event you have an employee that is not actively at work due to their own illness or injury, please contact Reliance to review the details of the employee and to start the Waiver of Premium process.

*Refer to your district's policy to determine the criteria that must be met to be considered totally disabled, and the provisions/requirements stated in the policy.

Making a Change to Basic Life Insurance Classes

Should you wish to change the life insurance classes and/or amounts please contact your Gallagher Benefit Consultant and/or Account Manager. Your Gallagher team member will work directly with Reliance to update your policy. Your Gallagher Account Manager will work with Businessolver to update the classes and/or amounts in Benefitsolver.

Evidence of Insurability Rules (EOI) – For Voluntary Products

When a newly eligible employee or spouse makes an election for Voluntary Life insurance he or she is able to elect up to the Guaranteed Issued (GI) amount without evidence of insurability. If the amount exceeds the GI amount, they are required to complete an Evidence of Insurability (EOI) form.

Any requests following the employee's initial eligibility are considered a late enrollment and subject to an EOI review.

Evidence of Insurability Process for Self-Serve Districts

Employees electing as late entrants or over the GI, have access to the PowerForm link through BenefitSolver when processing their enrollment elections. The PowerForm link allows enrollees to process their requirement of an EOI electronically with Reliance.

EOI Determination

Once Reliance receives the completed EOI form, their underwriting department reviews and makes their determination of an approval or denial. Determination typically takes 3 - 4 weeks if all of the required information has been provided by the employee.

Upon determination, Reliance will notify the employee either via email, if an email address is available, or via a letter sent by mail, if no email address is provided. The district will be notified via a monthly push report that is sent from Reliance each month.

Billing Options

LIST BILL

If your district is set up with list billing for your voluntary products with Reliance Standard, you are required to maintain enrollment information in Reliance's platform. Reliance will generate a monthly invoice based on the enrollment captured in their system and the district will pay according to the invoice provided by Reliance Standard. It is important that you maintain a clean enrollment record in Reliance's platform to ensure the monthly invoice reflects the accurate total monthly premium.

If you would like to schedule a training session to have Reliance walk you through their platform, please contact your designated Gallagher Account Manager and they will assist with coordinating the training.

SELF BILL

If your district is set up with self billing for your voluntary products with Reliance Standard, then each month you will report total number of lives, coverage volume, and total payroll deductions for the month. As a self bill district you do not have to capture enrollment in Reliance's platform, however, it is your responsibility to keep a clean record of enrollments and terminations, and to pay the applicable premium per the amounts reported.

Districts who are self-serve may utilize the invoices generated in Businessolver to pay their monthly premium. Please note: Reliance has to approve the use of Businessolver invoices. If you are interested in using the invoices generated by Businessolver, or if you are interested in moving to self-bill, contact your designated Gallagher Account Manager.

General Questions

Q. HOW DO I KNOW IF AN EMPLOYEE IS ELIGIBLE FOR BASIC LIFE AND VOLUNTARY LIFE COVERAGE?

A. Employees must meet two eligibility requirements as defined in your Reliance Standard Life policy. 1) is the employee working the minimum number of hours and 2) is the employee covered under an eligible class. Classes describe the types of employees who are eligible. If an employee falls under one of the listed classes and works the minimum hours shown in the policy, the employee must be permitted to enroll for coverage.

Q. CAN AN EMPLOYEE WAIVE BASIC LIFE COVERAGE, EVEN THOUGH IT'S A DISTRICT PAID BENEFIT?

A. Yes, an employee can waive the benefit. They must complete an Opt-Out Form, acknowledging that they decline coverage, and their beneficiaries will not be able to receive a death benefit. This form should be kept in their employee file and uploaded in Businessolver and provided to Reliance Standard Life.

If the employee later wishes to enroll in basic life coverage, Evidence of Insurability (EOI) will be required and will need to be approved before coverage can become effective.

Q. WHEN IS AN EMPLOYEE CONSIDERED TO BE "ACTIVE AT WORK"?

A. An employee must be working at the district, meet the minimum hours stated in the Reliance Standard Life policy, and not be on leave (even if receiving full pay). Policies have continuation for FMLA and during the summer months, allowing 10-month employees to still meet the Active at Work requirement, even if they are not working during the summer.

Q. A NEW CONTRACT WAS SIGNED BY AN EMPLOYEE/UNION WHICH HAS A DIFFERENT BENEFIT AMOUNT THAN WHAT IS STATED IN THE POLICY. WHAT SHOULD I DO?

A. You must contact your Gallagher team, providing the new benefit amount (and class if necessary). Gallagher will reach out to Reliance Standard Life providing the request for the new benefit amount. Reliance Standard Life should be made aware of any changes in benefit amount or class prior to benefits being offered to employees.

If a district fails to contact Gallagher to update their policy, any benefit payable will be based on the benefit as stated in the existing policy.

Leaves of Absence

Q. AN EMPLOYEE WILL BE GOING ON AN EXTENDED BOARD APPROVED LEAVE OF ABSENCE. SHOULD THE BASIC AND VOLUNTARY LIFE ELECTIONS BE TERMINATED? WHAT SHOULD I ADVISE THE EMPLOYEE?

A. If the employee will be going on a leave of absence that is not due to injury or illness, temporary lay-off, scheduled school break or FMLA and the board approved leave will be greater than 1 month, both the basic life and voluntary life benefits should be terminated. If the board approved leave of absence is not for injury or illness, temporary lay-off, scheduled school break or FMLA, advise the employee of below.

The employee should be advised they are not eligible for benefits beyond the continuation time period in the policy and should they pass away while on leave that extends beyond the continuation time periods stated in the policy, their beneficiaries will not receive a death benefit. If at the end of the continuation time period in the policy, should they wish to continue coverage, they can review the conversion and portability options. There are applications for conversion and portability and different rates for each, with the premium to be paid via the instructions on the application. Upon return to full-time status/actively at work, the district can re-enroll those employees who have ported their basic life or voluntary life coverage and now meet the eligibility requirements of the group policy. This does not apply to employees who have converted their coverage. For additional information on portability and conversion eligibility requirements, refer to the question, “What are portability and conversion requirements”.

Q. AN EMPLOYEE IS GOING ON AN APPROVED LEAVE FOR THEIR OWN PERSONAL INJURY OR SICKNESS. SHOULD WE TERMINATE THEIR BASIC LIFE AND VOLUNTARY LIFE ELECTIONS? SHOULD THE EMPLOYEE APPLY FOR A WAIVER OF PREMIUM? WHAT SHOULD I ADVISE THE EMPLOYEE?

A. The policy includes continuation of benefits for 12 months for a period of sickness or injury. If sickness or injury is expected to last more than 6 months, the employee should apply for a Waiver of Premium. If Waiver of Premium is approved, then neither the employee nor the district will need to remit a premium for this individual. If Waiver of Premium is not approved, then at the end of the Continuation time period, the employee is eligible to apply for conversion or portability. Once the Continuation extension has expired, but the employee has not “physically” returned back to work (regardless of pay status) review Portability or Conversion options (certain restrictions apply). For additional information on portability and conversion eligibility requirements, refer to the question, “What are portability and conversion requirements”.

Q. OUR CBA STATES THAT EMPLOYEES WILL HAVE ALL BENEFITS, INCLUDING LIFE INSURANCE, EXTENDED FOR A PERIOD OF ONE YEAR, OR AS LONG AS THEY REMAIN ON A BOARD APPROVED LEAVE OF ABSENCE. DOES THIS ALLOW THE BASIC LIFE COVERAGE TO CONTINUE?

A. No, refer to the policy for the different types of continuations covered for leave of absence and the amount of time allowed for each.

Q. WHAT IS WAIVER OF PREMIUM AND WHEN WOULD THIS PROVISION APPLY TO MY EMPLOYEE?

A. This policy provision is designed to waive premiums for an employee’s life insurance coverage when the employee meets the definition of Total Disability* for at least 6 months prior to the age of 60 while insured under the policy and the policy remains in force. You must notify Reliance Standard Life and file a claim within 1 year of the Insured’s date of disability. The employee may use the Conversion Privilege when the Waiver of Premium extension has ceased.

*Refer to policy to determine for definition of Total Disability.

Family Medical Leave Act (FMLA)

Q. CAN AN EMPLOYEE ON FMLA, STILL RECEIVING FULL PAY AND BENEFITS, ENROLL IN THE VOLUNTARY LIFE BENEFIT THAT IS BEING OFFERED FOR THE FIRST TIME DURING OPEN ENROLLMENT?

A. No, an employee on FMLA is not able to enroll in voluntary life if they do not meet the minimum hour requirement to be considered actively at work. Life insurance benefits require an employee to be physically at the district and not just receiving full pay and benefits. Upon the employee's return to work as a full-time employee, the employee has 31 days to elect voluntary life and is considered a late entrant and subject to medical underwriting. All employees on FMLA (intermittent or full FMLA) should be included on the list of employees not actively at work as part of the takeover census at the time of new case implementation.

Q. AN EMPLOYEE CURRENTLY ENROLLED IN BASIC/VOLUNTARY LIFE JUST ADVISED US THAT DUE TO AN ILLNESS DIAGNOSIS, THEY WILL HAVE TO MISS SOME HOURS WHILE GETTING TREATMENT. IT'S UNCERTAIN HOW MUCH TIME WILL BE NEEDED AND WILL VARY DAY TO DAY/WEEK TO WEEK. WHAT SHOULD THE DISTRICT DO?

A. Nothing. However, if the intermittent leave becomes continuous, then the district should notify Reliance Standard Life to determine if a Waiver of Premium application should be submitted. Basic and voluntary life should remain active. Coverage during the intermittent leave would be continued, with payment of premium, under the Family and Medical Leave of Absence provisions. If the intermittent leave becomes continuous, then there is a 12-month extension due to illness and/or injury on the policy, allowing employees to still have coverage, even if they are not actively at work.

Q. WHAT HAPPENS IF THE EMPLOYEE'S FMLA PERIOD ENDS ON THE LAST DAY OF SCHOOL, BUT DUE TO BEING A 10-MONTH EMPLOYEE, THE EMPLOYEE IS NOT EXPECTED TO RETURN TO WORK UNTIL THE NEW SCHOOL YEAR? SHOULD COVERAGE BE TERMINATED FOR THE SUMMER MONTHS?

