Independent Health

GROUP ADMINISTRATION MANUAL

INTRODUCTION

Thank you for choosing Independent Health as your health care partner.

This Group Administrative Manual was developed as a tool to be used by those who have the responsibility of administering group health benefits for employees within their company. As a reference document, it will assist in understanding the routine procedures necessary to effectively administer a group's plan.

The material contained within is subject to periodic re-evaluation by Independent Health Association, Inc.

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IMPORTANT CONTACT INFORMATION

Prospective member questions and all account level assistance with enrollment tools and validation, online bill payment and presentment, eligibility, coordination of benefits:

Independent Health Sales Department:
Phone: (716) 631-5392, option 4 or 1-800-453-1910, option 4
Fax: (716) 631-8554
Hours: Monday – Friday, 8:30 a.m. – 4:30 p.m.
Small Group Sales and Service Email: sales.administration@independenthealth.com
Large Group Sales and Service Email: LGSales@independenthealth.com

Enrollment applications, change requests and eligibility data for medical and pediatric dental:

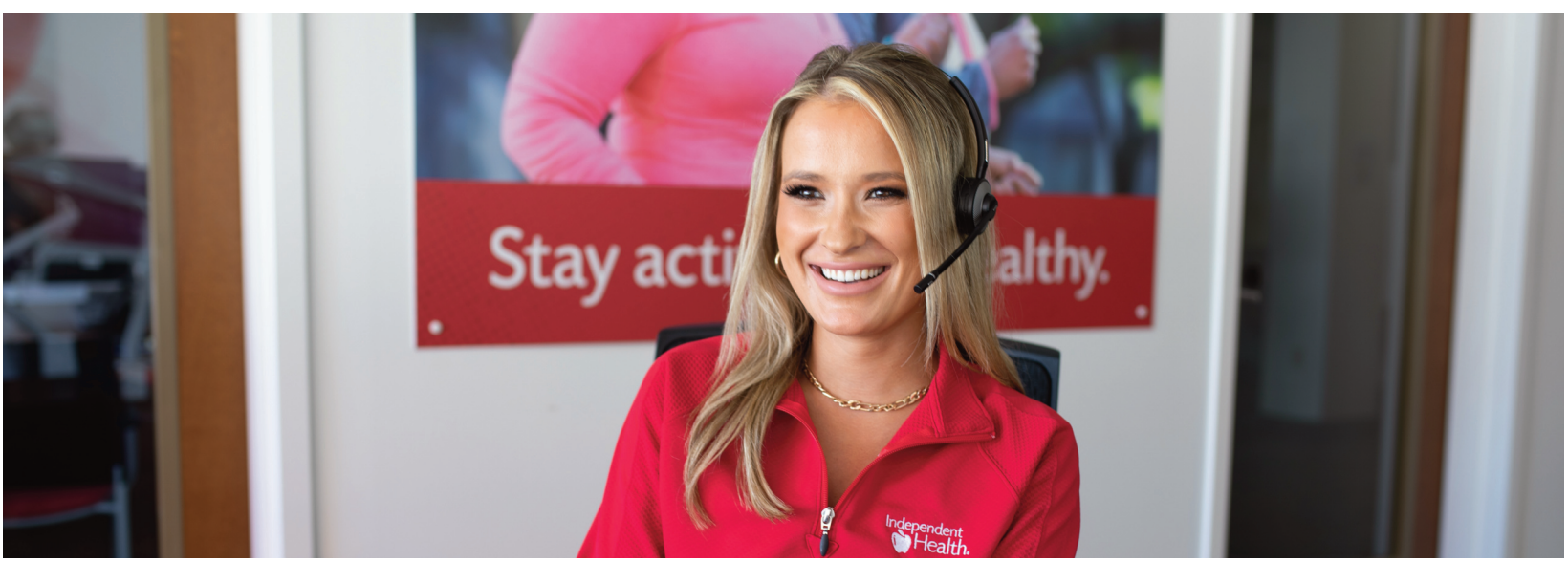
Enrollment:
Independent Health
P.O. Box 710
Williamsville, NY 14231-0710
Fax: (716) 631-4059
Email: enroll@independenthealth.com

Commercial Delta Dental offered through Independent Health:

Dental:
Delta Dental Customer Service (benefits/claims): 1-800-932-0783
Invoice/Billing Inquiries: DDPbilling@delta.org
Enrollment Applications (additions/terms): delta.enrollment@independenthealth.com

Member-specific assistance with claims, benefits and authorizations, please direct member to contact:

Member Services:
Phone: (716) 631-8701 or 1-800-501-3439 (TTY: 711)
Fax: (716) 631-1039
Hours: Monday – Friday, 8 a.m. – 8 p.m.
Email: memberservice@servicing.independenthealth.com



GROUP ELIGIBILITY

Employers are eligible to receive health insurance coverage through Independent Health if they have two or more employees who are regular full-time or regular part-time (minimum of 17.5 hours per week) or seasonal employees working at least nine months per year and who are eligible to receive health benefits. At least 1 common law employee who lives, works, or resides in our service area must enroll with Independent Health for the employer group to be considered eligible. To confirm group eligibility, Independent Health requires an annual verification of the total number of employees. Additionally, the group must have a physical address within New York State; post office boxes are not acceptable.

