

## **Office of Group Insurance**

### *Group Insurance Administration Manual*

(July 2007)



**C.L. "BUTCH" OTTER, GOVERNOR**

**Department of Administration**

Michael Gwartney, Director

[http://www.adm.idaho.gov/insurance/manual/admin\\_manual.pdf](http://www.adm.idaho.gov/insurance/manual/admin_manual.pdf)

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# GROUP INSURANCE ADMINISTRATION MANUAL

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The Office of Group Insurance, Department of Administration as established in Idaho Code 67, Chapter 57, sponsors and is responsible for the administration of all group life, accidental death and dismemberment, disability, medical, dental, and flexible spending account programs, insurance contracts and policies for State of Idaho employees, retirees and their dependents.

The Office of Group Insurance is pleased to provide this *Group Insurance Administration Manual* to all State agencies. It is designed to serve as a guide to your role in helping us administer the various group insurance plans.

## HOW THIS MANUAL WORKS

This Administration Manual is organized by event, that is, according to a variety of circumstances under which employees may enroll for benefits or make election changes. For each event, the manual includes:

- Rules that apply to employee elections;
- Your role, which includes verifying eligibility, making sure employees enroll accurately and on time, and completing the premium payment procedure; and
- Frequently Asked Questions, answers to questions about how benefit rules and administrative procedures work.

## OTHER RESOURCES

The *Group Insurance Administration Manual* is designed to be used in conjunction with:

- ***Employee Group Insurance Handbook.*** This handbook summarizes group insurance benefits available to eligible employees and their dependents. It also includes employee premiums for the current plan year as well as addresses, phone numbers and websites for contacting representatives for the various plans as well as the individual contracts for each plan. The Handbook is available online at the Department of Administration, Office of Group Insurance website at <http://adm.idaho.gov/insurance/contracts.htm>.
- ***State Controller's Office DSP Personnel/Payroll User Manual.*** This Manual is a resource for all agencies using the SCO payroll system. Among other information, the *DSP Personnel/Payroll User Manual* includes detailed instructions for the online medical and dental enrollment system. You can access this Manual on the State Controller's Office website at <https://ipops2.sco.idaho.gov/eisonline/prod/popshpdb.nsf>.

- **Office of Group Insurance Staff.** Our staff is available to answer any questions agencies or subscribers may have about group insurance or the administration of the plans. In addition, the Office of Group Insurance is your resource for all benefit material, including enrollment and other forms. We also deal directly with employees on such issues as continuation of benefits during COBRA, disability plan claims, appeal of denied claims, and enrollment for retiree medical benefits.

## CONTACTS

### Office of Group Insurance:

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**Mailing Address:** P.O. Box 83720  
Boise, ID 83720-0035

**Telephone Number:** 208-332-1860 (local); or  
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### Benefits Online:

**Department of Administration Home Page:** [www.adm.idaho.gov/](http://www.adm.idaho.gov/)

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# I. GROUP INSURANCE PLANS AT A GLANCE

Here in brief are the State of Idaho employee group insurance plans discussed in this *Group Insurance Administration Manual*. For more information about plan benefits and provisions, refer to the *Employee Group Insurance Handbook* available on the Department of Administration website at <http://adm.idaho.gov/insurance/contracts.htm>.

PLANS	DESCRIPTION OF COVERAGE	HOW MONTHLY PREMIUMS ARE PAID
<b>Premium Only Plan</b>	Employees who elect this plan can pay medical and dental premiums on a before-tax basis	Employee share of premiums is deducted before federal or State income or FICA taxes are withheld
<b>Medical</b>	Current options are: <ul style="list-style-type: none"> <li>• Blue Cross of Idaho Traditional Plan</li> <li>• Blue Cross of Idaho PPO Plan</li> <li>• Decline coverage</li> </ul>	Agencies and employees share the cost
<b>EAP</b>	Included in each medical plan. Provides coverage for all benefit-eligible employees and dependents	Cost included in medical plan employer premium
<b>Vision Benefits</b>	Included in each medical plan. Claims management provided by VSP (Vision Service Plan). Automatic for all employees enrolled in a medical plan (employees may decline dependent coverage)	Agencies and employees share the cost
<b>Dental</b>	Delta Dental, automatic for all employees enrolled in a medical plan (employees may decline dependent coverage)	Agencies and employees share the cost
<b>Basic Life / Dependent Life Insurance</b>	Automatic coverage for eligible employees equal to 1 times annual salary with minimum \$20,000 coverage; eligible dependents are also covered	Agencies pay full cost
<b>Disability Program</b>	Automatic coverage for eligible employees, includes: <ul style="list-style-type: none"> <li>• Short Term Disability</li> <li>• Long Term Disability</li> </ul>	Agencies pay full cost as part of Basic Life Premium
<b>Supplemental Life Insurance</b>	Employees may purchase additional coverage equal to 1 times annual salary	Employees pay full cost
<b>State Police Optional Life</b>	\$50,000 coverage, available for eligible employees of the Idaho State Police	Employees pay 50% of cost, agencies pay 50%
<b>Flexible Spending Accounts (FSAs)</b>	Eligible employees can use either or both accounts to pay eligible expenses on a before-tax basis: <ul style="list-style-type: none"> <li>• Dependent Care Account</li> <li>• Medical Reimbursement Account</li> </ul>	Employees make all FSA contributions

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## II. INSURANCE ADMINISTRATION IN GENERAL

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### 1. ELIGIBILITY RULES

**NOTE:** Temporary or part-time employees hired by your agency may be eligible for benefits if they are also working for another State agency. You'll need to coordinate with the other agency to determine eligibility status of these employees.

#### A. ELIGIBLE EMPLOYEES

**(1) IN ORDER TO BE ELIGIBLE FOR GROUP INSURANCE COVERAGES, AN EMPLOYEE MUST BE:**

- (a) An officer or an employee of a State department, agency or institution, working twenty (20) or more hours per week; and
- (b) Whose term of employment is expected to exceed five (5) months in any consecutive twelve (12) month period.

Board and commission members must also work twenty (20) hours per week, for at least five (5) months in any consecutive twelve (12) month period to be eligible for group insurance benefits.

Any employee scheduled to work eighty-four (84) hours per month and expected to work at least five (5) months during any consecutive twelve (12) month period shall be deemed to meet the twenty (20) hour per week requirement. These employees receive coverage only when they meet the eligibility requirements. Hours worked in any given month are used to determine the following month's eligibility for benefits.

#### B. ELIGIBLE DEPENDENTS

**(1) LIFE INSURANCE**

Eligible dependents are the employee's legal spouse, and each of the employee's unmarried children, including:

- (a) Stepchildren, legally adopted children and children under a court appointed guardianship who rely on the employee for principal support and maintenance and who are at least ten (10) days but less than nineteen (19) years of age;
- (b) Unmarried children between the ages of nineteen (19) and twenty-five (25) who are eligible to be claimed by the employee as dependents for federal income tax purposes will continue to be covered; and
- (c) Unmarried children insured under the plan prior to age twenty-five (25) and who are incapable of self-sustaining employment by reason of developmental disability or

physical handicap may qualify for coverage past age twenty-five (25). Please direct employees to our office if they have specific questions regarding this provision.

