MAYFLOWER MUNICIPAL HEALTH GROUP

EMPLOYEE MANUAL

July, 2018

Mayflower Municipal Health Group

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MMHG/Insurance Carriers/Other Programs Website/Contact Information:

Mayflower Municipal Health Group Website:

www.MMHG.org

Blue Cross Blue Shield of Massachusetts:

Phone: 1-800-782-3675 Website: www.bluecrossma.com

Blue Medicare RX Phone: 1-888-543-4917

Harvard Pilgrim Health Care:

Phone: 1-888-333-4742 Website: www.HarvardPilgrim.org

Delta Dental of Massachusetts:

Phone: 1-800-872-0500 Website: www.DeltaDentalMa.com

SmartShopper Incentive program:

Phone: 1-877-281-3722

CanaRx Prescription Drug program:

Phone: 1-866-893-6337

www.MMHGrx.com

Mayflower Municipal Health Group Website:

www.MMHG.org

Mayflower Municipal Health Group reserves the right to request additional documentation in order to support eligibility and/or satisfy the requirements for reinsurance purposes. Please contact your benefit personnel regarding eligibility/premium questions.

Disclaimer: The information provided in this guide does not constitute legal advice and does not establish a contractual relationship. Regulations and procedures can change according to the law and at the discretion of the MMHG.

Quick reminders: Plan information, change primary care physician, ID card replacement, address change.

PLAN INFORMATION:

- You will find all plan information available online at: **www.MMHG.org** or contact your Benefit Coordinator for printed materials or more information.

  Visit the insurance carrier's websites to review your claims, compare costs, find a doctor/provider, look up your prescription drug coverage tier, and much more.

CHANGE YOUR PRIMARY CARE PHYSICIAN:

- You may contact either Blue Cross Blue Shield of Massachusetts (BCBS) or Harvard Pilgrim Health Care (HP) to change your Primary Care Physician (PCP).

I.D. CARD REPLACEMENT

- You may order replacement I.D. cards by calling BCBS/HP/Delta Dental and please confirm your mailing address.

ADDRESS CHANGE

- Notify your employer and insurance providers of your address change within 30 days.

HEALTH PLAN OPTIONS

Please ask your employer for a list of MMHG plans offered and premium cost. Please research your insurance plan options to decide which plan is the best fit for your needs. If you have specific detailed questions regarding ongoing treatment or procedure that is not listed in the plan summaries please inform your Employer.

Resources: All benefit information is available on our Website: www.MMHG.org

Benefit information: Comparison of Benefits, Summary of Benefits, Summary of Benefits and Coverage (SBC), Subscriber Certificates/Handbook

Special Programs: Save money with the CanaRX prescription drug program and the SmartShopper incentive program. See our website for more information and upcoming new programs.

Wellness programs: Check out our online wellness calendar at www.MMHG.org for upcoming wellness events.

Insurance Carriers' websites: Visit the insurance carriers' websites to review your claims, compare costs, find a doctor/provider, look up your prescription drug coverage tier, and much more.

COVERAGE EFFECTIVE DATE

- Employees must enroll the first day of the month following date of hire. *Please note that if your date of hire/first day worked is the first day of the month , MMHG allows enrollment as of your date of hire in accordance with union contracts that may be in place.* Newly hired employees are not eligible for benefits before they actually begin employment.
- During the Annual Open Enrollment period (April 15th-May 15th) with an effective date of July 1st
- Qualifying event date (involuntary loss of coverage, marriage, birth, divorce, adoption, legal guardianship, etc.)*
- Employee turns age 26 and loses coverage under parent's plan (usually 1st day of the month following birthday)*
- Date dependent voluntarily canceled coverage under another health/dental plan due to the total cessation of an employer's contribution*
- Date the employee qualifies as part time (20 hours per week set by M.G.L. ch.32B Sect. 2)*
- Retirement Date (must be eligible retiree receiving allowance from your community)*

* You must notify your employer within 30 days and Medicare information is required

Attention: *Some private employers have established a Section 125 Trust plan (cafeteria plan) with the IRS that instructs when members may be added, removed, or transferred within the employer's group health plan. There might be a significant increase in cost or significant decrease in coverage under the member's current health plan and member is locked in the plan for calendar year. If we receive an enrollment request that doesn't comply with our eligibility policy, but does comply with the employer's Section 125 Trust Plan, the request can be approved with documentation of the employer's qualifying events as filed with the IRS*