Products and services offered are based on the total number of full-time equivalent employees (FTEEs) in the company. For employers with multiple locations located within and/or outside of our Western New York service area, the total number of FTEEs is used to determine product and service offerings.

Effective January 1, 2016, a small group is defined as a business with 100 or fewer full-time equivalent employees (FTEEs) nationwide. According to the Patient Protection and Affordable Care Act (ACA), the following factors are used to calculate an employer's total number of FTEEs:

- Full-time employees – Under the final regulations, for purposes of determining full-time employee status, 130 hours of service in a calendar month is treated as the monthly equivalent of at least 30 hours of service per week.
- Part-time employees – Prorated (total hours worked by all part-time employees in a month, divided by 120).
- Seasonal employees – Not counted for those working up to 120 days per year.
- Temporary agency employees – Generally counted as an employee of the temporary agency.
- Franchise employee/common ownership – All employees across the entities are counted in one sum.

More information about group size definition can be found on the Department of Financial Services website: https://www.dfs.ny.gov/consumers/small_businesses/small_group_expansion_faqs

Benefit Administrator Responsibilities

- Supervising the enrollment of employees into the plan.
- Ensuring application information is complete and accurate.
- Reporting changes, additions and deletions to the plan within 30 days of the qualifying event.
- Reconciling monthly billing statements.
- Remitting appropriate premium payments on the first day of each month.
- Administering COBRA benefits.

Independent Health Responsibilities

- Supplying appropriate marketing and informational material regarding benefit programs and enrollment procedures.
- Preparing and distributing new member materials, such as ID cards, contracts, member handbooks and provider directories.
- Assisting in the enrollment of your employees.
- Assisting group administrators and members in understanding how the plan works, how services can best be obtained through Independent Health's network of participating physicians and providers, and out-of-network benefits when appropriate.
- Notifying your employees when delinquent premium payments jeopardize their health benefits.
- Resolving group or member questions or problems in a timely manner.

OPEN ENROLLMENT AND CONTRACT RENEWAL

Anniversary Date

The anniversary date of your group contract:

- Sets the date for the employer group contract renewal.
- Is the time when the employer group can enroll or retire different products; rates are also set at this time.
- Is the date when your eligible employees can opt in for coverage, change their benefit plan selections and modify dependents without a qualifying event.
- Is the date when you can change your group's new hire policy.
- Must coincide with an open enrollment period.

Employee meetings and information sessions should be held at least six weeks prior to the effective date. This allows for timely processing of enrollment application or change forms, as well as the mailing of ID cards and plan information to members.

Designating a New Hire Policy

Each employer must designate a policy that determines when a newly hired employee is eligible to elect health insurance coverage. Independent Health will use this information to verify eligibility when enrolling future employees in the plan.

Sample new hire policies:

- Date of hire.
- First of month following 30 days.
- Following 60 days from date of hire.

If Independent Health is not notified of your new hire policy, the effective date of coverage will be the first day of the month following 60 days from date of hire. The ACA requires that new hire policies cannot be greater than 90 days from the date of hire.

EMPLOYEE ELIGIBILITY

Permanent full-time and part-time employees (working at least 17.5 hours per week) are eligible to enroll in Independent Health provided they reside or work within our designated WNY service area (Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming counties).

Who is an Employee?
Pursuant to the ACA, New York adopted the federal definition of employee in Insurance Law § 4235(d). Common law employees who are "employees" as defined in 42 U.S.C. 300gg-91(d)(5) are eligible for coverage. A common law employee is generally, anyone who performs services for an employer if the employer can control what will be done and how it will be done. The common law test to determine control would look at behavioral control, financial control and the type of relationship between the parties. An "employee" does not include the sole owner of a business or the spouse of the business owner.

More information on determining who is a "common law" employee is available on the IRS website at https://www.irs.gov/businesses/small-businesses-self-employed/employee-common-law-employee and https://www.irs.gov/businesses/small-businesses-self-employed/independent-contractor-self-employed-or-employee.

Eligible employees may enroll under five distinctly different conditions detailed below.
Meetings and information sessions should be held at least six weeks prior to the effective date. This allows for timely processing of enrollment application or change forms, as well as the mailing of ID cards and plan information to members.

1. Designated Open Enrollment

Open enrollment is the one time of year that an employer can add or remove plans. It is the time to review the needs of your employees. Ask your account manager about plans that will cover any dependent children who will age off the policy during the next policy year or plans we have available for Medicare Eligible employees/retirees. During the open enrollment period, eligible employees are given the opportunity to select Independent Health as their insurance carrier. They may also make changes to their existing coverage, such as electing other available benefit plans or adding dependents. Applications and/or change requests must be submitted prior to the effective date requested unless there are extenuating circumstances. For employed married couples wishing to enroll in two single policies, both individuals must meet the employee eligibility requirements to be considered for separate policies.

2. Newly Hired Employees

Newly hired employees are eligible to enroll in health insurance once the requirements of the New Hire Policy are met. The application to enroll must be submitted within 30 days of the initial eligibility date and coverage will be effective on the eligibility date or the first day of the following month. If the application is submitted beyond 30 days from the initial eligibility date, the employee must wait until the next designated open enrollment period to enroll in coverage.