## **(2) MEDICAL AND DENTAL COVERAGE**

Dependent means:

- (a) The legal spouse of the enrolled employee; and/or
- (b) The unmarried children of an enrolled employee or enrolled employee's spouse, up to their nineteenth (19<sup>th</sup>) birthdays. The term "children" includes natural children, stepchildren, adopted children, or children in the process of adoption from the time placed with the enrolled employee. The term "children" also includes children legally dependent upon the enrolled employee or enrolled employee's spouse for support where a normal parent-child relationship exists with the expectation that the enrolled employee will continue to rear that child to adulthood. However, if one or both of that child's natural parents live in the same household with the enrolled employee, a parent-child relationship shall not be deemed to exist, even though the enrolled employee or the enrolled employee's spouse provides support. Such children may be covered beyond their nineteenth (19<sup>th</sup>) birthdays so long as they are unmarried and are eligible to be claimed as dependents on the enrolled employee's most recent U.S. Individual Income Tax Return, but not beyond the end of the calendar month in which they attain age twenty-five (25).

Any unmarried child currently enrolled in the State of Idaho group who is or becomes incapable of self-sustaining employment by reason of mental or physical handicap prior to reaching his or her twenty-fifth (25<sup>th</sup>) birthday and who is chiefly dependent upon the enrolled employee for support and maintenance may be eligible for continued coverage under the group. Please direct employees to our office if they have specific questions regarding this provision.

## **2. PAYING PREMIUMS**

### **A. IF YOUR AGENCY IS ON THE STATE CONTROLLER'S PAYROLL SYSTEM**

The Division of Statewide Payroll (DSP) is the payroll system within the State Controller's Office. The Division of Statewide Payroll provides a *DSP Personnel/Payroll User Manual* located at <https://ipops2.sco.idaho.gov/eisonline/prod/popshpdb.nsf>, in which you'll find detailed procedures for paying premiums under the SCO payroll system. Keep in mind, since procedures can change from time to time, be sure to follow the most recent procedures outlined in the *DSP Personnel/Payroll User Manual*.

In general, your role in the premium payment process is to:

- (1) Complete the appropriate Idaho Paperless Online Personnel/Payroll System (IPOPS) set-up for each newly hired or eligible employee as close to the date of hire or benefit-eligibility as possible. This will ensure that Basic Life premiums are calculated and deducted appropriately and that employees have access to the online enrollment program. Agencies no longer set up medical/dental premium deductions, those deductions are now tied to the online

enrollment system. Any necessary medical/dental premium adjustments are processed by Office of Group Insurance staff.

- (2) Calculate Supplemental Life premiums. Each employee who elects this coverage pays the full premium — the cost depends on that person’s age and benefit amount. You calculate the monthly premium as shown below.

**NOTE:** Employees who apply for Supplemental Life after the thirty (30) day initial enrollment period must provide Evidence of Insurability as explained in Section III., 2. [When An Employee Makes Changes](#). Before you begin premium deductions, wait until the Office of Group Insurance notifies you that the employee’s application has been accepted.

### **Calculating Supplemental Life Premiums — SCO Payroll**

1. Determine the employee’s annual salary. Annual salary for:
  - Full-time employees = hourly rate of pay x 2080; or
  - Part-time employees = hourly rate of pay x 2080 x FTE.
2. Determine the employee’s coverage. For most employees, this equals annual salary, rounded up to the next higher \$1,000, unless already an even multiple of \$1,000. For Legislators, the amount of coverage is \$10,000.
3. Based on the individual’s coverage and age bracket, calculate the monthly cost using current premium rates found in the *Employee Group Insurance Handbook Summary* at <http://adm.idaho.gov/insurance/contracts.htm>.
4. After initial enrollment, you’ll need to adjust premium amounts when the employee’s salary changes. Since the coverage amount is based on annual salary, a change in pay may affect the monthly cost.

## **B. IF YOUR AGENCY IS NOT ON THE STATE CONTROLLER'S PAYROLL SYSTEM**

Your agency is responsible for sending the Office of Group Insurance monthly premiums on behalf of all eligible enrolled employees. Briefly, here’s how:

### **(1) MEDICAL AND DENTAL PREMIUMS**

To add employees and their dependents to a medical or dental plan, on the monthly billing statements you receive from our office:

- (a) Write in the employee’s name, Social Security number, and premium amount on the appropriate statement;
- (b) Recalculate the new total premium amount due; and

- (c) Send the Office of Group Insurance the billing statements along with the total premium due for the plan by the fifth (5<sup>th</sup>) of the month.

## **(2) BASIC LIFE PREMIUM**

On the monthly Premium Reconciliation form:

- (a) Calculate your agency's monthly premium for eligible active employees, including any new employees. To do this:
  - (i) In the appropriate sections, enter the total number of eligible active employees and the prior month's certified payroll for eligible employees. Multiply the certified payroll by the premium rate as listed on the Reconciliation form. Although all employees have a minimum of \$20,000 worth of basic life insurance coverage, the monthly premium is based on the actual monthly salary.
  - (ii) Explain all premium adjustments by entering the name of the employee, amount of adjustment, month to which the adjustment applies, and why the adjustment is necessary.
- (b) Sign the completed form and send it with your agency's premium payment to the Office of Group Insurance by the fifth (5<sup>th</sup>) of each month.

**NOTE:** If an employee is working in more than one (1) position and has enough hours to meet the eligibility requirements, life insurance premiums must be paid on all positions.

## **(3) SUPPLEMENTAL LIFE PREMIUMS**

Employees who elect Supplemental Life pay the full cost of the premiums. As shown below, you calculate employee premiums based on each person's age and coverage amount.

- (a) Complete the Supplemental Life Insurance Premium Reconciliation form and send it with your premium remittance to the Office of Group Insurance by the fifth (5<sup>th</sup>) of each month.
- (b) Adjust premium amounts when:
  - (i) The employee's salary changes. Since the coverage amount is based on annual salary, a change in pay may affect the monthly cost; or
  - (ii) The employee has a birthday that moves him or her into a higher premium bracket. These adjustments are made once a year, on July 1, for any changes that have occurred in the previous twelve (12) month period.

**NOTE:** Employees who apply for Supplemental Life after the thirty (30) day initial enrollment period must provide Evidence of Insurability as explained in Section III., 2. [When An Employee Makes Changes](#). Before you deduct premiums for employees who choose this option, wait until the Office of Group Insurance notifies you that the employee's application has been approved.

## ***Calculating Supplemental Life Premiums — Non-SCO Payroll***

1. Determine the employee's annual salary. Annual salary for:
  - Full-time employees = monthly salary x 12; or
  - Part-time employees = monthly salary x 12 times the actual full-time equivalent hours worked, times the actual full-time equivalent months worked.
2. Determine the employee's coverage. Employees may purchase insurance equal to annual salary, rounded to the next higher \$1,000, if not already a multiple of \$1,000.
3. Calculate the monthly cost, based on the individual's coverage and age bracket using current rates shown in the *Employee Group Insurance Handbook*.

