

MMIA EMPLOYEE BENEFITS ADMINISTRATION HANDBOOK

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up to date online at
www.mmia.net.

Please use this online
resource for the most
current information.



Questions?

Call MMIA at 1-800-635-3089 or
visit us online www.mmia.net.

Remember...MMIA is a member
owned organization. We value
your input and involvement.

This handbook is intended to provide an easy-to-use reference in the administration of employee benefits to members of the MMIA program. Complete information can be found in the Summary Plan Document. This handbook is not a replacement of that information.

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GENERAL INFORMATION

Montana Municipal Interlocal Authority (MMIA) is a member owned risk retention pool. Cities and towns join the program to cover each other's expenses and reap the benefits of the stability of being a pool member. Our Employee Benefits (EB) program provides self-funded medical, dental, and vision coverages to employees via their employer city or town. We also make available access to affordable life insurance coverage.

MMIA does use the services of third party administrators such as Allegiance to process claims, however, the ultimate plan design and implementation comes from MMIA. We comply with state and federal requirements and use the advisement of our EB committee, made up of members, to stay responsible and innovative.

The majority of MMIA EB plan costs are actual claim dollars. If you think of MMIA as a piggy bank the concept may be a bit clearer. We all contribute to this piggy bank and withdraw from it as claims arise. The only way to manage the rising costs of claims is to manage the reasons the claims are occurring. MMIA does this by promoting an annual wellness program that includes a health screening blood draw, encouraging utilization of cost containment initiatives through case/disease management, and providing education to our participants so that everyone can have ownership in their healthcare.

This handbook is designed to give our members a quick reference for common questions and issues that occur while administering employee benefits. It does not replace, nor supersede, the program agreement or other plan documents provided to your member city or town.

Finally, it's imperative to note that plan administrators, such as city clerks or managers, can find themselves in a position of assisting employees with health questions. Privacy laws under the Health Insurance Portability and Accountability Act (HIPAA) are fairly clear in their interpretation. **Employers should not be handling private health information for their employees.** This means that if an employee comes in with questions about claims, they should be directed to the customer service of Allegiance. Although it may seem like good service to do the footwork or even listen to the details that an employee freely provides, it is actually putting both you and your city/town in a dangerous position. HIPAA does enforce violations of private health information breeches and will fully investigate complaints.

ELIGIBILITY GUIDELINES

Employee eligibility is based upon the eligibility criteria of each city or town. This includes classification of eligible employees and statement of the number of work hours required to be eligible. These requirements are critical to coverage under your plan, and we recommend that you review the individuals who are listed as eligible from time to time to be sure they are actually within an eligible class and working enough hours to be covered under your health benefits.

Dependent children are eligible for the medical, dental and vision plans through age 26 regardless of student or marriage status.

Domestic partnerships is an area of confusion and whether or not they are eligible to be covered. As noted in our Summary Plan Document (SPD), the coverage is allowed but is up to the city or town and must be written into your personnel policy.

Changing coverage mid-year is only allowed within 31 days of a qualifying event. Qualifying events are things such as marriage, birth, divorce, or loss of other coverage. If such an event occurs and an employee wishes to add someone to their plan or change their choice of plans, they may do so.

Annual Changes and Group Enrollment

Each year, both individual participants and groups get the opportunity to make changes to their coverage. The first step in the annual enrollment process is for the group (city or town) to complete your Group Election Form.

MMIA members are given the option to offer one or multiple of the medical plans to their employees. MMIA strongly recommends allowing the menu selection to employees as it provides them with the most options to fit their individual needs. Offering only the highest benefit plan can be an unnecessary expense. If you are offering only one plan, consider opening up the options to the entire menu. The other options for the group to make include dental, vision and life options. This is also the time to review your required eligibility hours and probationary periods. This must be indicated on the Group Election Form and can only be altered during annual enrollment period.

Employees can waive out of the coverage only if they have eligible group coverage, such as through a spouse's insurance or Medicare. The top of the enrollment form still needs to be completed for those waiving coverage along with the back page of the form which asks for a signature. A copy of the ID card for the other group coverage may be requested for verification purposes.