3. Involuntary Loss of Other Coverage

Employees or dependents of employees who involuntarily lose other health insurance coverage are eligible to join the Independent Health plan. An application requesting enrollment into the plan must be submitted within 30 days of the loss of coverage. The effective date is the first day of the month following our receipt of the application. This circumstance is referenced in the member's certificate of coverage under "Special Enrollment Periods."

4. Birth, Adoptions, or Marriage

- Birth or Adoption of Child*
  - The effective date of coverage for a newborn will be the moment of birth when we receive notification within 30 days of the birth. If we do not receive notification of the birth within 30 days of the birth, coverage for the baby will begin on the date we receive notification about the birth. There are a number of different circumstances that arise when a member adopts a baby or child. The member's certificate of coverage is the best source of information about that.
  - Independent Health does not require a Social Security Number or birth certificate to enroll a newborn. Do NOT delay a newborn enrollment. The newborn can be enrolled upon birth and the parent can submit the Social Security Number and birth certificate upon receipt.
- Marriage*
  - The effective date of coverage for the new spouse will be the date of the marriage if we receive notification of the marriage and the associated premium payment within 30 days from the date of marriage. If notification and premium payments are submitted beyond 30 days from the marriage date, the spouse must wait until the next designated open enrollment period to enroll in coverage.

** Birth or Adoption of Child and Marriage – Adding a new spouse or dependent child creates a period of special open enrollment rights to the employee. The employee is allowed to change plans at this time.*

5. Change in Employment Status & Other Circumstances

- Change in Employment Status (e.g., retirement, hourly to salary, part-time [no health insurance offered] to full- time [health insurance offered], reductions in hours of employment, employer contributions towards employees' [and/or dependents'] health insurance coverage changed)
- Child no longer qualifies for coverage as a child under the employee's coverage
- Legal separation, divorce, or annulment
  - The effective date of coverage in these instances depends on Independent Health receiving notice of the change and premium payment within 30 days of one of the situations listed above under #5. If Independent Health receives notice of the change and premium payment within 30 days of one of the situations listed above under #5, coverage will begin on the first day of the month following the month Independent Health receives the member's application.

Eligible Dependents

Eligible dependents are generally:

- Married to the subscriber.
- A child of the subscriber, including any stepchild, foster child, legally adopted child or proposed adoptive child who is:
  - Dependent children who are married are still eligible to enroll under the parent's plan, providing they meet other eligibility criteria under the federal health care reform act that addresses "Age 26" coverage. The spouse of the dependent child is not eligible.
  - A member of the subscriber's household, and
  - Dependent upon the subscriber for support and maintenance,
  - Less than 26 years old and not on active duty in the Armed Forces
  - Greater than or equal to 26 years old who is:
    - Incapable of self-sustaining employment by reason of mental illness, developmental disability (as defined in the New York Mental Hygiene Law), or physical disability, and
    - Dependent upon the subscriber for support and maintenance. The child must have become handicapped prior to age 26 for the purposes of this provision.

- Disability/Handicap Waiver Forms are required to be submitted for review and approval or denial by an Independent Health Physician Reviewer. Forms can be requested through Independent Health's Sales Department or Member Services Team.

- Grandchildren may be added to the policy upon submission of formal legal documentation paperwork indicating adoption or legal guardianship.

Please Note: For parents who are both employees of the group and on the same plan, canceling a dependent's coverage (i.e., leaving only the parents on the plan) is not a special open enrollment where the employees would be allowed to split into two single policies. This change may be made at open enrollment. Independent Health has the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Subscriber and all other prospective or covered Members in relation to eligibility for coverage at any time.

APPLICATIONS FOR ENROLLMENT

Enrollment Procedure

As the group administrator, you are responsible for confirming the eligibility of all enrollees and reviewing each application to ensure it is complete, correct and legible.

Please remember to complete the following information:

- Effective date
- Account number / plan number
- Social Security Number (SSN), gender and date of birth for all members
  - All subscribers and dependents MUST have a SSN
- Qualifying event and qualifying event date
- Previous coverage dates
- Administrator sign and date
- Employee sign and date
- An application that is not complete, correct or legible will delay enrollment, the delivery of ID cards and potentially cause an interruption of health coverage services for your employee and covered dependent(s).
- Eligible employees or dependents must apply for coverage within 30 days of their eligibility date.
- Applications not received within 30 days of the eligibility date will be made effective during your next open enrollment period.

Please submit all enrollment/eligibility requests prior to the effective date whenever possible, but no later than 30 days of qualifying event, to:

Mail: Enrollment Department
Independent Health
P.O. Box 710
Buffalo, NY 14231

Email: enroll@independenthealth.com

Fax: (716) 631-4059

Requests that are not submitted directly to the address above may experience a delay in processing. New subscribers will receive a New Member ID letter within 3-5 business days of full enrollment welcoming them to the plan and providing the ID numbers for all participants enrolled under the subscription. They will receive the ID cards and plan information within 7-10 business days of enrollment.

Enrollment Tools

Independent Health offers various options for enrollment varying from paper to electronic. The options are outlined below, and the tools can be accessed using the icons under the "Enrollment Method Link" column.