A. Coverage can remain active throughout the summer. If, however, the employee does not return to work on the first day of school, coverage should be terminated. For additional information on portability and conversion eligibility requirements, refer to question, "What are portability and conversion requirements".

Q. WHAT HAPPENS IF AN EMPLOYEE DOES NOT RETURN FROM AN EXTENDED LEAVE OF ABSENCE ONCE THEY HAVE EXHAUSTED THEIR FMLA ENTITLEMENT AND THEIR EXTENDED LEAVE OF ABSENCE DOESN'T QUALIFY FOR CONTINUATION FOR THEIR OWN PERSONAL INJURY OR ILLNESS?

A. Coverage would terminate the day FMLA has exhausted. For additional information on portability and conversion eligibility requirements, refer to the question, "What are portability and conversion requirements".

Q. AN EMPLOYEE ON FMLA EXPERIENCES A QUALIFYING LIFE EVENT (BIRTH, ADOPTION, MARRIAGE, CHANGE IN JOB STATUS). CAN THE EMPLOYEE MAKE A CHANGE TO HIS/HER ELECTION?

A. Yes, the employee can enroll and pay the applicable premium for coverage. Evidence of insurability will not be required up to the guaranteed issue, provided they have not been previously declined and have enrolled no later than 31 days from the date of the qualifying life event.

Q. AN EMPLOYEE JUST HAD A BABY AND ANTICIPATES BEING OUT ON FMLA FOR 12 WEEKS. SHOULD BASIC AND/OR VOLUNTARY LIFE BENEFITS BE TERMINATED?

A. No, the benefits can remain active while on FMLA. Should the employee decide to take an extended leave and not return to work after FMLA has ended, the benefits must be terminated the day the extended leave begins. For additional information on portability and conversion eligibility requirements, refer to question, "What are portability and conversion requirements".

Portability and Conversion

Q. WHAT ARE PORTABILITY AND CONVERSION REQUIREMENTS?

A. Portability* – If an insured's coverage terminates under certain conditions and for reasons other than the policy terminating or the insured's retirement, the insured may elect to continue coverage. The insured must have been covered for 12 months under the policy; not have been approved for Waiver of Premium and remit application 31 days after termination of coverage.

B. Conversion* – The Conversion Privilege gives an insured the right, under certain conditions, to continue life insurance protection under a non-term permanent insurance policy. If an employee is no longer eligible for benefits as defined in the policy or retires, the employee must submit an application 31 days after termination of coverage.

*Refer to your Reliance Standard Life policy for more detailed information.

RELIANCE VALUE ADD PROGRAMS

reliancematrix

Employee Assistance Program (EAP)

Through Reliance Standard, EBC districts have access to an Employer Assistance Program (EAP) through Reliance's partnership with AllOne Health. To confirm your district's participation in this EAP, contact your respective Gallagher Account Manager.

This program is known for its 5 counseling sessions (per incident) and unlimited referrals within AllOne Health's vast network of specialists. The EAP also offers legal and financial consultation, bereavement services, and more. It can be best thought of as a first step when employees don't necessarily know where to turn to. Please reach out for more information.

InfoArmor: ID Theft Recovery Services and Wallet Armor Program

A free program that is available to employees who are covered under the district's Basic Life & AD&D policy. Services are also available to dependents who are 18 years or older. The InfoArmor program offers two branches of services. The first being WalletArmor. This encrypted service allows employees to store sensitive information like user ID's, passwords, debit/credit information, SSN's, etc. all in one place. The second being Recovery Services. This service monitors your stored information for suspicious activity. In the event your identity is leaked, advocates work on your behalf to contact the necessary institutions to mitigate any damage caused. Please reach out for more information.

24/7 Travel Assistant

A free program that is available to employees who are covered under the district's Basic Life & AD&D policy. Services are also available to dependents who are 18 years or older. The 24/7 Travel Assistance program applies for eligible members traveling 100+ miles away from home. This program offers a U.S. and a Worldwide toll-free phone line for members to call before, or during their trip in the event that something unexpected arises. Examples include: emergency medical transportation, prescription re-fills, emergency personal assistance services, vaccine mandates, and more. Please reach out for more information.

EBC WELLNESS

The EBC believes in wellness and offers a Wellness Program to all districts. EBC has partnered with Empower Health to offer free onsite biometric screenings to all insurance eligible employees. PPO spouses and dependents over the age of 18 covered on the district's plan can also participate and have their screening run through insurance. HMO spouses and dependents over the age of 18 will have to pay the full cost of the screening.

Districts can also offer free flu shots to insurance eligible employees through onsite clinics.

Part of the Wellness Program is an incentive, allowing districts to earn up to 0.75% of a district's projected annual premium. Below are the details of the program.

Visit the **Resource Hub** for wellness resources, communication materials and ideas to help you kick start your district's wellness!

EBC Wellbeing Incentive Program
Effective: July 1st, 2022

The EBC Wellbeing Incentive Program* is a tiered point system, which allows districts to determine the wellness approach that best meets their ever-changing needs. In order to be eligible for the incentive, the district must host a Biometric Screening event (does not need to meet 50% participation threshold), either onsite or by using Empower Health's lab partners.

Districts can choose from the list of activities to meet the required points for each tier and have until June 30th of each year to submit their supporting documents and checklist to the Gallagher Account Team.

Mandatory:	Host Biometric Screening Event
TIER 1:	5 Points Incentive Amount: 0.10% of projected annualized premium
TIER 2:	10 Points Incentive Amount: 0.25% of projected annualized premium
TIER 3:	15 Points Incentive Amount: 0.40% of projected annualized premium

Devoted to Wellness Awards

Introducing the EBC *"Devoted to Wellness, Silver Award"*, given to districts that meet Tier 3 (receiving at least 15 points) three years in a row, and "Devoted to Wellness, Gold Award" for those that meet Tier 3 five years in a row. Districts will receive a plaque and small reward, presented by the EBC Chairperson and Gallagher, recognizing their achievement and commitment to wellness.

*The EBC Wellbeing Incentive Program is funded by the EBC working cash. The funds are sent directly to the district and the district has flexibility in how the dollars are used.

EBC WELLBEING INCENTIVE PROGRAM CHECKLIST

This checklist details each of the activities that are part of the EBC Wellbeing Incentive Program.

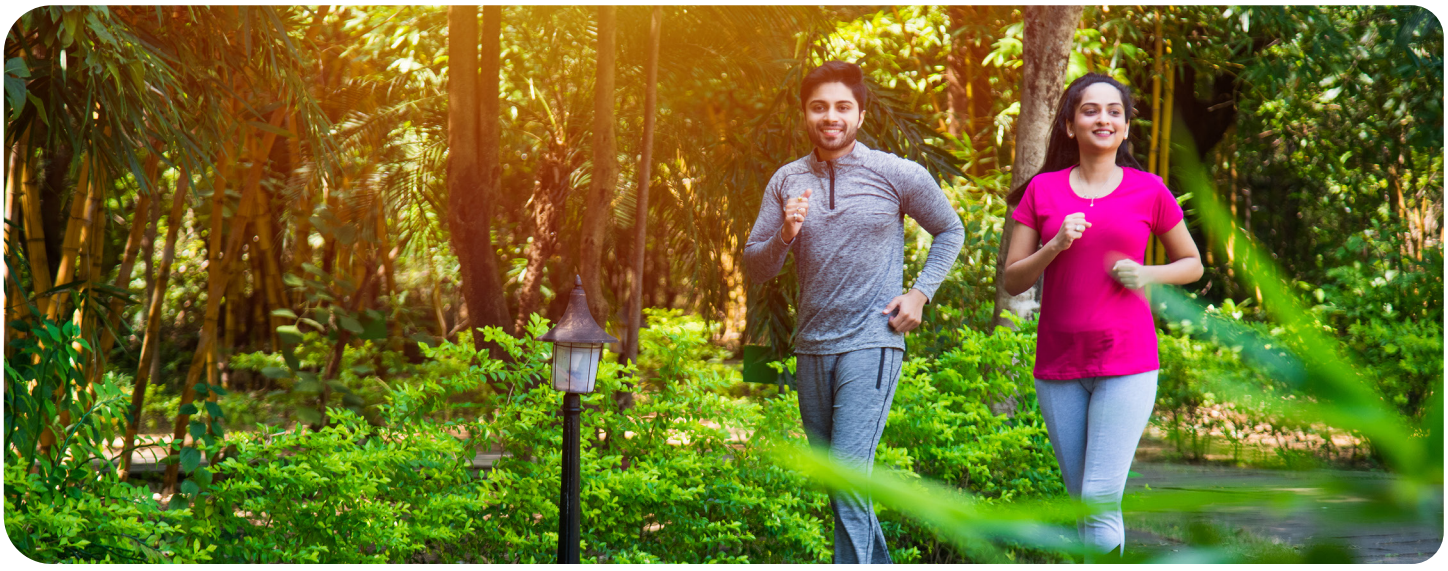
In order to participate a district must host a biometric screening during the school year. Districts can earn points by completing any of the activities below. In the Completed column, enter 1 to indicate the activities that have been completed during the year, and submit the checklist along with the required documentation noted next to the activity before June 30th. The points required to earn an incentive are:

Tier 1: 5 points
Tier 2: 10 points
Tier 3: 15 points

Activities	Points	Completed	Documentation Required If Indicated Activity is Complete
PLANNING AND ORGANIZATION			
Create a Wellbeing Committee, Meet 3 Times per Year, and Establish a Mission and at Least 1 Goal	1		List of meeting dates and times (sign in sheets and/or agenda if available, but not required), mission and goal
Leadership Memo to Staff	1		Copy of email sent to staff
Wellbeing Interest Survey	1		Copy of survey/results (if not using Gallagher survey resources)
EDUCATION and PROMOTION of BENEFITS			
Communicate 3 EBC Resources: EAP, Teladoc, Member Rewards, Wondr, Learn to Live OR Blue Access for Members (BAM)	1		Copy of email showing each benefit has been promoted
Achieve or Maintain Registration for the Navigate Portal (35% of Total Eligible Employees)	1		Gallagher to provide notification to any district that has met the participation requirements of Teladoc or Navigate in the fall and spring.
Achieve or Maintain Registration for Teladoc (35% of Total Eligible Employees)	1		
Host Benefit Meeting	1		Meeting date and copy of email advising staff of event
Insurance Committee Meeting with your Gallagher Representative with wellbeing as an agenda item	1		Date of Insurance Committee Meeting
FLU SHOT and SCREENING			
Host Flu Shot Event through Empower Health	1		Empower Health to provide required data to Gallagher Team
Achieve 50% Participation in Biometric Screening Event	2		
Achieve 75% or Higher Participation in Biometric Screening Event	1		
Improve your Health Score from the Previous Year	1		
Live Healthy, Stay Healthy - Score Remains in the Average Range (80%) Based on Empower Health Score Index	1		

Activities	Points	Completed	Documentation Required If Indicated Activity is Complete
ACTION BASED PROGRAM			
Host Action Based Program (3 Programs max)			
Program 1	1		Program details and dates
Program 2	1		Program details and dates
Program 3	1		Program details and dates
Participation in Navigate Challenge (At Least 5 People Enrolled)			
Challenge 1	1		Gallagher Team will run a report to confirm participation in the challenges
Challenge 2	1		
Challenge 3	1		
Total Points Available:	**20**		

- Districts can pick activities from any/all sections.
- Districts must request Gallagher to pull Teladoc and Navigate reporting.
- Gallagher will provide screening participation numbers to districts with 50% or higher participation.