Once the Group Enrollment process ends, individual selection begins with Open Enrollment on May 15th. This is a period of time for participants to individually assess their coverage and make any pertinent changes or additions. This could include adding an eligible spouse

or dependent or switching plan options if offered. The enrollment forms must be received by June 15th. The changes made on these forms become effective July 1st.

Notifying MMIA of changes

Changes to an employee's name, address and marital status can be reported by simply completing Part B of the MMIA enrollment form and submitting it to MMIA. Please reference Appendix B for details.

Identification Cards

Identification cards display the Group Name, Group ID number, name of covered person, and types of coverage. To protect individuals' privacy, Social Security Numbers are not displayed. Identification cards are issued at the following times:

- New Enrollment: A card is provided for each employee, covered spouse, and covered dependent child(ren) who are at least 18 years of age. The new employee also receives a packet of information that includes information on various plan details.
- If a replacement card is needed, contact MMIA at 1-800-635-3089 and we will get a new one out to you. (It takes about a week for the process to be complete.)

Terminations and Leaves of Absence

Termination of benefits must be handled in a timely manner. This is for a number of reasons, including complying with federal COBRA requirements. COBRA is the extension of benefits once someone leaves employment and must be offered by the employer. If the timeframe for notifying someone of their COBRA rights is missed, then the employer could be responsible for any medical costs during that time period. Again, this timeframe is thirty (30) days for employees and sixty (60) days for dependents. MMIA does not require a signature on our termination form. Just indicate the termination date on Part C of the enrollment form and get it to MMIA as soon as you receive the information. The rest is handled by MMIA.

If an employee's hours of work have dropped below the hours of work required to be eligible, then this creates a COBRA event. For employees, federal law requires that you notify MMIA of this COBRA event within thirty (30) days after it occurs. If we do not receive the notice within thirty (30) days, we may not be able to provide COBRA coverage for your employee and there may be issues within our plan coverage concerning eligibility for stop loss claims as well. Changes in coverage for dependents have their own timeframe requirements of sixty (60) days. **Timely notice is vital.**

In compliance with federal healthcare reform regulations, MMIA is not able to retroactively terminate coverage. That means that if you do not notify MMIA of a termination of benefits within 30 days, the city must still pay through the end of the month in which notification was given. The only exception to the retroactive rescission rule is if there is a non-payment of premiums or mis-representation by the participant. For example, if a participant fails to notify you of a divorce then retro adjustment may be made.

Your plan provides that employees and their families may stay on the policy and remain covered as active employees without having to elect COBRA in certain situations, including family medical leave, and other approved leaves of absence. However, for family and medical leave or any other approved leave of absence, in order to qualify you must have written policies regarding these leaves and must be able to provide copies of those written policies to MMIA if this situation arises. Note that you or your employee must continue to pay the premium for coverage during the periods covered by these leaves of absence. A convenient decision tree concerning leaves of absence is included in this document as Appendix A.

This chart will also help you if an employee gets injured on the job and is out on Workers' Compensation disability. Since the worker may not be receiving a paycheck while out on disability, this can be a very confusing situation. The basic rule to follow is to have a written policy and to follow it consistently.

Seasonal and temporary lay off workers must be terminated off of benefits when they are laid off. Their coverage will go through the end of the month in which they were terminated. If they are re-hired within 63 days, the terms of their coverage remain intact. If more than 63 days lapses, then they are treated as a new employee and all probationary periods apply.

Retirement

Retirees are eligible to stay on MMIA plans indefinitely, as long as they continue to pay the monthly premiums. Once they terminate coverage though, they can never come back on the plan. Spouses of retirees are also eligible to participate in the plan, if they were covered at the time of retirement. If a retiree deceases while covering a spouse, the spouse can maintain coverage as a surviving spouse, again as long as premiums are paid.

Once retired, and if over the age of 65, Medicare would be the primary coverage. If not retired but over the age of 65, MMIA remains primary until the participant retires. If you have an employee contemplating retirement and the complex world of supplement plans, be sure to encourage them to fully consider options. They can choose to just remain on the dental or vision coverage, for example, but if they do choose to leave the MMIA coverage to opt for a supplemental plan, they are not eligible to come back on our plan.