CANCEL EFFECTIVE DATE

- Coverage ends on the last day of the month in which your employment terminates or reduction of hours to fewer than 20 hours per week. School employees who give their notice at the end of the school year may be continued during the months of July and August provided that contributions for those months were deducted from their compensation in the preceding school year.*
- You may voluntarily cancel your insurance throughout the fiscal year but must give **advance** notice of the cancellation. Example: You sign termination form on May 15th so cancel date is effective May 31st. No retro voluntary terminations.
- Dependents may be voluntarily cancelled by the subscriber throughout the fiscal year with **advance** notice. Please indicate on form if the cancellation changes coverage type.
- Dependents-Coverage ends the last day of the month dependent turns age 26 or voluntarily cancels.
- Dependent child of Dependent-Coverage ends the last day of the month dependent turns age 26 or when dependent is no longer enrolled (whichever comes first).
- Deceased- Active plan members are cancelled the day after death;
  Medex/Blue Medicare RX PDP subscribers=last day of the month after death*
  Death certificate is required if death occurred more than 30 days ago.
- Former spouse-Date the employee or former spouse gets remarried/or sooner as specified in divorce decree.*

* Applications must be received within 30 days

Caution! Subscribers who want to immediately cancel their spouse and/or dependent due to domestic issues could be financially responsible for retroactive reinstatements and/or any claims incurred as ordered by the Court.

NEW HIRE- list of forms needed for coverage

NOTE: If you are a new employee and do not want to enroll in benefits you must sign the waiver on the last page and return it to your employer.

If you are a new employee and would like to enroll in health insurance, you must make your health benefit plan election within 30 days of your date of hire. The effective date for coverage is the first day of the month after your date of hire. (Example: Hire date is May 15th, you have until June 14th to submit your enrollment paperwork, and your insurance coverage is effective June 1st) *Please note that if your date of hire/first day worked is the first day of the month , MMHG allows enrollment as of your hire date in accordance with employer contract.*

To select your benefits, please submit the following forms completely and legibly to your employer. Keep a copy of all documents for your records.

Individual Coverage:

- ✓ Completed HP/BCBS/Delta Dental enrollment form (HMO plans must have primary care physician (PCP) listed with PCP # and reside in plan enrollment service area)
- ✓ Signed Employee Acknowledgement Form
- ✓ Copy of your Medicare card (if applicable) or proof of ineligibility

Family Coverage:

- ✓ Completed HP/BCBS/Delta Dental enrollment form (HMO plans must have primary care physician (PCP) listed with PCP # and reside in plan enrollment service area)
- ✓ Employee Acknowledgement Form
- ✓ Copy of Medicare card or proof of ineligibility for all members on your plan (if applicable)
- ✓ Spousal coverage- copy of certified marriage certificate **(church documents are not acceptable)** Retiree must have insurance in order for spouse to have insurance.
- ✓ Dependent Coverage (up to age 26): Copy of certified birth certificate showing parent-child relationship to the insured or his/her spouse. Copy of adoption placement letter.
- ✓ Dependent child of a Dependent coverage: Up to age 26 Dependent must be enrolled on subscribers plan in order for their child to be enrolled. Copy of certified birth certificate showing parent-child relationship is required. Once coverage ends for the dependent, their child's coverage also ends.
- ✓ Divorce or Legally Separated former spouse:
  - The following Separation Agreement/Divorce decree sections are **required**:
    - Page with Divorce Absolute Date
    - Signature Page
    - Health Insurance Language
    - Former Spouse's Address

Obtaining Required Documentation:

Documents such as marriage certificates and birth certificates can be obtained by contacting the Town Clerk's office where the event occurred.

Adoption verification information can be obtained by contacting the adoption agency used or the Clerk of Court's office where the event occurred.

We encourage you to contact the appropriate offices as soon as possible. There may be a waiting period to obtain information.

LOSS OF COVERAGE DOCUMENTATION

If you experience an involuntary loss of coverage (spouse leaves their employment, etc.) you must provide the following in addition to the new hire information listed above.

