ELIGIBILTY

EMPLOYEES

All full-time employees working at least 30 hours per week are eligible for group insurance benefits. Part-time employees working at least 20 hours per week may also be eligible for group insurance benefits if specifically provided by the funding source.

FAMILY MEMBERS

If you are an eligible employee, you may enroll the following dependents:

- Your spouse or domestic partner
- Your children up to age 26, including stepchildren, legally adopted children, children for whom you are the legal guardian, foster children, or children for whom you are legally responsible to provide health coverage under a Qualified Medical Child Support Order (QMCSO). Due to Affordable Care Act, your medical, dental, and vision plans cover dependents to age 26. However, for other plans, age limits may apply.
- Children are eligible for coverage regardless of their student status or whether they live with you.
- Children of children may not be covered unless they meet the plan's dependent eligibility rules.
- Disabled children over age 26 if unmarried, incapable of self-support, dependent on you for primary support and the disability occurred before the age of 26. Requirements for such coverage and documentation of disability depend on the insurance carrier. Please contact Benefits Department if you believe this applies to your family.

IF YOU COVER DEPENDENT(S)

You are required to complete and sign a **Dependent Attestation form**. If this step is not completed within 30 days of enrollment, your dependent coverage will be terminated from the medical, dental and vision plans. To meet health plan contract obligations, Heluna Health performs periodic reviews to verify family documentation (copy of marriage certificate, copy of certified birth certificate, copy of court order indicating legal guardianship or adoption, etc.) to verify eligibility.

Tax Implications of Domestic Partner Coverage:

If you cover your eligible registered domestic partner (or his or her children) under your Heluna Health sponsored benefits but your dependent(s) is not qualified as a tax dependent under Internal Revenue Code Section 152, be aware that in general, you must pay federal and state income and payroll taxes on the value of any benefit he or she receives under the plan. This value is called "imputed income."

Check with an accountant or tax attorney to determine whether your domestic partner qualifies as a tax dependent under Section 152 or is eligible for tax-favored health coverage.

ENROLLMENT & CHANGES

things have changed...

Am I covered?

Examples of Qualifying Life Events:

Newly hired as full-time benefits-eligible

Change in work schedule for you or your spouse (part-time to full-time)

Change in employment for you, your spouse or dependent (i.e. your spouse loses their job and benefits)

Change in marital status

Change in dependents

Gaining other coverage through your spouse

Loss of other coverage for your dependent

Change in residence causing loss of coverage

Medicare or Medicaid entitlement for you, your spouse or dependent

Qualified Medical Child Support Order (OMCSO)

BENEFITS AT A GLANCE

The following health and welfare benefit options are available for eligible employees:

Medical	Basic Life/AD&D & Supplemental Life/AD&D
Dental	Carve Out & Voluntary Short-Term Disability
Vision	Core & Buy-Up Long-Term Disability
Health Savings Accounts (HSA)	Voluntary Accident/Injury
Flexible Spending Accounts (FSAs)	Voluntary Critical Illness Identity
Employee Assistance Plan (EAP)	Theft & Cyber Security
403(b) Retirement	Voluntary Pet Insurance

WHEN COVERAGE BEGINS (NEWLY HIRED EMPLOYEES)

If eligible, your group insurance benefits will be effective the first day of the month after you complete your 30-day waiting period. Once you have completed your new hire waiting period, you have up to 31 days to enroll for benefits. If you do not enroll within that time period, you will be auto enrolled in the standard medical, dental and vision plans offered at zero cost to benefit eligible employees only.

MAKING CHANGES TO YOUR BENEFITS

Each year you have an opportunity to make changes without restrictions to your benefits and covered dependents during Open Enrollment. You must enroll by the Open Enrollment deadline for your benefits to be effective August 1st. All your elections will be locked in for the duration of the plan year (August 1st – July 31st).

CHANGING COVERAGE AFTER ENROLLMENT

You may change some of your elections during the year if you have a qualifying change in your status, provided the coverage change is consistent with your status change. You must notify and submit the appropriate forms to the Benefits Department within 30 days of experiencing a qualifying life event or you must wait until the next open enrollment period to make a change.

Providers may leave or join medical and dental plan networks at any time. If your provider leaves your plan's network during the year, this does NOT qualify as a change in status. As a result, you cannot change your medical or dental coverage.