## III. EVENTS

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### 1. WHEN AN EMPLOYEE IS NEW

#### ***Enrolling New Employees***

1. Premium Only Plan;
2. Medical and Dental;
3. Basic Life;
4. Disability Benefits;
5. Supplemental Life Insurance;
6. State Police Optional Life; and
7. Flexible Spending Accounts (FSAs).

New employees enroll for the coverage of their choice when they first come to work at your agency. The enrollment process differs from plan to plan and between payroll centers.

Employees of agencies using the State Controller's payroll system must use the online medical/dental and pre- or post-tax withholding (Premium Only Plan) enrollment program. Agencies are responsible for providing their employees with online enrollment instructions. The program is located on the Controller's Office website at <http://www.sco.idaho.gov/web/scoweb.nsf/displayview?ReadForm&L1=Payroll&L2=Applications&L3=IPOPS>. Employees will need to logon using their payroll system passwords. If an employee needs assistance with a password, please contact the State Controller's Office.

Online enrollment is not available to employees of agencies that do not use the State Controller's payroll system (e.g., universities, political subdivisions, etc.); employees of those agencies must submit hardcopy forms.

Employees of all payroll systems must submit hardcopy Life Insurance Enrollment/Beneficiary Designation forms. All hardcopy forms can be downloaded from our website at <http://www.adm.idaho.gov/insurance/insuranceforms.html>.

After initial enrollment, employees may make changes only as described in Section III., 2. [When An Employee Makes Changes](#).

## **A. RULES FOR ENROLLING NEW EMPLOYEES**

### **(1) PREMIUM ONLY PLAN**

- (a) All employees must elect or decline participation and submit their Premium Only Plan Elections within thirty (30) days of their hire dates.
- (b) For employees who elect to participate, medical/dental premiums are withheld on a before-tax basis.

### **(2) MEDICAL AND DENTAL**

- (a) To enroll themselves and their eligible dependents for coverage, employees must complete and submit the appropriate enrollment forms.
- (b) To decline medical plan participation, an employee must complete the declination of coverage portion of the enrollment form and submit it.
- (c) Coverage for employees and dependents begins:
  - (i) The first (1<sup>st</sup>) day of the month following the date of hire, provided the enrollment form is completed within thirty (30) days of hire; or
  - (ii) The first (1<sup>st</sup>) of the month after the enrollment form is signed, if the form is not completed within the initial thirty (30) day eligibility period.
- (d) Employees enrolled for medical coverage are automatically enrolled (and cannot decline enrollment) in the dental plan. Employees who enroll dependents for medical coverage are allowed to decline the medical plan's dependent vision benefits and/or dependent dental coverage. However, once declined, dependent vision benefits and dependent dental coverage cannot be obtained until an open enrollment period is held.

### **(3) BASIC LIFE INSURANCE**

- (a) Coverage is effective the first (1<sup>st</sup>) day of the month following the date of hire. If dependents are hospitalized on the day coverage is scheduled to begin, their coverage will start when they are released.
- (b) Employees must complete and submit a life insurance enrollment/beneficiary designation form to you within thirty (30) days of their hire dates. That form is available for downloading at <http://www.adm.idaho.gov/insurance/insuranceforms.html>.

### **(4) DISABILITY COVERAGE**

- (a) Short Term Disability (STD) and Long Term Disability (LTD) coverages are automatically provided to eligible employees as part of the Basic Life Insurance plan.
- (b) Coverage is effective on the same date as the Basic Life Insurance. For an employee who is not in active status that day, coverage begins when the employee returns to work.

**(5) SUPPLEMENTAL LIFE INSURANCE**

- (a) New employees must elect or decline coverage by selecting the appropriate box on the Life Insurance Enrollment/Beneficiary Designation form. The form is available for downloading at <http://www.adm.idaho.gov/insurance/insuranceforms.html>.
- (b) Coverage is effective the first (1<sup>st</sup>) day of the month following the date of hire, provided enrollment is completed within thirty (30) days of hire.

**(6) STATE POLICE OPTIONAL LIFE**

- (a) Employees must submit a State Police Life Enrollment/Beneficiary Designation form to you within thirty (30) days after date of hire. That form is available for downloading at <http://www.adm.idaho.gov/insurance/insuranceforms.html>.
- (b) Coverage is effective on the first (1<sup>st</sup>) day of the month following the date of hire.

**(7) FLEXIBLE SPENDING ACCOUNTS (FSA)**

The FSA is not available to new employees. Eligible employees may only enroll during the annual open enrollment period.

**B. YOUR ROLE**

**(1) PROVIDE EMPLOYEES WITH THE EMPLOYEE GROUP INSURANCE HANDBOOK**

If employees have Internet access, refer them to our website, <http://adm.idaho.gov/insurance/contracts.htm>, and indicate on your new employee orientation checklist that they have been given Internet access. If employees do not have Internet access, provide a printed copy of the Handbook.

**(2) VERIFY ELIGIBILITY**

Verify employee eligibility for benefits as outlined in Section II., 1. [Eligibility Rules](#).

**(3) SUBMIT AND FILE HARDCOPY FORMS**

- (a) Premium Only Plan: If your agency is not on the State Controller's Office payroll system, file the designated copies of hardcopy forms in employee personnel files.
- (b) Medical/Dental: If your agency is not on the State Controller's Office payroll system, send the designated copies of all hardcopy forms to the Office of Group Insurance and place your copies in employee personnel files.
- (c) Basic and Supplemental Life: Sign in the "State Agency to Complete" section and then file all forms in employee personnel files.
- (d) State Police Optional Life: Sign in the "State Agency to Complete" section, and then file all forms in employee personnel files.

## C. FREQUENTLY ASKED QUESTIONS

- Q. *What happens if a new employee fails to submit any enrollment forms?*
- A. That employee is assumed to have declined all elective coverage.
- Q. *If employees have declined medical for themselves or dependents, how are they enrolled for Employee Assistance Program (EAP) services?*
- A. EAP services are available to all benefit-eligible employees and dependents, no enrollment is necessary. When a participant first calls Business Psychology Associates to pre-approve EAP services, the Office of Group Insurance is contacted to verify eligibility. Coverage will become effective the first (1<sup>st</sup>) day of the month following the date of hire.
- Q. *Do we have to verify dependent eligibility for benefits?*
- A. While agencies are required to verify an employee's eligibility, you are not required to verify dependents' eligibility for enrollment.
- Q. *If an employee declines dependent dental coverage but later acquires a new dependent, is the new dependent eligible for dental coverage?*
- A. Once an employee declines dependent dental, coverage is declined for all dependents present and future. Once declined, dependent dental can only be obtained when the State holds a dental open enrollment.
- Q. *If an employee enrolls for medical but doesn't enroll his or her children for coverage, does that mean the employee has also elected to decline dependent dental?*
- A. In the case of this employee, if he or she later enrolls dependents for medical, they're still eligible for dental coverage. Only an employee who enrolls dependents for medical coverage and declines dependent dental coverage is considered to have a declination in force.
- Q. *Why would an employee submit a Beneficiary Designation With UTMA (Uniform Transfer to Minors Act) Custodian form instead of just a Beneficiary Designation form?*
- A. The Beneficiary Designation with UTMA Custodian form applies only to those who designate minors as their beneficiaries. Insurance proceeds cannot be paid to minors. Employees wanting to designate a minor as a beneficiary should complete the UTMA designation to ensure that the custodian of their choice controls any funds payable under the policy.