1) Letter from spouse's employer stating the loss of coverage was **involuntary** or they ceased contribution toward the premium cost for your spouse's plan **OR** COBRA offer letter containing reason for insurance termination. **AND**
2) Evidence of Coverage certificate letter from former insurance carrier listing covered members and confirming the date coverage ends.

LEGAL SEPARATION/DIVORCE

Your former spouse will remain eligible for coverage under your group membership until you are no longer required by the judgment to provide health insurance for the former spouse or the subscriber or former spouse remarries, whichever comes first.

REMARRIAGE OF SUBSCRIBER

Coverage terminates for former spouse on date of your marriage. Your ex-spouse may not continue to be covered on your family plan even if your new spouse doesn't want to be added. If divorce decree requires continued coverage for former spouse, he/she may be enrolled under an individual plan and you will pay 100% of the premium cost.

REMARRIAGE OF FORMER SPOUSE

Coverage terminates for former spouse on date of his/her marriage.

IMPORTANT: If you are covering your spouse or former spouse , you must notify your employer of Divorce/Legal Separation/remarriage within 30 days. Failure to notify MMHG could result in financial liability to you and/or former spouse.

SUBSCRIBER MOVES OUTSIDE OF PLAN SERVICE AREA

If you move out of the service area for your HMO plan you must notify your employer within 30 days and switch to either an HMO New England plan or PPO plan (effective date is the date you moved).

DEPENDENTS RESIDING OUTSIDE OF PLAN SERVICE AREA

HMO plans provide limited coverage for student dependents that live outside the service area. You should enroll in a PPO plan or attain coverage for the out of state student dependent elsewhere. If you have a dependent (not student) that lives out of state then you will need to enroll in a PPO plan.

RETIREMENT

Contact your employer about your retirement eligibility. Please inform your employer if you and/or any member on your plan are eligible for Medicare now or become eligible in the future.

MEDICARE ELIGIBILITY/ENROLLMENT

- All insured subscribers, including members under age 65, are required to notify their employer when they or any member on their plan becomes eligible for Medicare for any reason including disability or ESRD (End Stage Renal Disease).
- Medicare eligibility information must be completed on the enrollment form and if eligibility is due to End Stage Renal Disease (ESRD), the first date of treatment must be disclosed.
- Failure to notify MMHG may result in additional out of pocket cost for you due to insurance carriers' incomplete coordination of benefits information.

Retired Medicare enrolled subscribers and any member on their plan must maintain enrollment in Medicare Parts A&B and/or pay any Income Related Monthly Adjustment Amounts (IRMAA) in order to have coverage with MMHG.

If you are an Active employee: If you are actively working for your governmental unit, you and any Medicare eligible members on your plan must enroll in Medicare Part A only (Medicare secondary payer).

If you are a Retiree: If you are retired from your governmental unit, you and any Medicare eligible members on your plan must enroll in Medicare Parts A & B and move to supplement plan(s)*. Submit copies of Medicare Cards for all Medicare eligible members to your employer. (Medicare is primary payer)

- ***IMPORTANT: If you are retired and have a spouse plus dependent children on the plan you may remain on a family plan only if you and all Medicare eligible members on your plan enroll in Medicare Parts A & B (Medicare is Primary payer).**

MEDICARE PART D

MMHG offers a comprehensive Medicare Part D prescription drug plan (PDP) that is designed to work with our Medicare supplement medical plan. As a retired subscriber you (and Medicare enrolled members on your plan) must not voluntarily enroll and pay for another Medicare Part D plan as this cancels the MMHG PDP enrollment and will jeopardize your eligibility for the MMHG Medicare supplement medical plan. The only exception would be if a member is residing in a nursing home and /or receiving Medicare Part D coverage at no cost. **Please notify MMHG as soon as possible**.

MMHG WELLNESS PROGRAM

MMHG has a very active wellness program committed to helping members live a healthy lifestyle. We offer a wide variety of programs including healthy eating, exercise classes/challenges, mind-body connection, smoking cessation, support groups, quarterly newsletters and much more. You will be sent MMHG Wellness emails regarding upcoming programs. Visit our website www.MMHG.org for calendar of events and programs.