Enrollment Options for Commercial Groups

Enrollment Method Link	Overview and Process
Member changes and renewal file	• Use for large and small group renewals and/or ongoing enrollment changes. • Enter subscriber and dependent data using the format specified in each column. Several columns have picklists available. • Complete all required fields as outlined in the column header. NOTE: when entering dependent data, the subscriber SSN must be entered to associate the subscriber to dependent(s). • Email completed file to Enroll@independenthealth.com • COBRA applicants need to be sent in via paper application.
DocuSign Employer Sponsored Enrollment Application	• The workflow within this option is between the employer contact and the employee; submitted directly to Independent Health upon completion. • Group contact emails the hyperlink button to all eligible employees including the name and email address of the group administrator or contact who will review and initial the completed application. • Employee completes form and it automatically routes to the Group Administrator. • Group Administrator receives an email notification when there is an application ready for review and sign off. • Group Administrator clicks on "Review Document", then clicks "Continue". • Group Administrator clicks on "Initial" then "Adopt and Initial" and "Finish" at top of screen. • The document automatically routes to Independent Health for processing. • There is an option to convert the completed application to pdf which will allow the Group Administrator to send it to their broker if desired.
Paper Enrollment Application and Change Form	• Type all required information for subscriber and dependents as applicable. • Must be printed and signed (typed signatures are not accepted). • Group Administrator must review and initial completed form. • Form can be scanned and emailed to Enroll@independenthealth.com or mailed via USPS (not recommended).
EDI 834	• File format must be 5010 HIPAA compliant. • Requires 60-90 days to implement a new EDI 834 enrollment file once account and plan selections are finalized. • Timeframe is dependent upon readiness and support model of the accounts' 834 vendor. • Contact your Account Manager to initiate the process.

TERMINATION OF COVERAGE

When an employee and/or dependents are no longer eligible for coverage under the guidelines set forth by your company or the mandates of COBRA, an enrollment/change form must be completed to remove the employee or dependent from coverage. The processing of this form by Independent Health will be reflected on your next premium invoice. The employer group assumes all liability for failing to remove employees and/or dependents when eligibility ceases.

The age limits for dependent coverage are defined according to your Group Health Contract. A dependent who reaches the age limit becomes ineligible for coverage under the terms of the contract and should be removed from coverage. It is the employee's responsibility to notify their employer within 30 days of the date a dependent has aged off the policy. It is the employer's responsibility to offer COBRA coverage to that qualified beneficiary.

Canceling Employee Coverage

- Cancellation requests must be received in writing within 30 days of the requested cancellation date or date when the employee is no longer eligible for coverage.
- Eligibility will not be retroactively canceled greater than 30 days and the employer will be responsible for premium payments through the date of cancellation.
- Cancellation requests that are greater than 30 days may only be processed under the provisions of ACA under rescission, meaning the only reasons cancellation are approved beyond 30 days retroactively are for intent to defraud or material misrepresentation of fact.

Canceling Dependent Coverage

- Dependent coverage may be canceled at any time.
- In the case of divorce, the spouse is no longer eligible for health insurance under the employee policy and must be canceled.
  - The effective date of cancellation will be the file date on the final divorce decree which must be submitted with the cancellation request.
  - If the employee is under court order to maintain health insurance for the former spouse, a COBRA or Individual Conversion policy may be purchased. Under no circumstances can the divorced spouse remain on the employee's policy as a dependent.
- The cancellation of dependent coverage is not a qualifying event that would allow the employee to change plans at that time.
- If the cancellation of the dependent necessitates a change in tier (e.g., from family to single), that change will be made automatically at the time the dependent is canceled.

COBRA ADMINISTRATION

The Consolidated Omnibus Budget Recovery Act of 1985, Federal Public Law 99-272, Title X (COBRA) requires most employers to provide the option of continued coverage to "qualified beneficiaries" who would otherwise lose health care benefits because of a qualifying event. The following is a brief description of some of the highlights of COBRA. Independent Health recommends that you contact your legal advisor and accountant to advise you of the applicability of the law to your group and the provisions and penalties for noncompliance. The following summary is not intended to be a legal analysis upon which you can rely for a definitive explanation of the statute.

General information is available at: https://www.dfs.ny.gov/consumers/health_insurance/cobra_faqs

Qualified Beneficiary

Generally, a qualified beneficiary is any individual who, on the day before a qualifying event, is covered under a group health plan maintained by the employer of a covered employee by virtue of being the:

- Covered employee
- Spouse of the covered employee
- Dependent child of the covered employee

Exceptions include Medicare eligible individuals and certain nonresident aliens.

Each qualified beneficiary has separate COBRA election rights. For example, a family of four covered individuals represents four separate potential qualified beneficiaries who each have independent COBRA rights. This means that a family of four could elect family coverage for all four family members or single coverage for one, two, three, or all of the four family members.

Though COBRA coverage generally is required to be identical to the coverage enjoyed by the qualified beneficiary immediately before the qualifying event, a qualified beneficiary may "step-down" from family coverage to single coverage, as long as the single coverage is coverage under the same type of plan as was the family coverage.

That is, upon a qualifying event, a qualified beneficiary can switch from family coverage in the employer's indemnity plan to single coverage in the same indemnity plan but cannot switch to any level of coverage in any other type of plan offered by the employer.