Please note that MMIA is required to also send COBRA notices to retirees; however, in almost all cases, this is not going to be the best financial choice since a retiree can stay on the plan at rates less than COBRA and for a longer period of time than COBRA allows. When an employee leaves employment, consider if it is a retirement or a termination. If an employee retires, you would notify us that it is a change in status, rather than a termination.

Billing

MMIA generates a monthly invoice of all charges due. The cutoff for additions, changes and terminations for the following month is on the 15th of the month. This means that all paperwork should be mailed or faxed to the MMIA prior to the 15th in order for the billing to be accurate.

The bill you receive after the 15th of the month is for next month's premiums and is due on the first of the month. For example, the bill generated September 16th is for October premiums and is due October 1st.

MMIA does not prorate monthly premiums. If a city or town terminates employment mid-month, coverage always extends to the end of the month. If benefit coverage starts prior to the 15th, you will be billed for the entire month. If coverage starts after the 15th, you will not be billed until the first of the following month. Newborns are not automatically enrolled in the MMIA program, however, if the participant does choose to enroll them they will not be billed for the first thirty days.

The invoice is in two parts. The first page gives an overview of the content of the bill with the total amount due. The remainder of the bill is a detailed report listing individual, participant ID along with the exact coverage and its premium amount. Any credits or charges for previous changes, such as terminations, that are not received by MMIA by the 15th will be reflected on the top of the detail report identified by month. MMIA prefers to be paid "as billed" but realizes in some instances it is not possible. The differences should be noted on the reconciliation sheet, which is mailed with each bill. Be sure to note any modifications you have made to your payment on your reconciliation sheet and complete the date portion to identify when the appropriate paper work was forwarded to the MMIA office. Remember, payment is due on the 1st of the month.

LIFE PRODUCTS

Basic Life

Some cities and towns offer the Basic Life product to their employees. This is an employer paid product. The cities and towns decide the amount they want to offer their employees and whether or not they will offer dependent coverage and the amount. All eligible employees are required to participate. Active employees must work at least 30 hours a week. Each employee within the group or bargaining unit must have the same benefit level. Coverage is reduced by 50% at age 70. The rates are very competitive but are evaluated annually. Eligible children must be less than 19 years of age, or less than 23 years of age if the child is attending college as a full time student.

Voluntary Group Life and Accidental Death & Dismemberment (AD&D)

MMIA has available a competitively priced voluntary group life and AD&D program. The city or town must decide if they are going to offer this to their employees. Each employee can select an amount of life benefit that fits their needs. Rates are based on the age of the covered person. The premiums are paid 100% by the employee. The guarantee issue amount on this product is \$100,000 for the Employee and \$50,000 for spouse and a dependent child benefit up to \$10,000 in \$2,500 increments. Guarantee issue means that no health statement is required.

The maximum amount an employee can apply for is 7 times their salary, up to \$300,000 and \$50,000 for spouse. Amounts in excess of the guarantee issue will require a health statement. If an employee chooses not to enroll when they are hired, and wait until a later open enrollment, they will be subject to standard underwriting procedures by completing the health statement with no guarantee issue. Eligible children must be less than 19 years of age, or less than 23 years of age if the child is attending college as a full time student.

COORDINATION OF BENEFITS

Your plan contains provisions that state how it coordinates with other coverage that your employees or their dependents may have. It also states how it coordinates with Medicare for employees who are eligible.

For actively employed (non-retiree), MMIA will be primary for your employee and secondary for your employee's dependents who have other coverage through their employment. For retirees, MMIA may become secondary to Medicare depending on their current age.

MMIA coordinates benefits with Medicare as is mandated by federal law regarding coordination with Medicare. MMIA is not allowed to deviate from those rules. Further, the plan will coordinate with Medicare in instances where the policy should be secondary to Medicare, even if your employee has not enrolled in or purchased Medicare. This means that the plan will only pay the amount that Medicare would not have paid even if your employee does not have Medicare.

APPEALS

Although employers should not be involved with individual claims issues in order to comply with HIPAA, from time to time a participant may seek advice on how to formally dispute claim results. Every Explanation of Benefits (EOB) has appeal information on the backside and our Summary Plan Document (SPD) also provides details about the appeals procedure. In general, there are two types of appeals.