## 2. WHEN AN EMPLOYEE MAKES CHANGES

### ***Changing Benefit Elections***

1. Annual open enrollment changes, switching medical plans, adding or dropping Premium Only Plan and electing Flexible Spending Accounts (FSAs);
2. Enrolling newly acquired dependents;
3. Mid-year coverage changes, enrolling late for coverage, declining medical, declining dependent dental;
4. Mid-year Flexible Spending Account (FSA) changes, increasing contributions;
5. Supplemental Life changes, adding or dropping coverage;
6. Beneficiary Changes; and
7. Name changes.

Employees can change their current benefit elections for a variety of reasons. The rules for making those changes depend on the situation.

If your agency uses the State Controller's payroll system, your employees will submit medical/dental and pre- or post-tax withholding (Premium Only Plan) changes via the online enrollment program.

If your agency does not use the State Controller's payroll system, your employees must submit hardcopy forms to make medical/dental or premium withholding changes.

Employees of all payroll systems must submit hardcopy FSA and life insurance enrollment or beneficiary designation forms. All hardcopy forms can be downloaded from our website at <http://www.adm.idaho.gov/insurance/insuranceforms.html>.

### **A. RULES FOR CHANGING BENEFIT ELECTIONS**

#### **(1) ANNUAL OPEN ENROLLMENT CHANGES**

Annual open enrollment is the only time that employees may switch medical plans, change their Premium Only Plan elections or enroll in the FSA. Open enrollment is usually held in May. Benefit changes made at this time apply for the following plan year, from July 1 through June 30.

Each year, the Office of Group Insurance sends all agencies instructions in advance of the upcoming annual open enrollment. We include such details as the exact dates of the open enrollment period and employee deadlines for submitting election forms. We also provide

information for employees about available benefit options, upcoming changes, and how to enroll for the benefits of their choice.

To make changes during annual open enrollment, employees must submit applicable election forms by the end of the open enrollment period. Employees of agencies using the State Controller's Office payroll system submit their forms online. Employees of agencies not on the Controller's Office payroll system must submit hardcopy forms. All employee elections must be submitted during the open enrollment period; forms submitted after the end of that period cannot be accepted.

## **(2) ENROLLING NEWLY ACQUIRED DEPENDENTS**

After acquiring new dependents through marriage, birth or adoption, an employee may add them to coverage at anytime (unless a dependent dental or vision declination is currently in effect).

- (a) The employee must submit a revised enrollment form.
- (b) Coverage for newly acquired dependents (other than newborn natural and adopted children or children in the process of adoption) is effective the first (1<sup>st</sup>) of the month after they become eligible, provided enrollment is completed within sixty (60) days of the qualifying event.
- (c) Coverage will be effective the date of birth for a newborn natural child, or a child adopted or placed for adoption within sixty (60) days of the child's date of birth, provided the child is enrolled within sixty (60) days of birth.
- (d) Coverage for adopted children placed for adoption more than sixty (60) days after the child's date of birth is effective the date of adoption or the date of placement for adoption, provided the child is enrolled within sixty (60) days of adoption or placement.
- (e) Eligible new dependents who are at least ten (10) days of age are automatically covered under the basic life plan, no enrollment form is required. Their coverage begins immediately, unless they're hospitalized on the date coverage is supposed to begin. In that case, coverage is delayed until their release.

## **(3) MID-YEAR COVERAGE CHANGES**

### **(a) Enrolling for Medical Coverage**

Eligible employees can enroll themselves or dependents for medical plan coverage anytime. Vision and dental benefits are automatic for employees; employees may elect those coverages for dependents being enrolled in a medical plan, unless dependent declinations are already in effect. Those who enroll for coverage after the thirty (30) day initial eligibility period or after they have previously dropped coverage are considered late enrollees. Coverage begins the first (1<sup>st</sup>) day of the month following the date enrollment forms are completed.

(b) Declining Medical Coverage

A currently enrolled employee can drop medical coverage for himself/herself or enrolled dependents at any time.

- (i) To drop employee medical coverage, the employee must complete the declination of coverage section of the form. Vision benefits and dental coverage will automatically end as well, since they are only available to members enrolled in a medical plan. In addition, since dependents can only be covered if the employee is enrolled, their coverages will end too.
- (ii) To drop all dependents from medical coverage, the employee needs to select “Self Only” on the enrollment form. To only delete select dependents from coverage, the employee will need to list the name(s) of the dependent(s) to be dropped from coverage and choose a new enrollment tier (e.g., “Self and Spouse,” “Self and Child,” etc.) as applicable, if using the online enrollment program. If the employee is submitting a hardcopy enrollment form, a new enrollment tier needs to be chosen and the employee must list the names of dependents to **remain insured**.
- (iii) Employee coverage continues through the last day of the month in which the employee signs the revised medical plan enrollment form. Dependent coverage continues through the last day of the month in which the dependent loses eligibility or the employee signs the revised enrollment form, whichever occurs first.

(c) Declining Dependent Vision and Dental

Although employees have vision benefits at no cost to themselves and are required to take dental coverage, they can drop either vision or dental coverage for currently enrolled family members at any time.

- (i) To decline dependent dental or vision, employees submit a medical plan enrollment form and select the “Self Only” option in the applicable section(s).
- (ii) Coverage continues through the last day of the month in which the dependent loses eligibility or the employee signs the form, whichever occurs first.
- (iii) Once dependent vision or dental coverages have been declined, they can only be added when the State holds a special vision or dental open enrollment every three (3) years.

(d) Switching Medical Plans Mid-Year

Annual open enrollment is the only time employees may switch to a different medical plan option.

**(4) MID-YEAR FSA CHANGES**

If an employee elects to participate in an FSA, he or she may only change elections mid-year in the event of a qualifying family status change. No other mid-year changes are allowed.

- (a) To change contributions, the employee submits a revised FSA Election form indicating the new contribution amount. Employees may increase or decrease dependent care elections, but may only increase medical reimbursement account elections. All changes must be submitted within thirty (30) days of the qualifying event.
- (b) The Office of Group Insurance must review and approve any mid-year changes in FSA contributions. We will notify the employee and your agency if the change has been approved.

#### **(5) SUPPLEMENTAL LIFE CHANGES**

Employees can apply for or drop Supplemental Life coverage anytime. Those who elect coverage after the thirty (30) day initial enrollment period or after they've previously declined coverage are late enrollees.

- (a) To add coverage, employees submit a revised Life Insurance Enrollment/Beneficiary Designation form.
  - (i) Late enrollees also have to provide proof of good health by submitting a health statement along with their beneficiary designation forms. Health statement forms are available upon request from this office. Because the information requested on the form must be kept confidential, we will send the form directly to the employee with instructions to return the completed form to our office for processing.
  - (ii) The Office of Group Insurance will notify your agency when a determination regarding the employee's application has been made so that you can set up the appropriate premium deduction, if applicable.
  - (iii) Coverage is effective the first (1<sup>st</sup>) day of the month after the application has been approved.
- (b) To drop coverage, employees complete new enrollment/beneficiary designation forms on which they complete the declination of coverage section.