One exception to this rule is that when a qualified beneficiary covered by an HMO moves out of the HMO's service area to another area where the employer has employees covered by a group health plan. In such a case, the qualified beneficiary must be allowed to select the coverage available to the employees in that area. In addition, if a qualified beneficiary electing COBRA coverage is moving out of the area, they must elect the out-of-area benefit if one is offered. If an out-of-area plan is not offered, then they must remain with the plan selection they had when under active coverage.

A qualifying event is any one of the following events that would result in the loss of health insurance coverage:

- The death of the covered employee.
- The termination (other than for reasons of gross misconduct) of a covered employee's employment.
- A reduction in a covered employee's hours of employment. Reduction in hours includes a strike, layoff or a leave of absence, or as defined by the plan.
- The divorce or legal separation of a covered employee from the employee's spouse.
- A covered employee becoming entitled to Medicare benefits.
- A dependent child ceasing to be a dependent child of the covered employee under the terms of the group health plan.
- With respect to certain retirees and their dependents, bankruptcy proceedings of an employer under Title 11 of the U.S. Code, commencing on or after July 1, 1986.

Qualifying Event	Qualified Beneficiary	Duration of Eligibility
Termination, reduced hours	Employee, spouse, or dependent child	36 months
Employee entitlement to Medicare, divorce or legal separation, death of covered employee	Spouse or dependent child	36 months
Employee Death	Spouse or dependent child	36 months
Divorce or legal separation	Spouse	36 months
Loss of dependent child status under the plan rules	Dependent	36 months

Notification Requirements

The COBRA General Notice (or Initial Notification) must be provided to the employee (and spouse, if any) no later than 90 days after enrollment in the plan, or the first date which the plan administrator must furnish an election notice to the employee, spouse or dependent. This notice provides general information regarding COBRA along with the recipient's responsibilities and obligations for notifying the administrator of certain events and address changes. There are specific notice deadlines that must be followed for reporting these events or changes in order for the employee, spouse or dependent to have the right to be covered.

Administrators or employers who do not comply with notification requirements may be liable under ERISA for monetary restitution from the date of noncompliance. COBRA does not allow for a lapse in coverage.

Outline of Qualifying Event Notice Provisions:

- Date 1 – Qualifying event (or loss of coverage due to qualifying event).
- Date 2 – If the qualifying event is loss of coverage due to death, termination or reduction in hours of employment, Medicare entitlement or the employer's bankruptcy filing, the deadline for notice to plan administrator by the employer is 30 days after Date 1. If the qualifying event is divorce, legal separation or loss of dependent status, the employee has 60 days from Date 1 to notify the plan administrator.
- Date 3 – There is a 14-day window after receipt of notice of qualifying event to send the notice to all affected qualified beneficiaries (including spouse and dependent) of option to continue coverage or that COBRA coverage is not available.
- Date 4 – Qualified beneficiaries have 60 days to elect coverage from the date of loss of coverage or the notification of loss of coverage, whichever is later.
- Date 5 – Qualified beneficiaries have 45 days after the date of election to make the first payment of premium for coverage. It is up to the plan to decide whether to treat this payment as prospective or retrospective. (In the absence of any instructions from the group, Independent Health will treat the first payment received for a COBRA member as a retrospective payment.)

It is the employer's responsibility to provide all qualified beneficiaries the proper notices required under COBRA. The employer assumes all liability for potential penalties due to improper notification.

A request to terminate coverage for an employee should be sent as soon as the employee is no longer eligible for benefits. The employer is required to notify the employee of their COBRA options. If COBRA is elected, a new Enrollment Application/Change Form must be completed by the participant, signed and returned to the employer group for administrator sign-off and submission to Independent Health. Independent Health does not assume that the qualified beneficiaries have or have not elected coverage and/or do not qualify for continued coverage.

The coverage provided to the qualified beneficiaries will be identical to the coverage offered to other active employees in the group. The premium charged may be up to 102 percent of the applicable premium paid for employees still covered under the plan. The qualified beneficiary cannot be required to make the premium payment more frequently than once per month but may be required to pay in advance. The qualified beneficiaries must be afforded the same rights to elect plans as all active employees at the time of open enrollment.

Period of Coverage

COBRA coverage may be terminated before the end of the COBRA coverage period under the following circumstances:

- Failure to make timely payments. COBRA law requires a 30-day grace period for delinquent payers. The grace period may be longer under some circumstances.
- The qualified beneficiary becomes covered under another group health plan.
- The employer ceases to maintain group plan. If the group terminates the group plan with Independent Health but maintains other coverage for active employees, then the qualified beneficiaries must be offered the other coverage.
- The qualified beneficiary becomes entitled to Medicare after the date of COBRA election.
- Qualified beneficiaries may also be terminated for any other reason which would be grounds for terminating an active employee (i.e., fraud, etc.).

Independent Health will terminate members for any of the reasons specified above. Notice will be sent directly to the member upon the occurrence of any of the above events.

When COBRA coverage is terminated, beneficiaries may enroll directly with Independent Health by applying for a direct pay policy.