Pre-service appeals are for times when someone is trying to pre-authorize a service, such as surgery, and it has been denied. Post-service appeals are for when someone is trying to appeal an already processed claim and its outcome. For instance, if they disagree with a service being denied as non-emergency when it truly was an emergency. In both cases, the covered person must submit in writing an appeal within 180 days after the denial. **If they do not submit it within 180 days, they have no further steps that can be taken.** There are different levels of reviews so that there are multiple opportunities for the denial to be reconsidered.

Again, as the employer, the city and town should not become involved with individual claims issues. If a participant is not getting the results or information that they are seeking, direct them to either the appropriate vendor or MMIA. HIPAA does not provide leeway for trying to help out a neighbor or co-worker.

RESOURCES AND FORMS

The forms, documents, and internet resources mentioned in this Benefit Administration Handbook are listed below.

Forms

Current and up-to-date forms, such as those listed below, are available at http://www.mmia.net/eb_docs.asp. You may also call the EB department of the MMIA at 1-800-635-3089 for copies.

- Enrollment Form – New, Changes or Termination. Remember to complete the first box regardless of the reason, including the Group Name & Group Number on the top line.
- Authorization for Release of Information
- Prescription Drug Claim
- Vision Out-of-Network Claim Reimbursement
- Basic and Voluntary Life and AD&D
- Medical claim forms can be provided but almost all providers should give this to patients or submit claims directly. If there does arise an occasion to submit a claim, the form is available for use.

*** Forms are updated annually. When new forms are provided to the Member Group during Open Enrollment be sure to discard all old forms.**

Documents

Summary Plan Descriptions (SPD) for medical plans, dental and vision along with a plan index for easy reference are available at http://www.mmia.net/eb_plan_docs.asp.

The SPD is the most comprehensive information concerning the plan including reimbursement levels, exclusions and eligibility criteria. Claims are processed according to the SPD so it is a good idea to be familiar with the layout of the SPD and the summary of benefits that is included within each one.

Internet Resources

- U.S. Treasury Department website for Health Savings Accounts:
<http://www.treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx>
- Medicare Information:
<http://www.medicare.gov/>

Who to Contact or direct participants to:

- Allegiance Benefit Plan Management
<http://www.abpmtpa.com/mmia/> 1-866-339-4308
Call Allegiance for all medical claims questions. They process claims and verify eligibility. They can help explain benefits and also assist in finding network providers.
- Delta Dental
www.deltadentalins.com 1-800-521-2651
Call Delta for all dental claims questions. They process dental claims and verify eligibility. They will explain benefits and also have a network of providers that should be utilized in order to get the best level of reimbursement.
- Vision Service Plan
www.vsp.com 1-800-877-7195
Call VSP for all vision claims and benefit questions. They process routine vision claims and verify eligibility.
- Catalyst Rx
www.catalystrx.com 1-888-869-4600
Call Catalyst for all prescription issues including benefit clarification and claims questions. They can help provide formulary information, as well as assist with clinical questions.
- StarPoint
www.starpointmedical.com 1-800-342-6510
Call StarPoint to get approval of inpatient hospital services prior to the claim. They also provide Disease and Case Management at 1-877-792-7827 option 1. This is a service to assist participants with navigating through a recent high dollar case or with coordinating care for diseases. They do provide outreach based upon claim information but are available for self-referral.
- Employee Assistance Program – United Behavioral Health
www.liveandworkwell.com Access Code MMIA 1-866-248-4094
Contact the EAP to get a referral to a local professional for free counseling services.

BASIC PLAN INFORMATION & DEFINITIONS

What is the difference between PPO and Non-PPO?

PPO stands for Preferred Provider Organization. Essentially, providers are contracted with by Allegiance to join their provider network. Services rendered with a PPO will provide the highest level of benefit with lower deductibles, higher coinsurance and more deductible waivers than their out-of-network counterparts. The other benefit to seeing a PPO is that they cannot balance bill the patient any difference between their charge and the Maximum Eligible Expense (MEE). This is an allowable charge that they accept in full so there are no unexpected costs. Keep in mind that for those cities or towns on the MMIA dental plan, the Delta dental network should be utilized to avoid being billed over the set allowable charge or MEE.

What is the difference between Professional and Facility services?

Think of professional services as those that an individual doctor provides. Facility services are linked to a clinic or hospital. This is important to know, because otherwise it may be confusing why there is more than one bill for the same service.