#### **(6) BENEFICIARY CHANGES**

Employees may change their beneficiaries for Basic Life, Supplemental or Police Optional Life Insurance at any time.

- (a) To change Basic or Supplemental Life beneficiaries, employees must submit a new Beneficiary Designation form or, if applicable, Beneficiary Designation With UTMA Custodian form.
- (b) To change State Police Life beneficiaries, employees complete a new beneficiary designation form.
- (c) Married employees need written approval from their spouses to name someone other than their spouses as beneficiaries.

## **(7) NAME CHANGES**

An employee who changes his or her name needs to submit a revised enrollment form for each plan in which he or she is enrolled.

## **B. YOUR ROLE**

### **(1) PROVIDE EMPLOYEES WITH INFORMATION REGARDING ONLINE ENROLLMENT**

If your agency is on the SCO payroll system, your employees enroll for medical and dental coverages and make their pre- or post-tax premium withholding elections online. You will need to provide information regarding the online enrollment program to your employees. The *SCO DSP Personnel/Payroll Manual*, located at <https://ipops2.sco.idaho.gov/eisonline/prod/popshpdb.nsf>, includes an online tutorial specific to the Employee Self Service option, which contains the online enrollment program.

### **(2) SUBMIT AND FILE HARDCOPY FORMS**

- (a) **Premium Only Plan:** If your agency is not on the State Controller's Office payroll system, file the designated copies of hardcopy forms in employee personnel files.
- (b) **Medical/Dental:** If your agency is not on the State Controller's Office payroll system, send the designated copies of all hardcopy forms to the Office of Group Insurance and place your copies in employee personnel files.
- (c) **Basic and Supplemental Life:** Sign in the "State Agency to Complete" section, and then file all forms in employee personnel files.
- (d) **State Police Optional Life:** Sign in the "State Agency to Complete" section, and then file all forms in employee personnel files.

## **C. FREQUENTLY ASKED QUESTIONS**

- Q. *During open enrollment, do employees have to re-enroll if they want to continue benefit elections "as is" for the coming plan year?*
- A. That depends on the plan:
- For the FSA, employees must submit new election forms to participate each year.
  - For the Premium Only Plan, no re-enrollment is required.
  - For the medical plans, no re-enrollment is required.
- Q. *Do employees have to complete a new election form to switch from one medical plan to another during annual open enrollment?*
- A. Yes. To switch to a different plan, an employee must complete a medical plan enrollment form on which he or she indicates the new plan choice.

Q. *How are newly acquired dependents enrolled for Dependent Life?*

- A. There's no special procedure to enroll dependents for this coverage. If the employee ever makes a claim for dependent benefits, then we will verify that the dependent is eligible.

### 3. WHEN AN EMPLOYEE GOES ON LEAVE

#### ***Continuing Benefits While on Leave***

1. Leave Without Pay (LWOP);
2. Family Medical Leave Act (FMLA);
3. Disability; and
4. Military Leave.

Employees who go on authorized leaves of absence may continue group insurance coverages for a period of time. The rules differ depending on the kind of leave.

#### **A. RULES FOR CONTINUING BENEFITS WHILE ON LEAVE**

##### **(1) LEAVE WITHOUT PAY (LWOP)**

While on authorized LWOP, employees may elect to continue medical, vision, dental, Basic Life and Supplemental Life coverages for a period of time. Eligible employees may also continue State Police Optional Life Coverage.

- (a) For most Leaves Without Pay, continued coverage is available for six (6) months (twelve [12] months for authorized employer-sponsored leave for professional and educational purposes).
- (b) To continue coverage, employees must self-pay the total monthly premium, including the state contribution, for each continued plan.
- (c) Employees self-pay by sending your agency monthly checks or money orders made payable to the Office of Group Insurance. Cash payments are not accepted.
- (d) Coverage stops when an employee reaches the maximum benefit period or fails to pay the required monthly premiums, whichever comes first.
- (e) After reaching the maximum LWOP self-pay period, employees may continue medical, vision and/or dental for a period of time under COBRA provisions. For more information, see Section III., 8., [When a Participant Continues Coverage After Loss of Eligibility](#) or the *Employee Group Insurance Handbook*.

##### **(2) FAMILY AND MEDICAL LEAVE ACT (FMLA)**

FMLA is a federal law which entitles most employees to take up to twelve (12) weeks of unpaid leave in a twelve (12) month period for a variety of reasons — for example, following birth or adoption of their children, to care for their children, spouses or parents with serious medical conditions, or for their own serious medical conditions. For questions about FMLA,

including eligibility, contact the Division of Human Resources or your Deputy Attorney General.

While on FMLA, employees may continue medical, dental, Basic Life and Supplemental Life. Eligible employees may also continue their State Police Optional Life coverage.

- (a) Your agency will continue to pay all employer premiums.
- (b) To continue coverage, employees must pay their share of the monthly premiums. Employees who continue to receive paychecks while on FMLA pay their share of the premiums through payroll deductions.

Employees who are not receiving paychecks while on FMLA must self-pay their share of premiums by sending monthly checks or money orders to you, made payable to the Office of Group Insurance.

- (c) When FMLA ends, employees who continue to be on approved leave without pay may continue coverage for the balance of the six (6) month LWOP period by self-paying the total monthly premium, including the State contribution.

### **(3) DISABILITY**

Employees who become disabled may continue their group insurance coverages for a period of time. Following is a brief look at coverage options available to individuals on disability leave. The Office of Group Insurance provides disabled employees with a detailed explanation of these options (you will receive a copy of the correspondence), including what's available and how long benefits may continue.

#### **(a) Medical and Dental**

Coverage for the employee and eligible dependents may continue for up to thirty (30) months from date of disability (as determined by Principal Life Insurance Company) or until the disability claim closes, whichever occurs first.

- (i) While employees are on active status, they continue to have their share of monthly premiums payroll deducted, and your agency will pay the employer's share as usual.
- (ii) Once employees are on inactive status, the Office of Group Insurance will pay the employer's share of the premiums for the balance of the coverage continuation period, provided employees continue to self-pay their share of premiums. During short-term disability, employees send their checks or money orders to you, made payable to the Office of Group Insurance. When the employee goes on long-term disability, they send their self-pay checks directly to our office.
- (iii) When eligibility for active employee coverages ends, we provide the individual with information regarding options for continuing coverage under COBRA provisions and the state's retiree group medical plan. For more information, see Section III., 8., A., [Rules for Continuing Coverage](#).

(b) Basic Life

While on an approved disability, the employee and dependent life portions of the plan are extended at no cost to the employee for the duration of the claim.

(c) Supplemental Life

To continue this coverage, an employee must self-pay premiums during the first six (6) months of disability. After that, premiums are waived and coverage will continue at no cost to the employee for the duration of the claim.

**(4) MILITARY LEAVE**

(a) For the first six (6) months of military leave, employees may continue coverage for themselves and their eligible family members the same as described for Leave Without Pay. However, your agency must continue to pay the employer contribution for the first thirty (30) days of the employee's leave.