EBC WELLBEING PORTAL

EBC has partnered with Navigate Wellbeing Solutions to offer the EBC Wellbeing Portal. Benefit eligible employees can register for the portal and access the EBC Value Add programs as well as online tools and resources designed to improve their health.

On your portal ,you can:

- Access information on the EBC Value-Added programs that are provided to your district for being a part of the EBC.
- Join Group Challenges
- Sync your favorite devices and apps or download the Navigate Wellbeing App to seamlessly track activity such as: step count, activity minutes, nutrition, hydration, sleep, and weight. This information can also be tracked manually.
- Browse a library of recipes and workout videos. Search for exercises and meals you actually enjoy and add them to your Favorites for easy retrieval later!

How to Join the Portal

Visit **ebcwellbeing.com**.

1. Select **JOIN NOW**
2. Enter your first name, last name, date of birth and the last four digits of your SSN
3. Confirm your information
4. Create a username and password, the complete your profile

Action Based Programs Available Quarterly

The EBC Wellbeing Portal gives EBC districts an opportunity to offer, promote, and administer an action-based program under Tier 2 of the EBC Wellness Incentive. Action based programs, or wellness challenges, are housed within the platform and are live for a specific time for districts to offer to their staff. Communication materials for the action based programs are available in the **Resource Hub** under the EBC Wellbeing Incentive Program/EBC Wellbeing Portal/Challenge Materials folder.

TELADOC

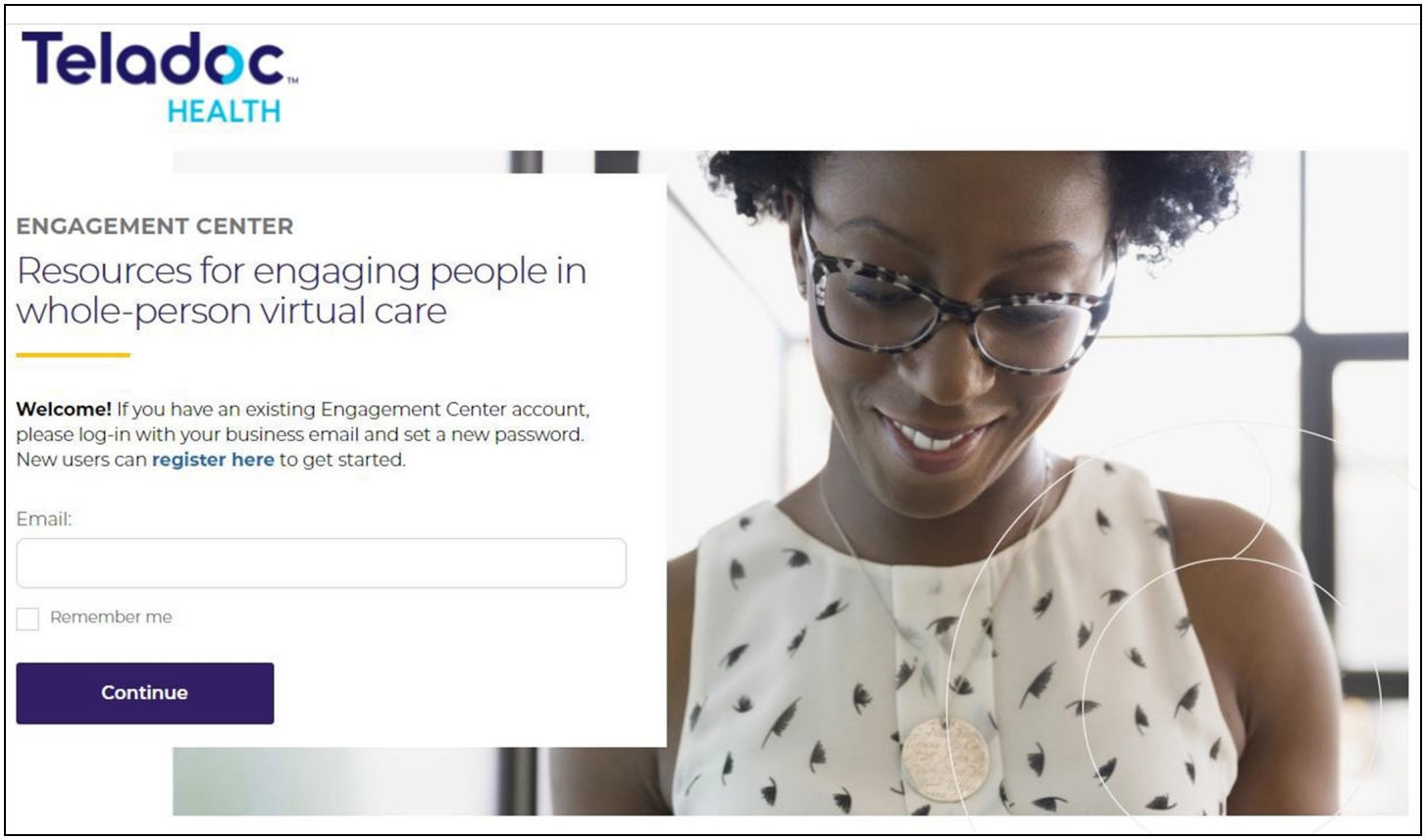
Teladoc is the telemedicine provider for EBC. Teladoc is available for employees and dependents who are covered by the district's health insurance. Consultations are free for HMO and PPO members. HDHP members are subject to a $55 consultation fee.

Engagement Center

Administrators have access to additional communication materials by visiting Teladoc's Engagement Center. The engagement center makes it easier to ensure members get the most out of their Teladoc Health services. Administrators will find:

- A library of free, customizable print and digital materials—including emails, postcards, flyers, and direct mail.
- Monthly seasonal content
- And much more!

If you encounter any issues with the engagement center, please contact Teladoc Client Services at **ClientServices@teladoc.com** or by calling them at **(866) 509.8954**.

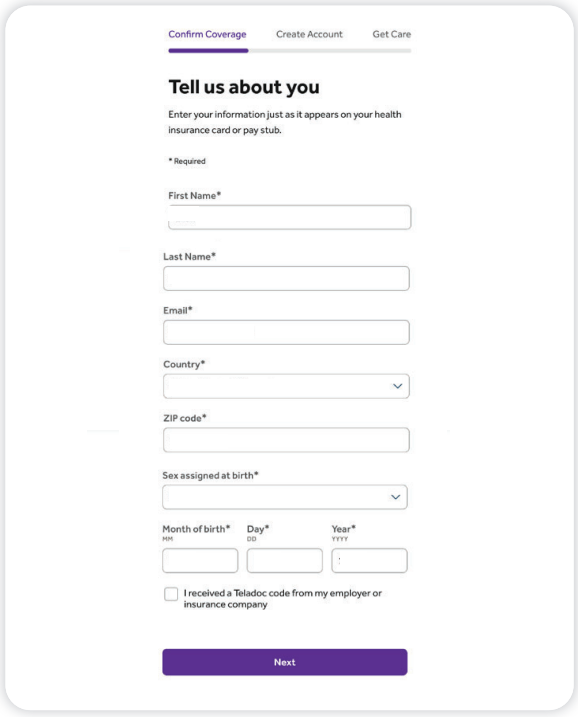


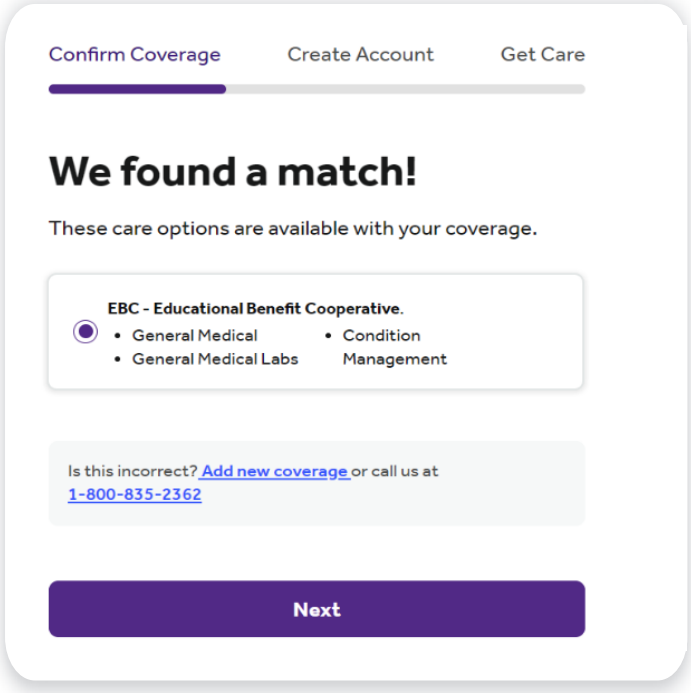
How to Register for Teladoc

Visit **Teladoc.com** and click **"Get Started"** or **"Sign up"** and then follow the instructions below.