Deductible:

A deductible is a set amount that either an individual or a family must meet per benefit period before the plan will reimburse anything.

Benefit Percentage:

This is the applicable percentage that the plan and the patient shares, normally after the deductible has been met. For example, the plan pays 80% of allowable and the participant pays the remaining 20%.

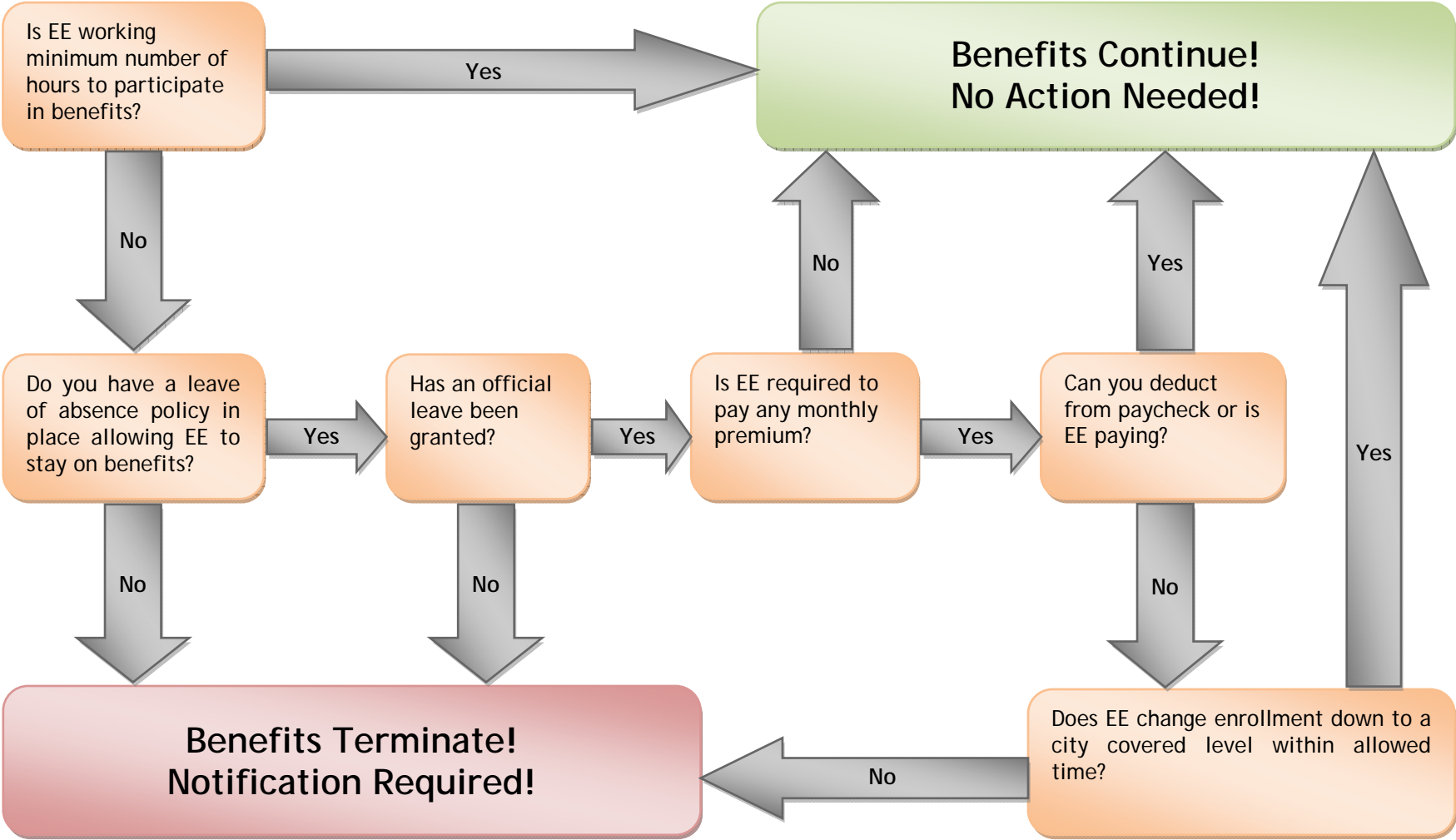
Annual Out-of-Pocket Maximum:

This is the most that the patient will be responsible before the plan pays 100% of the MEE.