Independent Health relies on the employer group to notify us when eligibility for a member's COBRA coverage ends. The group cannot rely on Independent Health to automatically terminate coverage at the end of the COBRA coverage period.

Recent regulations require that the plan administrator give the qualified beneficiary notice of early termination of COBRA coverage. The notice must inform affected qualified beneficiaries of the reason that COBRA coverage was terminated before the end of the maximum period, the date that COBRA coverage was terminated and any rights that the individual might have to alternative coverage.

Note: Independent Health is NOT the group's plan administrator. It is the responsibility of the employer group to send out all required COBRA notices.

Required COBRA notices include:

- COBRA General Notice (or Initial Notification) of COBRA entitlement – due within 90 days of enrollment in plan.
- Notice that the qualified beneficiary is eligible for COBRA due to death, termination or reduction in hours of employment – due within 30 days after loss of coverage or qualifying event.
- Notice to all qualified beneficiaries that COBRA coverage is or is not available.
- Notice of early termination of COBRA coverage.

PREMIUM INVOICES

Billing Procedures

Independent Health premiums are due on the first day of the month for that month of coverage. If premiums are not received within 30 days of the due date, the coverage will be retroactively canceled to the last day in which premiums were paid.

- Invoices are generated prior to the due date and reflect the membership information on the day they are run.
- To make billing administration easier for you, we recommend that you pay the exact amount billed regardless of pending membership changes. Any membership changes that affect the premium amount due will be reflected on a future invoice.
- Returned checks are re-deposited. If the check is returned a second time and is not replaced with guaranteed funds before the end of the current coverage period, the group's coverage may be terminated.

Independent Health uses the "Wash" proration as its standard. A subscriber who becomes effective on the 1st-15th of the month is billed for a full month premium. No premium is billed for subscribers who become effective on the 16th – end of month. Subscribers whose cancellation date is the 1st-15th of the month incur no premium charges. Subscribers whose cancellation date falls between the 16th–end of month incur a full month premium due.

Online Bill Payment and Presentment

Independent Health offers a secure online portal to view and pay your invoices. It's a simpler way to pay your invoices without the extra cost or time associated with stamps or paper checks.

- Get Started
  - You will be able to register with our ePay tool after you receive your first invoice.
  - Visit independenthealth.com/billpay
  - Register using your account number, contact information and email address.
  - Select your username and password – and securely save banking information.
- Manage your Account Online
  - Once registered, log in to view and pay your invoice.
  - Schedule payments in advance, for one-time pay or reoccurring.
  - View current and past invoices, along with "Balance Due."
  - Go paperless! Adjust your preferences to turn off paper invoices, and your electronic invoices will be sent directly to your inbox.
- Pay and Confirm
  - Pay by ACH (Automatic Clearing House).
  - Select the amount to pay and payment date (immediate or scheduled).
  - Click "Pay" to receive your immediate payment confirmation.

CREDITABLE COVERAGE

What is Creditable Coverage?

Creditable Coverage is defined as prescription coverage that is actuarially equivalent or better than the Standard Medicare Part D prescription drug benefit.

Medicare beneficiaries have the opportunity to receive subsidized prescription drug coverage through the Medicare Part D program. Beneficiaries who choose not to sign up at the first opportunity may have to pay more if they wait to enter the program after the open enrollment period. Beneficiaries who have other sources of drug coverage through a current or former employer or union, for example, may stay in that plan and choose not to enroll in the Medicare drug plan. If their other coverage is at least as good as the Medicare drug benefit (and therefore considered "creditable coverage"), then the beneficiary can continue to get the high-quality care they have now as well as avoid higher payments if they sign up later for the Medicare drug benefit.

Creditable coverage is needed to avoid the late enrollment penalty (LEP) on Medicare Part D should a member choose to elect Part D coverage at a date beyond their initial election period (IEP).

The Part D LEP is applied when a member has more than 63 days of non-creditable coverage during their Part D eligibility period. Non-creditable coverage occurs when a member does not have coverage that is actuarially equivalent to or better than the Standard Medicare Part D drug benefit.

Employer Group Responsibilities to Member

The Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicare, requires that certificates of creditable coverage are sent to all Medicare Part D eligible members with prescription coverage other than those currently enrolled in Medicare Advantage prescription drug plans.

Notices must indicate whether the individual's current prescription drug coverage is creditable or not, so they can make a decision on Part D coverage.

- Independent Health lists the "Medicare Part D Creditable Coverage Status" for our benefit plans on the plan specific Benefit Summary.

There are five occurrences when notices must be sent:

- Annually (by October 15th).
- When there is a change in creditable coverage status.
- Upon a member's IEP (i.e., if an individual is aging in).
- If an individual becomes disabled.
- Upon loss of creditable coverage or upon request from a member.

Employer Group Responsibilities to CMS

If you offer prescription coverage, you must disclose certain information about your coverage and those covered to CMS.

In accordance with CMS guidance, most employers with group health plans are required to submit an online disclosure form to CMS upon certain disclosure events. CMS is accepting disclosure only through the online form at www.cms.hhs.gov/CreditableCoverage/45_CCDisclosureForm.asp

COORDINATION OF BENEFITS

Coordination of Benefits (COB) is the process of sharing liability when a member has coverage with more than one health benefits carrier. Independent Health will make every effort to pursue COB revenue when another carrier is responsible for primary coverage. Primary coverage means the obligation of a plan to provide its services or benefits first. Any eligible expenses not then covered are to be assumed by whichever plan is not considered to be of primary responsibility.