(b) After the six (6) month LWOP period ends, employees may continue medical and dental coverages for themselves and dependents under COBRA. Basic Life and Supplemental Life may be converted to individual policies. For more information, see Section III., 8., A., [Rules for Continuing Coverage](#), or contact our office.

**B. YOUR ROLE**

**(1) SUBMIT EMPLOYEE PAYMENTS**

For employees who are self-paying premiums while on leave:

- (a) Complete the applicable self-payment reporting forms downloadable from our website at <http://adm.idaho.gov/insurance/insuranceforms.html>; and
- (b) Submit forms to the Office of Group Insurance, with employee payments attached, by the fifth (5<sup>th</sup>) of each month.

**C. FREQUENTLY ASKED QUESTIONS**

Q. *If employees become ineligible for benefits due to a reduction in work hours, what are their options for continued coverage?*

A. While these employees are not eligible for the self-pay provisions described for leaves of absence, they may be eligible for continued medical and life insurance coverage as described in Section III., 8., A., [Rules for Continuing Coverage](#).

Q. *What happens to coverages when an employee goes on leave with pay?*

A. As long as they are on leave with pay, their insurance coverages will continue the same as for any other active employee. Note that if an employee receives reduced pay while on leave, life insurance and disability coverage will be based on the reduced salary.

- Q. *What happens when an employee on LWOP completes the six (6) month self-pay period?*
- A. After the six (6) month period ends, employees may apply for continued medical and dental coverage under COBRA. Coverage under the State's Basic Life and Supplemental Life plans terminates, but individual conversion policies may be available. For more information, see Section III., 8., [When A Participant Continues Coverage After Loss of Eligibility](#).
- Q. *Can employees on authorized leave participate in annual open enrollment?*
- A. Yes, if they're enrolled for coverage during the annual open enrollment period, employees may participate while on leave of absence.
- Q. *Can employees continue Flexible Spending Account (FSA) participation when they are on Leave Without Pay?*
- A. Yes, but participation is available only on an after-tax basis, unless the employee is on FMLA. If an employee is interested in continuing FSA participation while on leave, refer the employee to the Office of Group Insurance for information.
- Q. *When do we start counting the six (6) month benefit continuation period for LWOP?*
- A. The six (6) month period starts effective the first (1<sup>st</sup>) of the month after the date the employee goes on leave without pay.

## 4. WHEN AN EMPLOYEE RETURNS FROM LEAVE

### ***Resuming Coverage After Leave***

1. Medical and Dental;
2. Basic Life;
3. Supplemental Life;
4. Optional State Police Life; and
5. Flexible Spending Account (FSA) Participation.

If employees continue their group insurance coverages while on leave of absence, those coverages will resume when they return to work but re-enrollment may be required. If coverage lapsed during the leave, employees may have the option to resume participation when they return. The rules for resuming coverage differ depending on the kind of leave.

#### **A. RULES FOR RESUMING COVERAGE AFTER LEAVE**

##### **(1) MEDICAL AND DENTAL**

To resume coverage, returning employees can re-enroll themselves and eligible family members in the same plans they were enrolled in before they went on leave.

- (a) State-paid coverage is effective the first (1<sup>st</sup>) of the month following the date the new enrollment form is completed (or immediately when returning from military leave, provided the new enrollment form is completed within thirty [30] days).
- (b) If employees allowed their coverage to lapse while they were on LWOP, all contract provisions, including new annual deductibles, out-of-pocket maximums and waiting periods, will apply the same as for new participants.
- (c) For employees returning from military leave, participation will resume at the same status in which they left. This means, for example:
  - (i) The time an employee was covered before the leave will count toward satisfying medical plan waiting periods for pre-existing conditions; and
  - (ii) If the employee returns within the same plan year as the leave began, any amounts he or she paid for covered expenses before the leave will still count toward satisfying that year's medical or dental plan deductibles or out-of-pocket maximums.

Please contact our office for re-enrollment instructions specific to employees returning from military leave.

- (d) For employees who previously declined dependent vision or dental, the declinations remain in effect when they return from leave.

## **(2) BASIC LIFE**

To resume this coverage, returning employees don't have to do anything. If they're eligible, coverage begins automatically the day they return to active status; you will need to ensure the appropriate premium payments resume.

## **(3) SUPPLEMENTAL LIFE AND OPTIONAL STATE POLICE LIFE**

To resume this coverage, returning employees must complete a new enrollment form.

- (a) Employees returning from military leave, who allowed the policy to lapse, may resume coverage without a health statement as long re-enrollment occurs within thirty (30) days. If coverage did not lapse during military leave, no re-enrollment is necessary but you will need to ensure that the appropriate premium deductions resume.
- (b) Employees who return from any other kind of leave, and who allowed coverage to lapse, must reapply and provide evidence of good health. Their coverage is effective the first (1<sup>st</sup>) day of the month after the insurance company approves the application. If coverage did not lapse, no re-enrollment is necessary but you will need to ensure that premium deductions resume.

## **(4) FLEXIBLE SPENDING ACCOUNT PARTICIPATION**

- (a) Employees who go on leave and subsequently return within the same plan year, must resume participation in the FSA. You will need to ensure that payroll deductions are activated when employees return to active status.
- (b) Employees who go on leave and do not return to work until a different plan year cannot re-enroll in the FSA unless they were on military leave. Please contact our office for re-enrollment instructions specific to employees returning from military leave.

## **B. FREQUENTLY ASKED QUESTIONS**

- Q. *When employees return from leave, do they have to fill out new Basic Life Beneficiary Designation Forms?*
  - A. No, not unless they want to change their beneficiaries.
- Q. *Do employees returning from leave have to re-enroll for the same coverage they had before?*
  - A. Employees don't have to resume any elective coverage unless they want to. However, to make changes to their previous elections, they must follow the rules described in Section III., 2., [When An Employee Makes Changes](#).

## 5. WHEN AN EMPLOYEE TRANSFERS AGENCIES

### ***Transferring Benefits***

1. Continuing Medical, Vision, Dental and Premium Only Plan Elections;
2. Continuing FSA Contributions;
3. Continuing Basic Life and Supplemental Life; and
4. Changing benefit elections.

This section addresses the rules that apply to benefit coverage when an employee transfers from one State agency to another.

#### **A. RULES FOR TRANSFERRING BENEFITS**

##### **(1) CONTINUING MEDICAL, VISION, DENTAL AND PREMIUM ONLY PLAN ELECTIONS**

- (a) To continue coverage, employees must submit updated enrollment forms to reflect the employing agency change. Employees who transfer from one agency to another cannot change from one medical plan to another, or change their pre- or post-tax Premium Only Plan elections. If your agency is on the State Controller's payroll system, employees will submit their forms online. If your agency is not on the Controller's payroll system, your employees will need to submit hardcopy forms, which can be downloaded from our website at <http://adm.idaho.gov/insurance/insuranceforms.html>.
- (b) Employees who previously declined dependent dental or vision benefits cannot obtain those coverages until a special open enrollment period is conducted.