Formulary Listing:

For those cities or towns utilizing the Prescription Card program, it is important that the Formulary drug listing is utilized. This is similar to a provider network but the savings are realized in the discounts provided.

Leaves of Absence and Employee Benefits Appendix A



MMIA Enrollment Form Appendix B

Always fill out the yellow section.



Montana Municipal Interlocal Authority
EMPLOYEE BENEFITS PROGRAM ENROLLMENT FORM
Please fax to: 406-449-7440 or submit to:
PO Box 6669 ~ Helena, MT 59604-6669

Group Name: (City/Town)		Group Number:		<i>Please print clearly on entire form</i>	
Last Name	First Name	Initial	Work Phone	Home Phone	Cell Phone
Current Address		City	State	Zip	<i>If waiting coverage stop here and proceed to the back side of this form</i>
<i>Please use this form for New Enrollments, Changes and Terminations - disregard all previous Enrollment, Change & Termination forms</i>					

SECTION 1 ~ Please fill out the section below that applies to a new enrollment, enrollment changes or termination of coverage	
Part A - New Enrollment Effective Date of Coverage: _____ First Day of Work: _____ Hours worked per week: _____ Plan Status: <input type="checkbox"/> Active Employee <input type="checkbox"/> Retiree Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated Medical Plan Choice - Please check only one appropriate box below: <input type="checkbox"/> Bridger <input type="checkbox"/> Madison <input type="checkbox"/> Mission <input type="checkbox"/> HDHP <input type="checkbox"/> Custom	Part B - Enrollment Changes Add/Drop spouse or dependent (Open enrollment & Qualifying Event Only) Medicare eligible (provide copy of card or letter) Retiree Status Death Other (reason): _____ Ineligible Dependent (reason): _____ Address Change (former address): _____ Name Change (former name): _____ Medical Plan Choice - Open Enrollment & Qualifying Events Only <input type="checkbox"/> Bridger <input type="checkbox"/> Madison <input type="checkbox"/> Mission <input type="checkbox"/> HDHP <input type="checkbox"/> Custom (if applicable) <i>(Must provide supporting legal documentation of divorce, marriage, adoption, etc. with this form)</i>
Part C - Termination of Coverage <i>If staying on coverage as a retiree see Part B</i>	
Last day worked (or last day with minimum hours for benefits): _____ <input type="checkbox"/> Voluntary by employee For employees terminating benefits, complete the month in which employee was active: _____	Notes: Use this space for clarification on any of the above

New Enrollment Sections 1, 2, 3 and maybe 4. (Orange & salmon)

Enrollment Changes: Sections 1, 2, 3 and maybe 4. (Aqua & salmon)

Terminations: Section 1, no employee signature required. (Green)

SECTION 2 ~ INDICATE ENROLLMENT REQUESTS BY CHECKING THE APPROPRIATE BOX			DATE CHANGE(S) OR NEW ENROLLMENT		Note: Your group may not offer all coverages listed										
FIRST	MI	LAST	DATE OF BIRTH	RELATIONSHIP	Sex	Medical		Dental		Vision		Group Life		Voluntary Life	
						Add	Drop	Add	Drop	Add	Drop	Add	Drop	Add	Drop
Employee:						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spouse:						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child(ren): (list)						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOTE: IF YOU OR YOUR DEPENDENTS HAD COVERAGE WITHIN THE LAST 63 DAYS, PLEASE ATTACH VERIFICATION OF CREDITABLE COVERAGE.