1. CONFIRM BENEFITS

Provide some information about yourself to confirm your eligibility. Make sure to use your name as it appears on your BCBS ID card. Note: Do not check the box asking for a code as you do not need a code to register.





2. FIND YOUR COVERAGE

Confirm the coverage has been matched to you. If you do not see EBC "Education Benefit Cooperative" there may have been an issue. Go back to Step 1 to verify your information.

3. CREATE ACCOUNT

Enter your contact information, username, password and security questions. Fill out your health information before scheduling an appointment to save you time before your next visit!

Note: Once a member's account is created, eligible dependents under 18 years old can be added to a member's account through their account settings under the primary member. Eligible dependents over the age of 18 should follow the exact steps above to create their own account.

HAVE ISSUES REGISTERING?

- Don’t use a nickname when registering, use your full legal name as listed on your BCBS ID card.
- Make sure your Zip code is up to date with your district.
- Make sure you see “EBC” as a match

ACCIDENTAL CHARGE – HMO/PPO MEMBERS

In the event a PPO or HMO member accidentally gets charged a consultation fee due to incorrect account set up, the member or district is able to reach out to Teladoc via phone or email for reimbursement.

- **Phone: 1.800.835.2361**
- **Email: clientservices@Teladoc.com**
  - » **Subject**: Member Refund Sought – Member’s Initials, EBC, Date
  - » Please be sure to include the member’s full name, zip code, date of birth, date of Service and why refund is being requested (accidental charge).

DEPENDENT ELIGIBILITY AUDIT

At the March 2024 Final Renewal meeting, the full Board of Directors approved conducting a Dependent Eligibility Audit for all employees who cover dependents on their medical plans. The audit is mandatory for all EBC districts.

An initial full audit was conducted for all employees with dependents in Businessolver as of September 1st, 2024, with an ongoing monthly audit beginning in December 2024 to capture any new hires or employees experiencing a qualifying life event that add dependents. Employees with dependents covered on their medical plan will be required to upload documents that show proof of dependent eligibility status, into a secure online portal.

Dependents will be dropped from the plan if either a dependent is determined ineligible during the audit; or, if an employee fails to submit documents for the dependent before the deadline. The date the dependent will be dropped is listed in the audit communication.

Dropped dependents are NOT eligible for COBRA.

Who are eligible dependents?

- Spouse
- Civil Union (all districts)
- Domestic Partner (some districts cover)
- Biological, adopted, step child
- Child under legal guardianship, foster child

What are examples of documents that will be required?

- The most recent tax return showing married filing jointly/ separately
- Birth certificate
- Court documents that show legal guardianship
- Marriage certificate AND two financial statements, such as bank statements, insurance bills, rental/mortgage contracts

What will districts have to do as part of the audit?

When entering new employees in the system, include the employee's district email address. The email communication from Impact Interactive will only be sent to employees with district emails. Employees with missing emails will only receive notifications of the audit in the mail.

Districts will receive weekly emails from the Gallagher Team listing any employees that have not responded to the audit. An email will also be sent at the end of each audit period should an ineligible dependent need to be terminated.

How will dependents be terminated?

Districts should select the "Dependent Eligibility Audit (DEA) – Ineligible Dependent" BAR in Businessolver and enter the last day of coverage, based on the email received from the Gallagher Team. The ineligible dependent(s) will then have to be selected and terminated. Only the ineligible dependent(s) should be terminated – the employee and any other eligible dependents should remain covered. When the COBRA screen appears, it will note that it is **NOT** a COBRA qualifying event.

NOTE: DO NOT MAKE ANY EDITS TO THIS PAGE. Manually changing the event to allow for COBRA will make the district liable for any claims of the ineligible dependent, should COBRA then be elected.

To supplement COBRA coverage, ineligible dependents recently terminated from the district's plan may contact Gallagher's Alternative Health Solutions department to seek their own personalized health plan options.

Visit **AJG.com/lfp-AHS** or call **800.975.3150** for more information.

Why is the audit required?

It's estimated covering an ineligible dependent can cost the plan at least $5,000 annually. In addition, should an ineligible dependent become a high-cost claimant requiring stop loss coverage, the carrier will deny claims leaving the district and the employee responsible for paying for ALL claims that have been paid.

QUALIFYING LIFE EVENTS

Plan elections must be made before a period of coverage begins and remain unchanged during the period of coverage. The period of coverage is usually a 12-month plan year, but may be a shorter period of time for a newly eligible employee or a new cafeteria plan. Elections changes must be permitted annually; however, there are other events throughout the year that give members special enrollment rights.

- Before allowing an employee to make a change to his/her elections, the district should ask the following questions:
- Is the requested change permitted by the IRS and included in the list of events that would permit a new election? Does the event apply to the particular benefit the employee is asking to change (e.g. medical coverage or health FSA)?
- Does the election change satisfy the consistency rule?
- Does the plan document permit the requested change?
- Has there been proper documentation? Has the employee provided a signed or electronic certification that the event occurred or that the change is consistent with the event?

A matrix outlining permitted election changes under IRS rules is contained in several charts on the following pages. If you have any questions, contact your Gallagher Account Manager.

CAFETERIA PLANS

CHART 1

Election Changes for Healthcare Plans Including Health FSA

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
HIPAA Special Enrollments (not required for HIPAA-excepted benefits)					
Marriage	• Enrollment of employee • Enrollment of new spouse • Enrollment of newly eligible dependents • Drop of coverage for dependents if enrolling in spouse's plan • Drop of coverage for employee if enrolling in spouse's plan	Required	• Enrollment in FSA • Increase in dollar election • Decrease in dollar election (if newly eligible under spouse's plan) • Drop in coverage (if newly eligible under spouse's plan)	HIPAA special enrollment rights apply to the employee, new spouse and newly eligible dependents, but not previously eligible dependents. Entering into a domestic partnership is not a marriage and does not create a HIPAA special enrollment right. However, see increase in dependents on page 15 and the rules for domestic partners on page 44.	☐ Yes ☐ No
Birth, adoption or placement for adoption	• Enrollment of employee • Enrollment of spouse • Enrollment of newly born/adopted/ placed child	Required	• Enroll in FSA • Increase in dollar election	Coverage must be retroactive to the date of birth/adoption. To drop coverage for the employee, spouse or dependents and enroll in another employer's plan, see page 24—Dependent gains eligibility under employer's plan. HIPAA special enrollment rights do not apply to previously eligible dependents. Children born/adopted/placed with a domestic partner have HIPAA special enrollment rights (as will the employee), but not the domestic partner.	☐ Yes ☐ No

Note: *This document does not include any of the rules for adoption assistance or 401(k) plans.*

CHART 1

Election Changes for Healthcare Plans Including Health FSA

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
HIPAA Special Enrollments (not required for HIPAA-excepted benefits)					
Loss of coverage under spouse's plan For example: • Divorce/legal separation • Death • Spouse's termination of employment • Spouse's change in employment status	• Enrollment of employee • Enrollment of individual losing coverage (may be subject to waiver restrictions—see comments)	Required	• Enrollment in FSA • Increase in dollar election	HIPAA special enrollment is available to the employee and other individuals who lose eligibility under the spouse's plan An employer is permitted to limit special enrollment rights to individuals who actually were enrolled in another plan at the time of the coverage waiver. To enforce this provision, the plan may require a written statement from an employee who is waiving coverage that the other coverage is the reason for the waiver. If the employer uses and communicates this requirement and the employee does not provide it, the plan is not required to offer a HIPAA special enrollment if the other coverage is lost.	☐ Yes ☐ No

CHART 1

Election Changes for Healthcare Plans Including Health FSA

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
HIPAA Special Enrollments (not required for HIPAA-excepted benefits)					
Loss of coverage under another employment-based group health plan For example: • 26-year-old employee loses coverage under parent's plan • Domestic partnership ends • Employee's 22-year-old child terminates employment	• Enrollment of employee • Enrollment of individual losing coverage (may be subject to waiver restrictions—see comments)	Required	• Enrollment in FSA • Increase in dollar election	HIPAA special enrollment based on the loss of other coverage is available to the employee and other individuals who are eligible under the plan, including domestic and civil union partners and their children. An employer is permitted to limit special enrollment rights to individuals who actually were enrolled in another plan at the time of the coverage waiver. To enforce this provision, the plan may require a written statement from an employee who is waiving coverage that the other coverage is the reason for the waiver. If the employer uses and communicates this requirement and the employee does not provide it, the plan is not required to offer a HIPAA special enrollment if the other coverage is lost.	☐ Yes ☐ No

CHART 1

Election Changes for Healthcare Plans Including Health FSA

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
HIPAA Special Enrollments (not required for HIPAA-excepted benefits)					
Loss of eligibility for individual health insurance For example: • Drops individual product line • Drops specific plan design such as PPO • Drops out of individual market • Stops offering a product at the end of the year	• Enrollment of employee • Enrollment of individual losing coverage (may be subject to waiver restrictions)	Required	• Enrollment in FSA • Increase in dollar election	HIPAA special enrollment based on the loss of other coverage is available to the employee and other individuals who are eligible under the plan, including domestic and civil union partners and their children. An employer is permitted to limit special enrollment rights to individuals who actually were enrolled in another plan at the time of the coverage waiver. To enforce this provision, the plan may require a written statement from an employee who is waiving coverage that the other coverage is the reason for the waiver. If the employer uses and communicates this requirement and the employee does not provide it, the plan is not required to offer a HIPAA special enrollment if the other coverage is lost. Loss of coverage for reasons such as failure to pay premium or fraud does not create a special enrollment right.	☐ Yes ☐ No

CHART 1

Election Changes for Healthcare Plans Including Health FSA

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
HIPAA Special Enrollments (not required for HIPAA-excepted benefits)					
Exhaustion of COBRA coverage at end of 18, 29 or 36 months	• Enrollment of employee • Enrollment of individual losing coverage (may be subject to waiver restrictions)	Required	• Enrollment in FSA • Increase in dollar election	HIPAA special enrollment based on the loss of other coverage is available to the employee and other individuals who are eligible under the plan, including domestic and civil union partners and their children. The HIPAA special enrollment right is only available as the result of exhaustion of the maximum COBRA duration. Voluntary termination does not give the individual special enrollment rights even if the individual is losing free COBRA coverage. For example, if a former employer does not charge for COBRA for three months after a layoff, there is no special enrollment with a new employer at the end of that three-month period.	☐ **Yes** ☐ **No**