Guidelines for determining which health benefits carrier is primary:

1. It is not unusual for a member to be covered by two health insurance policies covering similar services. When that is the case and a service is received that would be covered in part under either carrier, Independent Health will coordinate benefit payments with the other carriers up to the allowable expense (as defined herein as the necessary, reasonable and customary items of expense for covered health care). The other carrier will provide secondary benefits, if necessary, in an effort to reduce the member's expenses. This prevents duplicate payment and overpayments.

2. In order to determine which carrier is primary, certain rules have been established:
    a. The benefits of a carrier that does not have a COB provision or does not comply with Regulation 11 NYCRR52 No. 62 will be primary.
    b. The benefits of a carrier that covers the person as an employee, member or subscriber are determined before those of a plan that covers the person as a dependent.
    c. When two carriers cover the same child as a dependent of different persons, called "parents":
        i. The benefits of the carrier of the parent whose birthday falls earlier in a year are determined before those of the carrier of the parent whose birthday falls later in that year; but
        ii. If both parents have the same birthday, the benefits of the carrier that covered the parent longer are determined before those of the carrier that covered the other parent for a shorter period of time;
        iii. If the other carrier does not have the rule described above, but instead has a rule based upon the gender of the parent and if, as a result, the carriers do not agree on the order of the benefits, the rule in the other carrier will determine the order of benefits;
        iv. The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born.
    d. If two or more carriers cover a person as a dependent child of a divorced or separated parents, benefits for the child are determined in this order:
        i. First, the carrier of the parent with custody of the child is primary;
        ii. Then, the carrier of the spouse of the parent with custody of the child;
        iii. Finally, the carrier of the parent not having custody of the child;
        iv. If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the carrier of that parent has actual knowledge of those terms, the benefits of that carrier are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
    e. The benefits of a carrier that covers a person as an employee who is neither laid off nor retired (or as the employee's dependent) are determined before those of a plan that covers that person as a laid off or retired employee (or as that employee's dependent). If the other carrier does not have this rule and if, as a result, the carriers do not agree on the order of benefits, this rule is ignored.
    f. If none of the above rules determines the order of benefits, the benefits of the carrier covering an employee, member or subscriber longer are determined before those of the carrier that covered that person for the shorter time.

CMS MEDICARE SECONDARY PAYER REPORTING

The mandatory Medicare Secondary Payer (MSP) reporting under Section 111 of the Medicare, Medicaid SCHIP Extension Act of 2007 (MMSEA 111) requires that the insurer and employer groups provide certain information on a quarterly basis. We need to work together to meet the obligations under the Medicare Secondary Payer (MSP) requirement of Section 111 of the Medicare, Medicaid and State Children's Health Insurance Plan Extension Act of 2007 (MMSEA).

Below is a sampling of the information we are required to provide:

- Employer Taxpayer Identification Number (TIN).
- Total number of employees size.
- Social Security Number (SSN) for all employees and dependents.
- Medicare Beneficiary Identifier (MBI) for all Medicare entitled individuals.
- Employment status and corresponding effective dates for all employees.

The Section 111 reporting process will improve the coordination of benefits between CMS and insurers and reduce the overall administrative and coverage costs to all parties. Fewer mistaken payments made by Medicare will result in fewer recovery actions against employers.

As your Responsible Reporting Entity (RRE), Independent Health exchanges the MMSEA 111 required information on a regular basis with CMS. This ongoing exchange of data improves the accuracy of processing claims for members entitled to Medicare and supports efforts to avoid a potential penalty of $1,000 per day for any member not properly reported.

An employer's total employee group size is one of the most important factors in determining how a member's claims are paid between CMS and the insurer. Independent Health conducts an annual group size survey with our employer groups to validate the information we have on file is accurate. Failure to provide this information may result in an employee's claims not being processed correctly or timely. We ask that you return your annual questionnaire in a timely manner and we will continue to follow up until we have it on file.

Additional MSP resources to help guide you:
CMS provides valuable information related to the MSP employer requirements and how they relate to the Coordination of Benefits for you and your employees. For more information, please review the CMS Mandatory Insurer Reporting GHP User Guide at https://www.cms.gov/files/document/mmsea-section-111-ghp-user-guide-version-68-april-2023.pdf and the CMS Employer Services website at https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/EmployerServices/IRS-SSA-CMS-Data-Match.html

ERISA OVERVIEW

The federal Employee Retirement Income Security Act (ERISA) of 1974 was enacted to regulate employee benefit plans not provided by government entities. Although much of the law addresses financial standards for retirement benefits, it also specifically governs health plans and continues to be an extremely important piece of legislation.

ERISA codifies amendments to health care coverage through other federal laws, including the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), the Affordable Care Act (ACA), the Mental Health Parity and Addiction Equity Act (MHPAEA), the Newborns' and Mothers' Health Protection Act (the Newborns' Act) and the Women's Health Cancer Rights Act (WHCRA).

