Guidelines & Important Notices

Enrollment Frequently Asked Questions

Why is open enrollment so important?	Open enrollment is your annual opportunity to enroll in or change your benefit elections. Once the enrollment period has ended, you may not add, change, or drop coverage unless you experience a qualifying event.
Who is eligible to enroll?	• Employees who work 30+ hours per week in a benefits-eligible position. • Employees' legally married spouse, and/or dependent(s) (dependents are generally children who are less than 26 years of age). See your Benefits Summary's definition of legally married spouse and/or dependent(s).
When do benefits begin?	• Eligible employees can receive benefits on date of hire. Life and Disability coverage begins first of the month following date hire (provided forms are properly submitted); • Employees hired after the plan year begins will select their coverage choices for the remainder of that plan year at the time of eligibility. All the necessary enrollment and change forms are available through the Human Resources department.
How do I make changes during the year?	Benefits that are paid for on a pre-tax basis through the cafeteria plan are subject to cafeteria plan IRS regulations, and elections cannot be revoked or changed during the plan year without a qualifying event. However, you must contact Human Resources to determine if your plan and circumstances allow such a change. If so, you must complete and return a change form to Human Resources, generally within 30 days.
What are possible qualifying events? All changes (other than adding a new child or new employee elections made within 30 days of the event) will be implemented prospectively, generally at the beginning of the month following the change notification.	• Marriage, divorce, or legal separation; • Change in number of dependents (e.g., Birth or adoption of a child); • Change in employment status of employee, spouse, or dependent that causes loss of eligibility; • Dependent ceases to satisfy eligibility requirements; • Change in residence that causes loss of eligibility; • Significant changes in company benefit plan(s), including cost change, significant coverage curtailment, and additional or significant improvement of company-offered benefits; • Change in coverage under another employer plan (including mandatory or optional change initiated by your spouse's employer or a change initiated by your spouse); • Loss of coverage from government plans/programs or educational institution; • COBRA qualifying event (termination/reduction of hours, employee death, divorce/legal separation, ceasing to be a dependent); • Judgments, Decrees, or Orders; • Medicare or Medicaid entitlement; • FMLA leave of absence; • Loss or gain of CHIP or Medicaid subsidy eligibility (60 Days).
How long do I have after a qualifying event to make changes?	You generally have 30 days after the event to notify Human Resources of a change in status. *Note that all changes (other than the addition of a new baby or new employee elections if made within 30 days of the event) will be implemented prospectively, generally at the beginning of the month following the change notification.*

Social Security Numbers

You must provide a valid Social Security Number for each person to be covered by any medical plan sponsored by your employer (yourself, your spouse, and all dependent children).

Medicare Part D

If you have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage. See Human Resources for more information.

HIPAA Privacy Notice

The Health Insurance Portability and Accountability Act (HIPAA) requires employers to adhere to strict privacy guidelines and establishes employees' rights with regard to their personal health information. If you have any questions regarding HIPAA, please speak with your Human Resources.

IRS Regulations

Failure to meet IRS deadlines will affect your insurance coverage! IRS regulations govern how and when an employee may make cafeteria plan elections and changes to those elections.

These rules require that employers enforce firm deadlines with respect to employee benefit enrollment and related cafeteria plan elections. This means that changes made after open enrollment ends cannot be accepted. Furthermore, if you experience a qualifying event allowing you to add, drop, or modify your coverage and related cafeteria plan election mid-year, HR must be timely notified of such event. The required enrollment generally must be completed within 30 days of such event, or you cannot make the change. Note that all changes (other than the addition of a new child or new employee elections if made within 30 days of the event) will be implemented prospectively, generally at the beginning of the month following the change notification.

In addition, please be aware that with the exception of the birth, adoption, or placement for adoption of a child, any plan or a plan election changes can only be implemented prospectively, meaning on the first paycheck or period of coverage following HR's receipt of the form or online change. Therefore, if you are making a change based on a qualifying event other than a new child, and you want changes implemented as of the date of the event, you must inform HR of the change in advance.

If you do not enroll on time, you will not receive coverage or be able to change your elections mid-year unless you have an IRS qualifying event.

Definitions & Glossary of Key Insurance Terms

Co-pay

Typically refers to a fixed dollar amount a member must pay for a particular service (such as a physician visit or ER visit).

Coinsurance

Typically refers to a member's share of covered costs after any deductible has been satisfied.

Deductible

Amount that must be paid by the member before an insurance carrier will pay a claim; benefits offered after deductible are indicated with AD.

Out-of-Pocket Maximum (OOPM)

The maximum amount members pay for covered network essential health benefit expenses during the benefit year, including co-pays, coinsurance, and deductibles.

Network (In Network)

Providers who have agreed to accept contracted rates from an insurance carrier.

Non-Network (Out-of-Network)

Any non-contracted providers. The services from these providers are subject to balance billing, meaning members can be billed for the difference between the insurance carrier's fee schedule and the billed charges.

Preferred Provider Organization (PPO)

This type of plan utilizes both network and non-network benefits.

Health Maintenance Organization (HMO)

An Health Maintenance Organization (HMO) plan covers in-network providers and services only; it does not cover any out of network services.