ANNUAL OPEN ENROLLMENT

Non-Medicare Health/Dental insurance plans

Annual Open enrollment for non-Medicare Health/Dental insurance plans is from April 15th-May15 with effective date of July 1st.

If you are switching between MMHG plans, you do not have to provide supporting documentation (marriage certificates, dependent birth certificates, etc.) if you have already provided them when you initially enrolled.

Medicare supplement plans with PDP (for retirees and their dependents with Medicare Parts A&B)

Annual Open enrollment for Medicare supplement plans (with PDP) takes place every fall with effective date of January 1st.

KEEP THIS COPY FOR YOUR RECORDS

Employee Acknowledgement:
(Employees/Retirees must sign and return to employer)

- I understand that I am required to notify my employer within thirty (30) days of the following events if I plan to enroll on the insurance now or in the future:

  a. Marriage
  b. Birth of a child
  c. Adoption of a child or placement for adoption/legal guardianship
  d. Divorce or Legal separation
  e. Dependent child turns age 26
  f. Death of a dependent
  g. Dependent's enrollment in another plan
  h. Myself, or any member on my policy becoming **eligible for Medicare** and/or enrolling in Medicare
  i. Former spouse's re-marriage-former spouse is cancelled when subscriber or former spouse gets remarried
  j. Change of address

Caution: Failure to notify your employer that your spouse/dependent(s) is/are no longer eligible may result in you being financially responsible for any claims that were paid for an ineligible member. Your contract may be cancelled retroactively if you have committed fraud or misrepresented yourself and/or dependent(s).

- I understand that I may cancel health insurance for myself and/or dependent(s) voluntarily at any time by submitting a signed application with advanced notice for future effective date.

- If I decline insurance or cancel coverage I understand that I may only enroll during the next open enrollment period (effective July 1st) unless a valid qualifying event occurs. I will provide notice to my employer within 30 days of qualifying event.

- I have received the comparison of benefits, summary of benefits and coverage (SBC) and/or other benefit plan summary information that explain my insurance benefits, HIPAA notice of privacy practices **or** have gone online to receive this information at www.MMHG.org

Mayflower Municipal Health Group reserves the right to request additional information to support eligibility in accordance with G.L. c.32B section 6. Failure to supply required information may result in an employee/retiree being declared ineligible.

Acceptance/Waiver of Insurance-THIS IS YOUR COPY

Please check off your selection:

☐ **I ACCEPT enrollment at this time** **Or** ☐ **I DECLINE enrollment at this time**

_____ _____

Signature (subscriber) **Date**

Print Name:_____ / Employer/Governmental Unit:_____

Email address _____Spouse's email address:_____

Please provide email address for important MMHG updates including wellness emails with incentive programs. Your email address will not be sold, shared or rented.

SUBMIT TO YOUR EMPLOYER

-Employee Acknowledgement:

(Employees/Retirees must sign and return to employer)

- I understand that I am required to notify my employer within thirty (30) days of the following events if I plan to enroll on the insurance now or in the future:

  k. Marriage
  l. Birth of a child
  m. Adoption of a child or placement for adoption/legal guardianship
  n. Divorce or Legal separation
  o. Dependent child turns age 26
  p. Death of a dependent
  q. Dependent(s) enrollment in another plan
  r. Myself, or any member on my policy becoming **eligible for Medicare** and/or enrolling in Medicare
  s. Former spouse's re-marriage-former spouse is cancelled when subscriber or former spouse gets remarried
  t. Change of address

Caution: Failure to notify your employer that your spouse/dependent(s) is/are no longer eligible may result in you being financially responsible for any claims that were paid for an ineligible member. Your contract may be cancelled retroactively if you have committed fraud or misrepresented yourself and/or dependent(s).

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Acceptance/Waiver of Insurance-EMPLOYER COPY

Please check off your selection:

☐ **I ACCEPT enrollment at this time** **Or** ☐ **I DECLINE enrollment at this time**

_____ _____

Signature (subscriber) **Date**

Print Name:_____ / Employer/Governmental Unit:_____

Email address _____Spouse's email address:_____

Please provide email address for important MMHG updates including wellness emails with incentive programs. Your email address will not be sold, shared or rented.