##### **(2) CONTINUING FSA CONTRIBUTIONS**

Employees must continue their FSA elections when they transfer agencies. An updated election form must be submitted, so that the plan administrator is aware of the change in employing agencies and can properly account for payroll contributions. Your agency must obtain a copy of the employee's original election form from the previous agency to verify that the employee's updated form reflects the original pay period elections. You will also need to ensure that the appropriate payroll deductions are set up.

##### **(3) CONTINUING BASIC LIFE AND SUPPLEMENTAL LIFE**

Your agency is responsible for obtaining life insurance enrollment/beneficiary designation forms from the previous agency and ensuring that the appropriate premium deductions occur.

#### (4) CHANGING BENEFIT ELECTIONS

Transferring employees may change current benefit elections only according to the rules described in Section III., 2., [When An Employee Makes Changes](#).

### ***Effective Dates of Coverage for Transferring Employees***

- If an employee transfers out of an agency between the 1<sup>st</sup> and the 14<sup>th</sup> of a month, that agency will continue to pay applicable employer premiums through the end of that month. Starting the 1<sup>st</sup> day of the next month, the new agency will begin to pay premiums for the employee's coverage.

**For example**, an employee transfers out of an agency on March 14. The previous agency pays the employer portion of premiums through March 31. The new agency pays applicable premiums on the employee's behalf starting April 1.

- If an employee transfers out of an agency between the 15<sup>th</sup> and the last day of a month, that agency will continue to pay applicable employer premiums through the end of the following month. The new agency will begin to pay premiums as of the first (1<sup>st</sup>) day of the month after that.

**For example**, an employee transfers out of an agency on March 15. The previous agency pays the employer portion of premiums through April 30. The new agency pays applicable premiums on the employee's behalf starting May 1.

## **B. FREQUENTLY ASKED QUESTIONS**

Q. *If a transferred employee declined Supplemental Life at the previous agency, can the employee enroll at the new agency?*

A. Not automatically. Eligible employees who previously declined coverage may apply for Supplemental Life at any time. Of course, just like other late enrollees, they must provide evidence of good health before their applications may be approved.

Q. *If employees declined dependent dental at their previous agencies, what happens if they don't select the "Self Only" option on the enrollment forms submitted at their new agencies?*

A. Delta Dental keeps a record of each dependent declination, and the declination will stay in force. In the event an ineligible dependent dental election is submitted, Delta Dental will advise our office of the discrepancy so that corrective action can be taken.

## 6. WHEN AN EMPLOYEE FILES A CLAIM FOR BENEFITS

### ***Rules for Filing Claims***

1. Medical, IBHP, Vision and Dental Claims;
2. Life Insurance Claims;
3. Basic Life Accelerated Benefits;
4. Accidental Dismemberment Claims;
5. Short Term Disability Claims; and
6. Flexible Spending Account (FSA) Claims.

The rules for filing benefit claims differ from plan to plan. Employees handle their own health care and FSA claims and work directly with the Office of Group Insurance when they file disability claims, but your agency provides employment-related information for disabled employees and plays a role in filing life insurance claims.

### **A. RULES FOR FILING CLAIMS**

#### **(1) MEDICAL, VISION AND DENTAL CLAIMS**

- (a) In general, employees simply show their plan identification cards to providers at the time of services. The providers then bill the plans directly.
- (b) When employees are required to file claims (for example, if services are provided by a non-participating provider who will not bill insurance), they send their itemized receipts (no claim forms required) directly to the applicable carrier.

#### **(2) BASIC LIFE, SUPPLEMENTAL LIFE, STATE POLICE LIFE INSURANCE CLAIMS**

- (a) To file a claim for these benefits, beneficiaries submit a Group Life Claim and Settlement Information form to you. Beneficiaries must complete sections II and III of the form; you will need to complete section I.
- (b) Along with the claim form, a beneficiary must include:
  - (i) A certified copy of the death certificate; and
  - (ii) For Accidental Death claims, include a police report or a news clipping about the accident.

- (c) Completed claim forms need to be submitted to the Office of Group Insurance. The deadline for filing a life insurance claim is one (1) year from date of loss.

**(3) BASIC LIFE ACCELERATED BENEFITS**

- (a) To file a claim for these benefits, terminally ill employees file an Accelerated Benefits Claim form directly with the Office of Group Insurance.
- (b) The insurance company determines if the employee is eligible for accelerated benefits and how much the benefit will be.
- (c) We include information about Accelerated Basic Life benefits in our communications to employees filing for short-term disability benefits.

**(4) ACCIDENTAL DISMEMBERMENT CLAIMS**

- (a) To claim Accidental Dismemberment benefits, the employee submits the completed Dismemberment form, plus a police report or a news clipping about the accident, directly to the Office of Group Insurance.
- (b) Claim forms are available from the Office of Group Insurance upon request.

**(5) DISABILITY CLAIMS**

(a) Short Term Disability (STD):

- (i) To apply for benefits, the employee and attending physician must complete a Principal Life Insurance Company disability claim form.
- (ii) To obtain a claim form, employees or their representatives should contact the Office of Group Insurance directly at:

(208) 332-1860 or 1-(800) 531-0597

E-mail: [ogi@adm.idaho.gov](mailto:ogi@adm.idaho.gov)

- (iii) After the insurance company has reviewed the claim, we'll notify your agency whether the claim has been approved, unless the employee requests that we not release that information. The insurance company will send a claims determination letter directly to the employee.

- (iv) We will apprise each employee who files a claim what his/her options are for continuing group insurance coverages while on disability.

(b) Long Term Disability (LTD):

If employees are still disabled after Short-Term Disability benefits end, the claim is transitioned from STD to LTD by the insurer. Consequently, no claim forms are required.

## **(6) FLEXIBLE SPENDING ACCOUNT (FSA) CLAIMS**

- (a) At the beginning of each plan year, employees who elect to participate in the FSAs receive reimbursement claim forms and filing instructions from the FSA plan administrator, Stanley, Hunt, DuPree and Rhine. Claim forms are also downloadable from our website at <http://adm.idaho.gov/insurance/insuranceforms.html>.
- (b) Participants file reimbursement claims directly with the plan administrator.

## **B. YOUR ROLE**

### **(1) MEDICAL, VISION AND DENTAL CLAIMS**

Most providers will bill insurance carriers for their services. In the event an employee receives services from a non-participating provider who will not bill directly, the employee will need to submit the claim to the carrier.

### **(2) LIFE INSURANCE CLAIMS**

Make sure submitted forms are accurate, legible, complete and that the beneficiary has included any required additional information.

- (a) Complete the employer's section of the form.
- (b) Submit the claim to the Office of Group Insurance along with the most recent beneficiary designation(s) and any applicable back-up paperwork.

### **(3) DISABILITY CLAIMS**

The Office of Group Insurance will send you a Statement of Agency form and a Job Description Questionnaire whenever an employee files a Short-Term Disability claim. Your agency must complete and return both forms to us in the specified time period. The purpose is to provide us with employment-related information about the employee.

### **(4) FSA CLAIMS**

Employees must submit their claims directly to the claims administrator on the specified claim form.