ERISA requires notification of various aspects of Federal law to members of group insurance plans and divides the responsibility for providing notifications between employers and insurers. The most important document employers provide to their employees is the Summary Plan Document. According to the Department of Labor, a Summary Plan Document is described as follows:

One of the most important documents participants are entitled to receive automatically when becoming a participant of an ERISA-covered retirement or health benefit plan or a beneficiary receiving benefits under such a plan, is a summary of the plan, called the summary plan description or SPD. The plan administrator is legally obligated to provide to participants, free of charge, the SPD. The summary plan description is an important document that tells participants what the plan provides and how it operates. It provides information on when an employee can begin to participate in the plan, how service and benefits are calculated, when benefits become vested, when and in what form benefits are paid, and how to file a claim for benefits. If a plan is changed, participants must be informed, either through a revised summary plan description, or in a separate document, called a summary of material modifications, which also must be given to participants free of charge. (https://www.dol.gov/general/topic/health-plans/planinformation)

For additional information on compliance with ERISA, there is a self-compliance tool available from the Department of Labor at https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/cagappa.pdf

INDEPENDENT HEALTH ONLINE

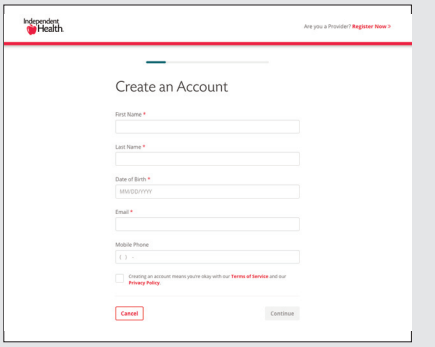
Members of Independent Health have exclusive online access to the benefits of their health plan. This includes a variety of tools and resources designed to engage a member in their overall health and well-being, which could potentially lower out-of-pocket costs in the long run.

As a member of Independent Health, you can get quick and easy access to the benefits of your health plan by creating an account at MyIH.com or by using the MyIH mobile app. Here, you will also find a variety of tools and resources you can use to help you get and stay healthy, which could potentially lower your health care costs in the future.

Create an Account

- Visit **MyIH.com/register** to create your account.
- Your name and other personal information will be needed during setup.
- The username and password you choose will be used to log in to your account when you visit us online or through the MyIH app.

Each time you log in, you'll be automatically directed to a personalized dashboard that provides a general overview of your benefits and other important features of your health plan.



Features

We make it easy to find the information you need on your health plan benefits:

Health Dashboard
Use this list as a Personal Action Plan to work with your doctor to create a wellness plan that's right for you.

Claims and Explanation of Benefits (EOBs)
Keep track of your billing by viewing medical or pharmacy claims online. Download an Independent Health claim form. Plus, easily access EOBs through your member account.

Deductible Tracker
If you're in a deductible plan, this tool will give you a snapshot of your deductible balance (i.e., how much you've already spent on health care services and how much is left to meet your requirement).

Member ID Card
View your member ID card, print a copy to use or keep on file, or order a replacement card online.

ONLINE TOOLS & RESOURCES

Nothing is more important than your health. That's why we provide you with a variety of online tools and resources that can help you get healthy and stay healthy:

Teladoc®
When you can't reach your primary care physician, talk with a doctor 24/7 by phone or online video. Copays may apply.

24-Hour Medical Help Line and Live Nurse Chat*
When you can't reach your primary care physician, you can call or chat online 24/7 with an experienced registered nurse for free.

Find a Doctor
Search online for eligible, in-network providers or medical facilities by entering a name, specialty or condition. Change or add a primary doctor as well.

Healthwise®
Access interactive tools, information on medications and drug interactions, as well as a video library.

Ways to Save
Learn about health care options that can save you time and money.

FitWorks®
Enjoy the rewards of healthy living through wellness challenges designed to keep you motivated and on track with your health. Easily log in through your MyIH account!

Compare Rx Costs
Easy-to-use online tool accessible from your account to look up medication uses, alternatives, compare costs, shop and save.

Compare Medical Costs
Estimate your costs for hundreds of common conditions, procedures, tests and health care services or visits.

Wellness Discounts
Show your member ID card and save money at local businesses. Use our online tool to find the right discount for you.

Healthy Living Tips and Guidelines
Stay up-to-date with today's health care trends by reading guidelines and our member magazine, HealthStyles.

Brook Health Companion
Quick chat messaging with Brook experts and interactive tools help you get and stay healthy, on your smartphone or computer.

Remember, you'll always have access to our "Helpful Links" at the bottom of every page, including frequently used forms, find a doctor and a glossary of health care terms.

*Independent Health's 24-Hour Medical Help Line should not be used for diagnosis or as a substitute for a physician.
Benefits vary by plan. Check summary of benefits for plan details. Verbal translation, alternate formats of written materials, and/or assistance for those with special needs, may be available upon request.
Traducción verbal, formatos alternativos de materiales escritos y/o asistencia para quienes tienen necesidades especiales, disponibles a solicitud.

QUESTIONS?

Contact our Member Services Department at **(716) 631-8701** or **1-800-501-3439 (TTY: 711)** from 8 a.m. – 8 p.m., Monday – Friday, or email at memberservice@servicing.independenthealth.com.

You Deserve the RedShirt Treatment.®

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