SECTION 3 ~ OTHER INSURANCE: Will you, your spouse or your children have any other coverage while on any of the coverages listed above? Yes No

If yes, please provide the required information below: Employer Name, Insurance Carrier Name & Address

	TYPE OF COVERAGE
Self <input type="checkbox"/> Yes <input type="checkbox"/> No	MED DEN VIS
Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Child (ren) <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

SECTION 4 ~ BENEFICIARY (for groups with group life insurance coverage)

PRIMARY - FULL NAME	ADDRESS	SOCIAL SECURITY #	RELATIONSHIP	% OF BENEFIT
CONTINGENT- FULL NAME				

PARTICIPATION CERTIFICATION: I CERTIFY THAT THE ABOVE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND I HAVE READ AND UNDERSTAND THE PARTICIPANT AUTHORIZATION AND STATEMENT OF HIPAA PORTABILITY RIGHTS ON THE REVERSE SIDE OF THIS FORM. I HEREBY AUTHORIZE MY EMPLOYER TO DEDUCT FROM MY EARNINGS ANY REQUIRED CONTRIBUTIONS FOR THE COST OF BENEFITS FOR WHICH I AM OR MAY BECOME ELIGIBLE.

Participant's Signature _____ (New enrollment or changes only) Date: _____

Employer's Signature _____ Date: _____

MMIA
PO Box 6669
Helena, MT 59604-6669
Fax: 406-449-7440

Employee Name: _____
Group Employer Name (city/town): _____

Participant Authorization

I hereby request coverage for myself and my dependent(s) listed on this enrollment application who are currently enrolled or may become eligible for coverage under the plan agreement purchased by the Montana Municipal Interlocal Authority (MMIA). I agree that my dependents and I will comply with the following:

- ~ That we will be bound by the terms and conditions of the Group Agreement, as it may be amended;
- ~ That all providers that have rendered services to me and my dependents are authorized to make medical information and records regarding such services available to the Plan and their providers for the purpose of coordinating such records among themselves; and,
- ~ That I shall assist the Plan in the completion and submission of consents, releases, assignments and any other documents related to the protection of the Plan's rights under the Group Agreement including, but not limited to, the coordination of benefits with other health benefit plans, insurance policies or Medicare.

I understand that I am responsible for notifying the Plan within 31 days of any changes in my or my dependent(s)' eligibility status, such as change of address, birth, adoption of a child, marriage, termination or additional coverage.

Complete when filling out for waiver.

Statement of HIPAA Portability Rights

Pre-existing condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "pre-existing conditions exclusions." A pre-existing condition exclusion can apply only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a specified period of time before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period. In addition, a pre-existing condition exclusion cannot last for more than 12 months after your enrollment date (in some cases, 18 months if you are a late enrollee.). Finally, a pre-existing condition exclusion cannot apply to pregnancy or genetic information and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a pre-existing condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage. COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment according to the Special Enrollment provisions of your plan (usually within 30 or 60 days). (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption).

- Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage. Under HIPAA, if you are an "eligible individual," you have the right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a pre-existing condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
 - Your most recent coverage was under a group health plan;
 - Your group coverage was not terminated because of fraud or nonpayment;
 - You are not eligible for COBRA continuation coverage or you have elected COBRA continuation coverage;
 - You are not eligible for another group health plan, Medicare, or Medicaid.
- Therefore, if you are interested in obtaining individual health coverage as soon as possible to avoid losing your eligibility for such coverage, you should apply for this coverage as soon as possible to avoid losing your eligibility for such coverage.

Complete for waiver and make sure employee and spouse signs. Also provide copy of ID card from other coverage.

Health Coverage Waiver

(Complete this section only if you are waiving coverage for yourself and/or any dependent)

If waiving coverage upon initial eligibility and want to continue to waive coverage during the next open enrollment period, you must sign a waiver every plan year during open enrollment. Proof of other creditable group coverage is required with the submission of this waiver.

I decline to enroll in coverage with the MMIA for: (please print)

- | | |
|--------------------|--------------------|
| 1. Employee _____ | 4. Dependent _____ |
| 2. Spouse _____ | 5. Dependent _____ |
| 3. Dependent _____ | 6. Dependent _____ |

Employees may waive coverage if they have other group health coverage, and provide evidence of such acceptable coverage. Please submit evidence of coverage under another group health plan with this form.

I understand that this waiver of coverage may affect the ability of each person listed above to obtain coverage at a later date. Specifically, except during applicable "Enrollment Periods", each person listed above may be considered to be a Late Enrollee, and subjected to an exclusionary period of up to eighteen (18) months for any pre-existing condition, as that term is defined by Federal Law (HIPAA).

Employee Signature: _____ Date: _____

Spouse Signature: _____ Date: _____
(if spouse is waiving coverage)