CHART 1

Election Changes for Healthcare Plans Including Health FSA

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
HIPAA Special Enrollments (not required for HIPAA-excepted benefits)					
Loss of Medicaid eligibility	• Enrollment of employee • Enrollment of individual losing coverage	Required	• Unclear whether permitted	Employees must be given at least 60 days to exercise special enrollment rights.	☐ Yes ☐ No
Loss of SCHIP eligibility	• Enrollment of employee • Enrollment of individual losing coverage	Required	• Unclear whether permitted	Employees must be given at least 60 days to exercise special enrollment rights.	☐ Yes ☐ No
Gain Medicaid premium assistance	• Enrollment of employee • Enrollment of dependent	Required	• Unclear whether permitted	Employees must be given at least 60 days to exercise special enrollment rights. If already enrolled, employee may be able to reduce salary reduction election to reflect lower employee contribution.	☐ Yes ☐ No
Gain SCHIP premium assistance	• Enrollment of employee • Enrollment of dependent	Required	• Unclear whether permitted	Employees must be given at least 60 days to exercise special enrollment rights. If already enrolled, employee may be able to reduce salary reduction election to reflect lower employee contribution.	☐ Yes ☐ No

CHART 1

Election Changes for Healthcare Plans Including Health FSA

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Status Changes - these are the only categories of status changes that are permitted					
Loss of coverage sponsored by a government institution For example: • Under a Indian Tribal government plan • State health benefits risk pool, or • Foreign governmental group health plan (e.g., Canada's provincial health program).	• Enrollment of individual losing coverage	Yes	• No change permitted	Not a HIPAA special enrollment	☐ Yes ☐ No

CHART 1

Election Changes for Healthcare Plans Including Health FSA

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Status Changes - these are the only categories of status changes that are permitted					
Gain of coverage sponsored by a government institution	• No change	No	• No change permitted		☐ Yes ☐ No
Divorce, annulment, legal separation and/or death of spouse	• Drop of coverage for spouse losing eligibility • Drop of coverage for stepchildren losing eligibility	Yes	• Decrease dollar election • End of enrollment	Legal separation and annulment are events permitting a change only in states that recognize them. In the event of divorce, the employee's natural or adopted children do not lose eligibility under parents' plans, but the employee's stepchildren would generally lose eligibility. An employee enrolled in the spouse's group health plan who loses coverage under the spouse's plan may be eligible for a HIPAA special enrollment (see page 8).	☐ Yes ☐ No

CHART 1

Election Changes for Healthcare Plans Including Health FSA

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Status Changes - these are the only categories of status changes that are permitted					
Increase in the number of dependents other than birth, adoption or placement for adoption	• Enrollment of newly eligible dependent(s)	No	• Enrollment • Increase in dollar election	Newly eligible dependent and other dependents that previously were not covered (under the tag-along rule) may be enrolled under IRS rules.	☐ Yes ☐ No
Decrease in number of dependents For example: • Death • Loss of eligibility under the plan (e.g., child reaches age 26)	• Drop of coverage for dependent losing eligibility	No	• Decrease in dollar election • End of enrollment	If the event causing loss is a COBRA qualifying event and the child is the employee's dependent, the employee may make a change in the salary reduction amount to pay for COBRA coverage pre-tax.	☐ Yes ☐ No

CHART 1

Election Changes for Healthcare Plans Including Health FSA

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Status Changes - these are the only categories of status changes that are permitted					
Gain in eligibility due to employee's change in employment status For example: • Class (e.g., salaried to hourly) • Hours (e.g., part-time to full-time) • Union (e.g., non-union to union)	• Enrollment of newly eligible employee after allowing new plans to be selected	Select from newly available options	• Enrollment if newly eligible	May only change election where eligibility for a benefit/plan affected (e.g., if different medical options for salaried and hourly or different contributions, make new elections). If eligibility has not changed (e.g., same health FSA plan for salaried and hourly), no health FSA change permitted.	☐ Yes ☐ No

CHART 1

Election Changes for Healthcare Plans Including Health FSA

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Status Changes - these are the only categories of status changes that are permitted					
Loss of eligibility due to employee's change in employment status For example: • Termination • Strike/lockout • Class (e.g., hourly to salaried) • Hours (e.g., full-time to part-time) • Union (e.g., union to non-union)	• Cancellation of coverage	Yes, if the change in employment results in eligibility for new or different plan option, then the employee can select the new or different plan or option. (see comments)	• End of enrollment	If the change in employment status results in eligibility for a new or different plan (or new coverage option), then employee can select the new or different plan.	☐ Yes ☐ No

CHART 1

Election Changes for Healthcare Plans Including Health FSA

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Status Changes - these are the only categories of status changes that are permitted					
Reduction in hours of service, where employee expected to average less than 30 hours per week For example: • Strike/lockout • Class (e.g., hourly to salaried) • Hours (e.g., full-time to part-time) • Union (e.g., union to non-union)	• Cancellation of coverage	No	• No change permitted	The employee must be in a position that was expected to average at least 30 hours of service per week, and there was a change so that the employee will reasonably be expected to average less than 30 hours of service per week. Eligibility for the employer's health plan need not be affected by the change in the expected hours of service. The cancellation of coverage under the employer's health coverage corresponds to the intended enrollment of the employee (and any related individuals) in another plan that provides minimum essential coverage. Coverage under the new plan must be effective no later than the first day of the second month following the month that the employer coverage is canceled. Employer may rely on a reasonable representation of an employee and related individual who have enrolled or intend to enroll in another plan.	☐ Yes ☐ No

CHART 1

Election Changes for Healthcare Plans Including Health FSA

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Status Changes - these are the only categories of status changes that are permitted					
Employee seeks to enroll in a Qualified Health Plan (QHP) when the employee is eligible for a Marketplace special enrollment	• Cancellation of coverage	No	• No change permitted	An employee seeking to revoke employee's election to enroll in a Marketplace QHP may do so if the employee is eligible for Marketplace special enrollment period. The revocation of the election for employer coverage must correspond to the intended enrollment of the employee (and any related individuals) in a QHP through the Marketplace. Coverage under the Marketplace QHP must be effective no later than the day immediately following the last day the original coverage was revoked. For additional insight on Marketplace special enrollments, go to www.healthcare.gov.	☐ Yes ☐ No

CHART 1

Election Changes for Healthcare Plans Including Health FSA

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Status Changes - these are the only categories of status changes that are permitted					
Employee seeks to enroll in a QHP during the Marketplace's annual open enrollment	• Cancellation of coverage	No	• No change permitted	The revocation of the election for employer coverage must correspond to the intended enrollment of the employee (and any related individuals) in a QHP through the Marketplace. Coverage under the Marketplace QHP must be effective no later than the day immediately following the last day the original coverage was revoked.	☐ Yes ☐ No

CHART 1

Election Changes for Healthcare Plans Including Health FSA

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Status Changes - these are the only categories of status changes that are permitted					
Dependent seeks to enroll in a QHP when dependent is eligible for Marketplace special enrollment	• Revocation of coverage for dependent(s) moving to Marketplace	No	• No	Only an employee's tax dependents (e.g., spouse and dependent children) are eligible for the election change. For example, an employee's child who is age 25 may be eligible for the plan, but might not be the employee's tax dependent. Beginning January 1, 2023, a cafeteria plan may allow an employee seeking to revoke a dependent's election to enroll in a Marketplace QHP to do so if the dependent is eligible for Marketplace special enrollment period. The revocation of the election for employer coverage for the dependent(s) must correspond to the intended enrollment of the dependents in a QHP through the Marketplace. Coverage under the Marketplace QHP must be effective no later than the day immediately following the last day the original coverage was revoked. For additional insight on Marketplace special enrollments, go to www.healthcare.gov.	☐ **Yes** ☐ **No**

CHART 1

Election Changes for Healthcare Plans Including Health FSA

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Status Changes - these are the only categories of status changes that are permitted					
Dependent seeks to enroll in a QHP during the Marketplace annual enrollment	• Revocation of coverage for dependent(s)	No	• No change permitted	Only an employee's tax dependents (e.g., spouse and dependent children) are eligible for the election change. For example, an employee's child who is age 25 may be eligible for the plan, but might not be the employee's tax dependent. Beginning January 1, 2023, a cafeteria plan may allow an employee to revoke coverage for a dependent when the dependent is eligible for a Marketplace open enrollment event. The revocation of the election for employer coverage must correspond to the intended enrollment of the dependent(s) in a QHP through the Marketplace. Coverage under the Marketplace QHP must be effective no later than the day immediately following the last day the original coverage was revoked.	☐ Yes ☐ No
Rehire employee within 30 days of termination	• Reinstatement of old election • Denial of reinstatement until the next plan year	No	• Reinstatement of prior coverage • Denial of reinstatement until the next plan year	If another event occurs that permits a change (which must be specified in the plan), then a rehired employee may be able to make new selections.	☐ Yes ☐ No

CHART 1

Election Changes for Healthcare Plans Including Health FSA

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Status Changes - these are the only categories of status changes that are permitted					
Rehire employee 30 or more days after termination	• Denial of reinstatement until next plan year • Reinstatement of previous election • Enrollment employee, allowing new plan selections	Yes	• Enrollment • Reinstatement • Denial of reinstatement until the next plan year	After 30 days, rehired employees are treated as new employees under the cafeteria plan election rules.	☐ **Yes** ☐ **No**
Gain in eligibility under another plan because spouse or dependent commences employment	• Drop coverage if employee enrolls in the other plan • Drop coverage for spouse, dependent and/or other family members enrolling in the other plan	No	• Decrease in dollar election • End of enrollment	Corresponding changes required. Employee may not drop coverage unless employee (and/or family members) actually enrolls in the other plan.	☐ **Yes** ☐ **No**