### **(5) DENIAL OF CLAIMS**

If a claim is denied, employees have the right to follow the plan's formal claims appeal process explained in the *Employee Group Insurance Handbook*. If the employee requests assistance with an appeal, you can refer him/her to the Office of Group Insurance for help.

## 7. WHEN A PARTICIPANT LOSES ELIGIBILITY

### ***Losing Eligibility***

1. Why Participants May Lose Eligibility; and
2. When Coverage Ends.

When employees or their dependents lose eligibility for benefits, their coverage will end. After group coverage ends, participants may be able to continue certain coverages for a period of time. For more information, see Section III., 8., [When A Participant Continues Coverage After Loss of Eligibility](#).

#### **A. RULES FOR LOSS OF ELIGIBILITY**

##### **(1) WHY PARTICIPANTS MAY LOSE ELIGIBILITY**

- (a) Employees lose eligibility when they no longer meet the plans' definition of "eligible employee," as described in Section II., 1., A., [Eligible Employees](#). This may happen, for example, because they terminate employment for any reason, including retirement, or they may become temporarily ineligible due to a temporary reduction in hours.
- (b) For seasonal or part-time employees whose eligibility is determined on a month by month basis, "termination" means they have formally resigned and would have to be rehired by your agency to return to active status.
- (c) Family members lose eligibility when they no longer meet the plans' definition of "eligible dependents," as discussed in Section II., 1., B., [Eligible Dependents](#).

##### **(2) WHEN COVERAGE ENDS**

After eligibility ends, coverage may continue for a period of time depending on the date that eligibility was lost.

- (a) For employees who lose eligibility:
  - (i) From the first (1<sup>st</sup>) through the fourteenth (14<sup>th</sup>) of a month, coverage for that employee and enrolled family members continues through the end of that month; or
  - (ii) On or after the fifteenth (15<sup>th</sup>) of a month, coverage extends through the end of the following month.
- (b) For family members, coverage only continues through the end of the month in which he or she loses eligibility. When a family member no longer qualifies as an eligible dependent for health care benefits, the employee must submit a new medical plan enrollment form.

## **B. YOUR ROLE**

You will need to advise employees losing eligibility for benefits when their coverage will end. Please direct employees to our office for information regarding coverage continuation options available to them.

## **C. FREQUENTLY ASKED QUESTIONS**

Q. *If my agency paid premiums while an employee was ineligible, how do we get a refund for the overpayment?*

- A. If your agency is on the State Controller's Office payroll system, send our office a refund request. We will process the refund through IPOPS. If your agency is not on the SCO payroll system, you will need to take a credit on your next premium payment.

## 8. WHEN A PARTICIPANT CONTINUES COVERAGE AFTER LOSS OF ELIGIBILITY

### ***Continuing Coverage***

1. COBRA;
2. Life Insurance Conversion; and
3. Retiree Coverage.

After coverage ends, employees have options for continuing most coverages, on an individual basis, for a period of time. Eligible retirees may also purchase retiree group medical coverage for themselves and their dependents; there is no retiree group dental plan.

#### **A. RULES FOR CONTINUING COVERAGE**

##### **(1) COBRA (CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985)**

After eligibility for group coverage ends, individuals may be able to purchase continued medical and dental coverage for a period of time under COBRA. The Office of Group Insurance administers COBRA for the State's group and determines who is eligible to continue coverage.

Blue Cross and Delta Dental send each terminated individual a letter stating the date group coverage ended and directing him/her to our office to obtain COBRA enrollment information. Individuals have sixty (60) days after their group coverage ends to elect COBRA coverage. In general, COBRA coverage is available for up to:

- (a) Eighteen (18) months when eligibility for group coverage ends due to employee's termination or reduction of hours.
- (b) Thirty-six (36) months for family members who lose eligibility for group coverage due to other reasons, such as divorce or because a child is no longer an eligible dependent as defined by the plan.

Special provisions apply to participants who are receiving Social Security disability benefits.

##### **(2) LIFE INSURANCE CONVERSION POLICIES**

After group coverage ends, participants in Basic, Supplemental or State Police Optional Life plans may purchase life insurance conversion policies for up to the amount of coverage in force at the time of termination. Benefits, provisions and costs of a conversion policy may differ substantially from those available under the State's group plans. Disability coverage cannot be converted to an individual policy.

- (a) Evidence of insurability is not required for conversion policies purchased within thirty-one (31) days after group coverage ends.
- (b) Upon request, the Office of Group Insurance sends terminating employees a package of information explaining life insurance conversion options.

### **(3) RETIREE MEDICAL**

**NOTE:** The retiree medical benefits referred to in this section are presently available to eligible retirees. The plans, benefits, provisions or premium payment arrangements described here may change in respect to current or future retirees. If eligible, employees who retire from State employment can elect retiree medical coverage for themselves and their dependents. (Dental and vision benefits are not available.) The Office of Group Insurance:

- (a) Determines eligibility for retiree medical benefits;
- (b) Handles all retiree medical enrollment; and
- (c) Provides retiring employees with enrollment forms and instructions as well as premium rates.

Currently, eligible retirees may elect coverage under the Blue Cross of Idaho PPO or Traditional plan. Details of the plans, including provisions and benefits, are included in the *Retiree Group Insurance Handbook* provided to retirees when their initial enrollment form is received, and each plan renewal date thereafter. The *Retiree Handbook* is also available on the State website <http://adm.idaho.gov/insurance/retired.htm>.

To be eligible for medical coverage, retirees must:

- (a) Draw a monthly retirement benefit from a State-sponsored retirement system (PERSI, Department of Commerce and Labor, Judicial Branch or, for higher education employees, the ORP); and
- (b) Have either an unreduced Regular Retirement Allowance which equals or exceeds the single retiree premium rate in effect on the date of enrollment in the plan OR at least ten (10) years (20,800 hours) of credited State service.

To enroll, retiring employees must submit a Blue Cross of Idaho Retiree Medical Plan Enrollment Application form to the Office of Group Insurance.

### **(4) BASIC LIFE FOR RETIREES**

Eligible retirees from the following State agencies continue to be covered by Basic Life after they leave work:

- (a) Judges and justices;
- (b) Department of Commerce and Labor; and
- (c) Idaho State University, Boise State University, Lewis-Clark State College and Eastern Idaho Technical College.

The individual agencies make the eligibility regulations, apprise their employees if they are eligible for coverage and pay the premiums. Basic Life coverage for retirees can vary based on age and position.

## **B. YOUR ROLE**

### **(1) COBRA, LIFE INSURANCE CONVERSION POLICIES AND RETIREE MEDICAL**

Refer employees to the Office of Group Insurance for information and application forms.

### **(2) RETIREE BASIC LIFE**

If applicable to your agency, refer to your procedure manual for adjusting premiums and updating reporting forms.

## **C. FREQUENTLY ASKED QUESTIONS**

Q. *Are medical and dental coverages exactly the same for retirees as for active employees?*

A. We do not have a retiree group dental plan. The medical plans are the same with these exceptions:

- Each plan has the choice of a limited or unlimited prescription drug benefit;
- There are no vision care benefits; and
- There is no EAP. Inpatient and outpatient mental health/substance abuse benefits are included in each plan and claims are managed by Blue Cross of Idaho.

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