CHART 1

Election Changes for Healthcare Plans Including Health FSA

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Status Changes - these are the only categories of status changes that are permitted					
Dependent gains eligibility under employer's plan	• Enrollment of newly eligible dependent • Drop coverage for employee, spouse, and/or dependents if enrolling in spouse's plan	No	• Enrollment • Increase in dollar election	Group health plans that provide coverage for children must extend eligibility to age 26 without condition (age 26 mandate). When this event is used to enroll children, it is only applicable to children older than age 26 or children outside the age 26 mandate. This event may also be used to drop medical coverage if the same individuals will enroll in the spouse's plan, or when enrolling in excepted benefits, like dental and vision plans, that are not subject to the age 26 mandate, and can place conditions on eligibility for all children (e.g., school enrollment after age 19).	☐ Yes ☐ No
Change in residence that causes employee to gain eligibility For example: • Employee moves into an HMO's service area	• Enrollment of newly eligible employee and dependents	No	• No change permitted	Previously eligible dependents may be added under the tag-along rule in addition to newly eligible spouse and dependents. Employee may only enroll in the plan if newly eligible. No other changes permitted.	☐ Yes ☐ No

CHART 1

Election Changes for Healthcare Plans Including Health FSA

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Status Changes - these are the only categories of status changes that are permitted					
Change in residence that causes employee to lose eligibility For example: • Employee moves out of an HMO's service area	• Drop of coverage if moving out of network area • Change to another similar option	Yes	• No change permitted.	HIPAA special enrollment rights may also apply due to a loss in coverage. See loss of coverage on page 9.	☐ **Yes** ☐ **No**
Change in residence that causes dependent to gain eligibility	• Addition of newly eligible dependent	No	• No change permitted	The change in residence must change the dependent's eligibility to enable the employee to change the election. The ACA prohibits group health plans from placing a residence condition on children under age 26. Despite the ACA prohibition, some HMOs might be designed to permit children moving into the HMO service area to enroll. It may be possible to use the significant change in coverage rules to permit enrollment of the children.	☐ **Yes** ☐ **No**

CHART 1

Election Changes for Healthcare Plans Including Health FSA

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Status Changes - these are the only categories of status changes that are permitted					
Change in residence that causes dependent to lose eligibility	• Drop of coverage for dependent that loses eligibility	Change to another option that provides coverage to both employee and dependent	• Decrease in dollar election • End of enrollment	The change in residence must change the dependent's eligibility to enable the employee to change the election. The ACA prohibits group health plans from placing a residence condition on children under age 26. Despite the ACA prohibition, some HMOs might be designed to limit benefits for children living outside the HMO service area. It may be possible to use the significant coverage curtailment with a loss of coverage, on page 37. HIPAA special enrollment rights may also apply due to a loss of eligibility for coverage. See loss of coverage on page 9.	☐ Yes ☐ No

CHART 1

Election Changes for Healthcare Plans Including Health FSA

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Status Changes - these are the only categories of status changes that are permitted					
Commencement of paid leave of absence (non-FMLA) with a loss of eligibility	• Cancellation of coverage (reinstate on return)	No	• End of enrollment	May cancel coverage. Paid leave includes periods when an employee is receiving replacement income such as salary continuation, short-term disability and long-term disability benefits.	☐ Yes ☐ No
Commencement of paid leave of absence (non-FMLA) without loss of eligibility	• No change	No	• No change permitted	Because there is no loss of eligibility, no changes are permitted.	☐ Yes ☐ No
Commencement of unpaid leave of absence (non-FMLA) with loss of eligibility	• Cancellation of coverage (reinstate on return)	No	• End of enrollment	May cancel coverage.	☐ Yes ☐ No

CHART 1

Election Changes for Healthcare Plans Including Health FSA

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Status Changes - these are the only categories of status changes that are permitted					
Return after paid leave of absence (non-FMLA) (gain eligibility)	• Reinstatement of previous coverage	No	• Reinstatement with blended dollar election • Enroll with new dollar amount (see comments)	May reinstate if eligibility was lost upon commencement of leave. Health FSAs may reinstate with blended dollar election or new short period. For health FSAs, employee has the choice to reinstate prior election or prorated reduction. For example, an employee with a two-month unpaid FMLA and a $1,200 election amount could continue the $1,200 or $1,000 election (10/12 x $1,200).	☐ Yes ☐ No
Return after unpaid leave of absence (non-FMLA) (gain eligibility)	• Reinstatement of previous coverage	No	• Reinstatement if eligibility was lost • Enroll with new dollar amount (see comments)	May reinstate if eligibility was lost upon commencement of leave. FSAs may reinstate with new dollar amount – short period. For health FSAs, employee has the choice to reinstate prior election or prorated reduction. For example, an employee with a two-month unpaid FMLA and a $1,200 election amount could continue the $1,200 or $1,000 election (10/12 x $1,200).	☐ Yes ☐ No

CHART 1

Election Changes for Healthcare Plans Including Health FSA

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Government Programs/Legal					
Commencement of paid FMLA leave of absence	• Continuation of existing election see comments • Cancellation of coverage	No	• Continuation of existing election • End of enrollment	An employer may require continuation of health coverage during paid FMLA if continuation is required for paid non-FMLA leave.	☐ Yes ☐ No
Commencement of unpaid FMLA leave of absence	• Continuation of existing coverage • Cancellation of coverage (reinstate on return)	No	• End of enrollment	If coverage is canceled, the employee must be permitted to reinstate coverage upon return from unpaid FMLA leave.	☐ Yes ☐ No
Return after paid FMLA leave of absence	• Continuation of coverage • Reinstatement of previous coverage	No	• Continuation of coverage • Reinstatement of previous coverage • Election of a pro rata reduction in dollar election	No change permitted after returning from a paid leave unless another event which would permit a change occurs. Coverage may be reinstated whether lost due to nonpayment or by employee election.	☐ Yes ☐ No

CHART 1

Election Changes for Healthcare Plans Including Health FSA

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Government Programs/Legal					
Return after unpaid FMLA leave of absence	• Continuation of coverage • Reinstatement of previous coverage	No	• Reinstatement with prior dollar election • Election of a pro rata reduction in dollar election	Employer may require an employee to be reinstated to his or her election upon return from leave if employees who return from a non-FMLA leave are required to be reinstated in their elections. Employee may make new election only if another event, such as birth of a child, would permit a new election. For health FSA, employee has the choice to reinstate prior election or prorated reduction. For example, an employee with a two-month unpaid FMLA and a $1,200 election amount could continue the $1,200 or make a $1,000 election (10/12 x $1,200).	☐ Yes ☐ No
Judgment, decree, QMCSO, National Medical Support Notice (NMSN) or other legal proceeding	• Must adhere to court order	Must adhere to court order	• Must adhere to court order	Under QMCSO or NMSN rules, a plan must enroll child (and employee, if necessary) in the plan option specified in the order or notice.	☐ Yes ☐ No

CHART 1

Election Changes for Healthcare Plans Including Health FSA

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Entitlement to Medicare	• Drop of coverage for affected individual	No	• Decrease in dollar amount • End of enrollment	An election may only be made upon actual enrollment (i.e., entitlement) into Medicare. Gaining Medicare eligibility only (e.g., reaching age 65) is not sufficient to allow an election change.	☐ **Yes** ☐ **No**
Loss of Medicare Eligibility	• Enrollment of affected individual	Yes	• Enrollment • Increase in dollar election	Not a common event. Could occur if individual entitled to Medicare on the basis of disability or ESRD after a specified recovery period. Could allow employee to add coverage of family members as well under tag-along rule.	☐ **Yes** ☐ **No**
Entitlement to Medicaid (not gain of premium assistance)	• Drop coverage for affected individual	No	• No change permitted	Gain of Medicaid with premium assistance is a HIPAA special enrollment (see page 12).	☐ **Yes** ☐ **No**

CHART 1

Election Changes for Healthcare Plans Including Health FSA

Event	Permitted Changes to Salary Reduction Agreement to Reflect:			Comments	Event Applies to the Plan
	Health Plan	Ability to Change Coverage Option (e.g., HMO, PPO)	Health FSA		
Gain eligibility for SCHIP (not gain of premium assistance)	• No change permitted	No	• No change permitted	Gaining eligibility for SCHIP premium assistance is a HIPAA special enrollment (see page 12).	☐ Yes ☐ No
Gain eligibility for premium assistance in Marketplace	• No change permitted	No	• No change permitted	Under current regulations, this is not a status change that would permit an election change.	☐ Yes ☐ No
Drop Medicare Coverage (not loss of eligibility)	• No change permitted	No	• No change permitted	This is not a change in status that would permit a new election unless there is a loss of eligibility for Medicare. Voluntarily terminating coverage by discontinuing premium payments is not a loss of eligibility.	☐ Yes ☐ No
Lose eligibility for premium assistance in Marketplace	• No change permitted	No	• No change permitted	Under current regulations, this is not a status change that would permit an election change.	☐ Yes ☐ No

CHART 2

Election Changes for Healthcare Plans Except Health FSA

No Health FSA Changes are Permitted Based on Cost or Coverage Change

Event	Permitted Change(s) to Reflect:	Ability to Change Coverage Option	Comments	Event Applies to the Plan
Change in Cost				
Insignificant increase	• Automatic increase in cost	No	A cost increase may be the result of employee action (e.g., switching from full-time to part-time while remaining eligible for plan coverage) or employer action (e.g., a change in the amount of contributions required from employees). The plan document must require the automatic election change in the event of an insignificant cost change.	☐ Yes ☐ No
Insignificant decrease	• Automatic decrease in cost	No	A cost decrease may be the result of employee action or employer action. The plan document must require the automatic election change in the event of an insignificant cost change.	☐ Yes ☐ No
Significant increase	• Payment of increased contributions • Election of another similar, less expensive plan • Drop of coverage if similar plan is not available	Yes, but limited (see comments)	The IRS has not provided guidance on what is a "significant" change in coverage. Employers must look at the facts and circumstances to determine if the increase is significant. Not an "open" enrollment. Only specified changes permitted. For example, if medical cost increased, employee may select less expensive medical. The employee may not make other changes such as drop dental coverage.	☐ Yes ☐ No

CHART 2

Election Changes for Healthcare Plans Except Health FSA

Event	Permitted Change(s) to Reflect:	Ability to Change Coverage Option	Comments	Event Applies to the Plan
Change in Cost				
Significant decrease	• Enrollment • Payment of decreased cost • Enrollment in a more expensive option	Yes, but limited (see comments)	The IRS has not provided guidance on what is a "significant" change in cost. Employers must look at the facts and circumstances to determine if the decrease is significant. Not an "open" enrollment. Only specified changes permitted. For example, if medical cost decreases employee may select a more expensive medical option. The employee may not make other changes such as add dental coverage.	☐ Yes ☐ No
Change in Coverage				
Another employer's open enrollment	• Drop coverage due to enrollment in spouse's plan • Enrollment due to drop of coverage in spouse's plan	Yes, but limited (see comments)	Usually this is related to a spouse's open enrollment. Corresponding changes required (e.g., enrollment in spouse's plan if dropping employer's plan). Other employer's plan must be a cafeteria plan and have a different plan year.	☐ Yes ☐ No

CHART 2

Election Changes for Healthcare Plans Except Health FSA

Event	Permitted Change(s) to Reflect:	Ability to Change Coverage Option	Comments	Event Applies to the Plan
Change in Coverage				
Plan coverage improvement For example • Addition of a new option under the plan	• Enrollment • Election of improved plan option	Yes, but limited (see comments)	Employees may enroll in the option even if they did not previously enroll in another plan option. May enroll dependent(s) not previously covered. Employees enrolled in an existing option may change to the new option. Not an open enrollment. No other changes permitted. For example, if a new option is added to the medical plan, employees may not make changes to other health coverage such as dental or vision.	☐ Yes ☐ No
New plan	• Enrollment in new plan	Yes, but limited (see comments)	May enroll employees and dependents in the new plan. Not an open enrollment. No other changes permitted. For example, if an employer offers dental for the first time, employees may enroll in the dental plan, but may not make changes in other plans such as a new medical plan election.	☐ Yes ☐ No

CHART 2

Election Changes for Healthcare Plans Except Health FSA

Event	Permitted Change(s) to Reflect:	Ability to Change Coverage Option	Comments	Event Applies to the Plan
Change in Coverage				
Significant coverage curtailment without loss of coverage	• Revocation of election • Election of coverage, on a prospective basis, that provides similar coverage	Yes, but limited (see comments)	A significant curtailment in coverage is defined as an overall reduction in coverage provided to participants under the plan so as to constitute reduced coverage to participants generally. This includes a significant increase in employees' plan deductibles, copayments or out-of-pocket cost-sharing limits. Might involve substantial changes to providers in a network (e.g., 1/3 of the hospitals leave the network), but would not be available for situations such as the loss of a single physician even if that physician is the employee's primary care physician.	☐ Yes ☐ No
Significant coverage curtailment with loss of coverage	• Election of a similar plan • Drop coverage, but only if a similar plan is not available	Yes, but limited (see comments)	Curtailment must apply overall and be considered a virtual loss of coverage. This includes: elimination of a benefits option or an HMO ceasing to be available in the coverage area. It could also include reduction in benefits for a specific condition or treatment that participant in undergoing. This event may allow an employee to change coverage options when a dependent's coverage is reduced by moving outside an HMO service area but the dependent retains plan eligibility.	☐ Yes ☐ No

CHART 3

Election Changes for Dependent Care Assistance Plans (DCAPs)

Event	Permitted Change(s) to Reflect	Comments	Event Applies to the Plan
Change in dependent care provider For example • Change in residence affects available care providers	• Enrollment in DCAP • Increase in dollar election • Decrease in dollar election • End of enrollment in DCAP	Consistency rule applies (e.g., employee may change salary reduction to reflect enrollment if a new provider becomes available or the end of enrollment if losing existing provider). Election change is permitted even if provider switches from day care center to relative.	☐ Yes ☐ No
Change in the cost of day care	• Increase in dollar election • Decrease in dollar election	Election change is permitted only if the provider is not related to the employee.	☐ Yes ☐ No
Change in the number of hours of dependent care and care costs	• Increase in dollar election • Decrease in dollar election	Consistency rule would apply (e.g., an employee could increase an election if she increased her work hours and needed more hours of day care for her child).	☐ Yes ☐ No
Marriage	• Enrollment in DCAP • Increase in dollar election • Decrease in dollar election • End of enrollment in DCAP	Enrolling or increasing the dollar election can occur to accommodate newly qualified dependents. Ending enrollment may be needed if new spouse is not employed.	☐ Yes ☐ No

CHART 3

Election Changes for Dependent Care Assistance Plans (DCAPs)

Event	Permitted Change(s) to Reflect	Comments	Event Applies to the Plan
Divorce, annulment or legal separation	• Enrollment in DCAP • Increase in dollar election • Decrease in dollar election • End of enrollment in DCAP	Enrolling or increasing the dollar election can occur to accommodate newly qualified dependents. For example, an employee's ex-spouse begins employment and can no longer provide care while the employee works.	☐ Yes ☐ No
Birth or adoption	• Enrollment in DCAP • Increase in dollar election	An increase in the dollar election can occur to accommodate newly eligible dependents.	☐ Yes ☐ No
Child attains the age of 13	• Decrease in dollar election • End of enrollment in DCAP	Child ceases to be a qualified dependent on his/her 13th birthday. After age 13, the child must be physically or mentally incapable of self-support to be a qualified dependent. A decrease in dollar election is permitted to account for a dependent losing eligibility. May end enrollment if no more eligible dependents.	☐ Yes ☐ No
Child over the age of 13 becomes disabled	• Enrollment in DCAP • Increase in dollar election	After age 13, the child must be physically or mentally incapable of self-support to be a qualified dependent.	☐ Yes ☐ No

CHART 3

Election Changes for Dependent Care Assistance Plans (DCAPs)

Event	Permitted Change(s) to Reflect	Comments	Event Applies to the Plan
Previously disabled child over the age of 13 recovers from the disability	• End of enrollment in DCAP • Decrease in dollar election	A decrease in dollar election is permitted to account for a dependent losing eligibility. May end enrollment if no more eligible dependents.	☐ Yes ☐ No
Change in employment status that causes the employee to gain eligibility For example: • Part-time to full-time	• Enroll in DCAP • Increase in dollar election	Employee may gain eligibility for dependent care or may have increased need (e.g., such as a change from part-time to full-time).	☐ Yes ☐ No
Change in employment status or termination that causes an employee to lose eligibility For example: • Unpaid leave • Strike • Lockout • Layoff	• End of enrollment in DCAP • Decrease in dollar election	Employee will have no qualified expenses during a leave of absence (paid or unpaid).	☐ Yes ☐ No

CHART 3

Election Changes for Dependent Care Assistance Plans (DCAPs)

Event	Permitted Change(s) to Reflect	Comments	Event Applies to the Plan
Begin FMLA or other leave (paid or unpaid)	• Decrease in dollar election • End of enrollment in DCAP	Employee may have qualified expenses during short, temporary absences of two consecutive weeks or less. After the two weeks, the employee will have no qualified expenses during the remainder of the leave.	☐ Yes ☐ No
Return from FMLA or other leave (paid or unpaid)	• Reinstatement of coverage		☐ Yes ☐ No
Return from strike, lockout, or layoff	• Reinstatement of coverage		☐ Yes ☐ No

CHART 3

Election Changes for Dependent Care Assistance Plans (DCAPs)

Event	Permitted Change(s) to Reflect	Comments	Event Applies to the Plan
Rehire employee within 30 days	• Reinstatement of prior election • Denial of reinstatement until the next plan year		☐ Yes ☐ No
Rehire employee after 30 days or more	• Selection of new election • Reinstatement of prior election • Denial of reinstatement until the next plan year		☐ Yes ☐ No
Commencement of employment by spouse	• Enrollment in DCAP • Increase in dollar election	Enrolling or increasing the dollar election can occur to accommodate newly qualified dependents.	☐ Yes ☐ No
Loss of eligibility under another plan due to spouse's termination or change in employment status	• Enrollment in DCAP • Increase in dollar election	Employee may choose to enroll if coverage was provided under the spouse's DCAP.	☐ Yes ☐ No

BENEFIT ADMINISTRATOR OVERVIEW AND CHECKLISTS

This is an overview of items pertinent to day-to-day tasks for benefit administration, this is not all-encompassing and more details can be found throughout this Admin Manual. As always, if you have questions reach out to your Gallagher team.

Carrier Logins/Set Up	
Gallagher	**Completion Status**
Notify Gallagher of your new Administrator. Provide their name, job title, email address, and phone number.	
Meet with Gallagher Account Manager to go over EBC Admin Manual*	
Carriers	**Completion Status**
Businessolver Login Credentials Received/ Confirm Access*	
Blue Access for Employers (BAE) Login Credentials Received/ Confirm Access*	
Login Credentials for Add'l Carrier Platforms Received/Confirm Access	
BenefitSolver	**Completion Status**
Review training videos in Heart2Heart	
Review ACA videos	

Carrier Login/Setup Notes:

- Your Gallagher Account Manager will reach out after getting the notification of the new Administrator to set up a day and time for the Admin Manual Training
- Your Gallagher Account Manager will request the login credentials for BenefitSolver and Blue Access for Employers (BAE).
  - » Note: The district is responsible for setting up new administrator for any other carrier portals.

Please note: The district should ensure that the tasks noted in the chart above are completed for new benefit administrators at their district. These tasks should be completed shortly after the start date of the new administrator.

Ongoing BenefitSolver Related Tasks

Change in Employment Status	
Task	**Completion Status**
Add newly hired, benefit eligible employees in BenefitSolver. • As early as 60 days before their start date • No later than 30 days from when they start	
Terminate employees in BenefitSolver timely • No later than 30 days from when they terminate	
If an employee is going on Leave of Absence (LOA), update BenefitSolver • No later than 30 days the event	
If a person retires and *does not keep their coverage* with the district, process an employment termination.	
If a person retires and keeps their benefits with the district, follow these steps: 1. Terminate the employee 2. Reinstate them as a retiree	

BENEFITSOLVER TRANSACTION NOTES:

- File Feeds - Any updates you make on Businesssolver will be sent over to any carriers that have a **file feed** set up. Files run after midnight on Tuesday night/Wednesday morning each week.
- If you need a **haste enrollment**, issue a case in BeneftitSolver and assign it to your Gallagher Account Manager. A haste enrollment typically takes up to two business days to process.
- Utilize the Case Manager option in Businesssolver if you need to update an employee's record (because you are unable to) or if you have any questions about that record.
- **IMPORTANT:** Unless you are self-serve and have a file feed setup, you are responsible for entering new hires and terminations in the carrier's platform. As a reminder, a file feed will always be sent to BCBS and MetLife.

ACA Reporting (applies to districts who utilize Businessolver for ACA reporting)	
Task	**Completion Status**
Q1 ACA Data Reviewed and Certified	
Q2 ACA Data Reviewed and Certified	
Q3 ACA Data Reviewed and Certified	
Q4 ACA Data Reviewed and Certified	
Total Employee Count vs FT Employee Count Confirmed	
Address ACA Transmittal Errors	
Sign off ACA Transmittal Status	

ACA REPORTING NOTES:

- There are two methods for you to review your ACA data. Please refer to page 45 of the EBC manual.

Evidence of Insurability (EOI) Transactions (applies to district who are self-serve and offer voluntary products)	
Task	**Completion Status**
Review pending EOI elections following Open Enrollment or when you know a new employee logged into the system to make elections	
Follow up with employees who are pending EOI to remind them to submit their EOI application • Note – We recommend giving employees 30 days from when they make the election to complete the EOI application.	
Approve/Deny/Expire elections that are pending EOI	

EVIDENCE OF INSURABILITY (EOI) NOTES:

- You should not begin employee deductions for any amount that is pending EOI, until it has been approved by the carrier.
- If your carrier is Reliance Standard:
  - » You will receive a monthly push report that will provide the status of all current submitted EOI forms.

EBC Invoices (released on the 25th of each month)	
Task	**Completion Status**
Does the 15th day rule apply to your district?	Yes or No
Retrieve and review BCBS Medical Invoice	
Retrieve and review Reliance Basic Life/ADD Invoice	
Retrieve and review MetLife dental Invoice (if it applies to you)	

BILLING/INVOICE NOTES:

- EBC 15th Day Rule
  - » There is a 15 day rule for EBC lines of coverage –
    - Start Date: if a newly enrolled employee has an effective date of coverage from the 1st to the 15th of the month, the district will be charged premium for the month. However, if hired from the 16th of the month on, the district will not be charged.
    - Term Date: If an employee terminates between the 1st and the 15th of the month, the district will not be billed for that month's premium. However, if an employee terminates after the 15th of the month, the district will be billed the premium for that month.
- Any changes entered after the 19th of the month will captured in the following month's invoice.
- If Businessolver produces invoices for other lines of coverage that are not listed above, please be sure to retrieve and review those invoice as well.
- It always recommended that you compare your invoices against your payroll report.
- If you notice an error in an invoice, pay the invoice in full and notify your Gallagher Account Manager. Adjustments/ credits will be reflect in the following months invoice.

Carrier Cheat Sheet

Recommendation: Populate the following carrier sheet with your applicable carriers for quick reference.

Line of Coverage	Carrier
Medical	BCBSIL
Basic Life/ADD	Reliance Standard
Dental	
Vision	
Voluntary Life/ADD	
H.S.A	
F.S.A	
H.R.A	

Contact Cheat Sheet

Recommendation: Populate the following contact sheet with your designated account managers and benefit consultants for quick reference.

Carrier/Vendor	Contact Name	Phone Number	Email Address
Gallagher Account Manager			
Gallagher Benefit Consultant			
Businessolver Support Team	Admin Support	844.411.4784	ebc@businessolver.com
Reliance Standard Account Manager			

QUICK OPEN ENROLLMENT CHECKLIST

Note: Districts may have additional tasks to complete for Open Enrollment that are not included in this checklist.

Task	Notes	Completion Status
Open Enrollment Schedule (Dates or Month)	• Notify Gallagher • Share the dates with your employees	
District Employee Communication	• Prepare emails, newsletters, memos, and/or intranet notices • Include Open Enrollment period • Include benefits that will be offered during the given Open Enrollment period	
COBRA Members	• Run a COBRA report in Businessolver to identify COBRA population • Share Open Enrollment communication with COBRA participants	
Open Enrollment Meetings	• Provide dates/times/location to Gallagher • Request the carriers you would like to attend the meeting (BCBS, Guardian, etc.)	
Carrier Open Enrollment Employee Communication	• Notify Gallagher if you would like to receive benefit summaries and booklets from the carriers (MetlIfe, VSP, Guardian, etc.)	
Gallagher Benefit Summary	• Approve draft version • Confirm receipt of final version (electronically) • Request hard copies from Gallagher (if necessary)	
BCBS SBCs	• Distribute to all employees during OE. Rules regarding electronic delivery are included in the SBC email sent by Gallagher	
BCBS Member Profile Change Forms (if requested)	• Request from BCBS following annual process if applicable	
Include Notices in OE Packet	• Grandfathered Plan Notice (if applicable) • Women's Health and Cancer Rights Notice • CHIPRA State Premium Assistance Notice • Summary of Benefits and Coverage (SBC) • Gallagher Benefit Summary	
Businessolver		
Clean House	• Run an Employee Dependent Benefit Census and audit records to ensure they are up-to-date • Approve/Deny any pending transactions • Approve/Deny any transactions that are pending EOI (Vol Life, LTD, CI)	
Rates	• Provide Businessolver with rates for any lines of coverage Gallagher is not the broker	
***** Self-Serve Districts *****	• Share OE dates with Businessolver • Provide ER/EE rate breakdown to Businessolver • Approve platform messages • Test Site	

NOTICES

Notice	District Action
Notices for new employees and/or during open enrollment	
Certificate of Creditable (or non-creditable coverage) Drug Coverage	Give to employees upon enrollment.
HIPAA Privacy notice (if applicable)	Distribute notice to new members upon enrollment.
Summary of Benefits and Coverage (SBC)	Districts should distribute SBC's to new hires with their benefit materials and to all employees during their annual open enrollment (two sided, no more than four pages in length). Please note there are specific rules regarding electronic delivery (refer to the Electronic Distribution Matrix Notice included in the SBC email sent by your Account Manager annually).
Market Notice Exchange	Districts are required to provide the notice to all employees, regardless of plan eligibility or enrollment status, part-time/full-time status, or status as a regular, temporary or seasonal employee, within 14 days of the employee's start date.
Women's Health and Cancer Rights Act Notification	Distribute notice to new members upon enrollment and all employees during the district's annual open enrollment.
Annual Notices (not including open enrollment)	
Certificate of Creditable (or non-creditable) Drug Coverage	An email is sent to all districts from an EBC representative to notify the Centers for Medicare and Medicaid Services (CMS) of your creditable coverage within 60 days of the beginning of the plan year (July 1).
	Districts should also provide a notice to members on an annual basis prior to October 15. Reminder is sent to all districts in September.
CHIPRA State Premium Assistance Notice	Assistance is not available in Illinois, but could be applicable to employees with children residing in a different state. Districts should provide to members on an annual basis.
Grandfathered status notice (if applicable)	Districts should distribute this notice each year for plans which are still grandfathered. If district offers multiple plans, identify which plan(s) the grandfathered notice applies to and remember to include the district's contact information on the notice.
Nonfederal Governmental Plan Opt Out Notice (if applicable)	If your district opted out of Mental Health Parity, provide employees and CMS an annual notice informing
Wellness Program Notice (if subject to HIPAA and if applicable)	If your district provides a reward for the completion of a wellness program or initiative, your district will need to provide an annual notice informing employees of the ability to obtain this reward by an alternative means. Model notices are available.
Notice sent every three years	
Notice of availability of HIPAA Privacy Notice	Districts should provide to members every three years. EBC representatives send sample notice when HIPAA Privacy Notice is due.
COBRA Notices	
COBRA general/initial notice – provided to employee and spouse within 90 days of commencement of coverage	Businessolver provides notice to new members.
COBRA Early Termination Notice	Businessolver will provide notice to COBRA participants.
COBRA Election Notice – within 14 or 44 days of qualifying event	Businessolver will provide notice to members who have a qualifying event.
COBRA Unavailability Notice – within 14 days of qualifying notice	Consult with your district's legal counsel if a member will not be offered COBRA.
HIPAA Certificate of Creditable Coverage – upon termination of coverage	Consult with your district's legal counsel if a member will not be offered COBRA.

Notice	District Action
Event Specific Notices	
30-Day advance notice of rescission	EBC districts did not have wording relating to rescission prior to PPACA requirements. The plans do not allow for rescission.
Material modification to Summary of Benefits notice	Notifications will need to be provided for any plan changes is 60 days prior to the plan change. Model notice is available.
Michelle's Law (if applicable)	Medical coverage has increased limiting age to 26 regardless of student status.
Patient Protection Model Notice (PCP and OB/GYN Choice Notice) for non-grandfathered plans only	Notification should be sent out the first day of the first plan year starting on or after the date grandfathered status is lost, or whenever an SPD or other similar description of the plan benefit is provided.
Qualified Medical Child Support Order (QMCSO) Notices: (1) Notification of receipt of order – promptly after receiving order or, (2) Notification of determination – within a reasonable period	If a custodian of an employee's child produces a Qualified Medical Child Support Order, districts are required to respond to the order and provide coverage to the child. If you district receives one of these orders, please contact your Gallagher representative and legal counsel or guidance.
	Districts are required to notify employees that the child will be placed on the plan. Sample notices are available.
Notices included in BCBS booklets or provided by BCBS	
Newborns' and Mother's Health Protection Act Disclosure	No action necessary, included in BCBS booklet.
Notice of HIPAA Special Enrollment Rights	No action required, included in BCBS booklet.
Summary Plan Description	No action required. Responsibility of BCBSIL for the HMO Plan.
Notices included in BCBS booklets or provided by BCBS	
Section 125 Automatic/evergreen election notice (if applicable)	If your district automatically enrolls employees in the prior years' Section 125 elections, work with your vendor to develop the appropriate notices to provide to employees upon enrollment.
Section 125 pre-tax salary reduction agreement	If your district has a Section 125 plan, work with your vendor to develop agreement.
Pending Notices	
Quality of Care notice (non-grandfathered plans)	Awaiting further guidance.

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This benefits guide prepared by

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