# Health Benefits

## *Effective January 1, 2019. Subject to change.*

**Purpose:**
To outline the guidelines related to medical, prescription, dental and vision benefits.

**Scope:**
All team members of Hackensack Meridian Health.

**Policy:**
Hackensack Meridian Health, HMH, provides a group Health Benefits Program to eligible team members.

Eligibility
Team members are eligible for the Health Benefits Program if they are in a regular full-time or regular part-time benefit-eligible position, (working 20 - 35.99 hours per week) with standard hours of 20 hours or more per week. Team members whose standard hours are less than 20 hours per week, have a status of Per Diem or Temporary are not eligible for the program. Coverage becomes available effective the first day of the month following date of employment. Benefit-eligible team members and their covered dependents may participate in single, employee/spouse, employee/child(ren), or family medical, prescription, dental, or vision coverage.

It is the team member's responsibility to notify HMH in the event of a change in enrollment status within 31 days of a qualifying life or enrollment event. Failure to do so will result in disciplinary action, up to and including termination of employment. (See Qualifying Life Events section below for more details)

HMH shares a portion of the cost of coverage for team members and their covered dependents for the medical/Rx and dental plans. Team members pay the full cost of any vision election.

Definition of Eligible Dependents
- Legal Spouse shall mean the person recognized as the covered team member's husband or wife under the laws of the state where the covered employee lives.
- Civil Union is a legally recognized union of a same-sex couple, with rights similar to those of marriage. Imputed income applies for civil union partners unless he/she meets definition of dependent as defined under Section 152 of the Internal Revenue Code (“IRC”)
- Defense of Marriage Act (DOMA) - The IRS ruled that the same-sex couples, legally married in jurisdictions that recognize same-sex marriage, will be treated as married for Federal tax purposes. The ruling's broad impact extends to matters such as:
    - Spousal protections and rollover rights in retirement plans Taxation of group health benefits
    - COBRA health coverage elections
    - Special enrollment rights under the Health Insurance Portability and Accountability Act Leave rights under the Family and Medical Leave Act
- Grandfathered Domestic Partners, of the same or opposite sex, both of whom are at least 18 years of age, must share a close personal relationship, and have shared the same residence for no less than six (6) months. This is a closed group who must still meet certain eligibility criteria in order to maintain eligibility. The cost of the benefit is subject to imputed income unless DP is considered a dependent under IRC Section 152.
- Children who have not attained age 26 will be eligible for coverage under the medical plan regardless of their eligibility for other insurance coverage, student status, tax dependency or marital status.

- Children who have not attained age 19, or are full-time college students (12 credits for undergrad, 9 credits for graduate) age 19-23, will be eligible for coverage under the dental and vision plans.
- In order to maintain eligibility as dependents under the dental or vision plans, student documentation showing eligibility must be submitted in the Spring and Fall upon request. Documentation must include a bursar's receipt or transcript for the semester in question.
- The term "child" or "children" shall include:
  - natural children
  - adopted children
  - Children placed with a covered employee in anticipation of adoption. The term "placed" means the assumption and retention by such team member of a legal obligation for total or partial support of the child in anticipation of adoption of the child. Coverage of these pre-adoptive children is in accordance with the requirements of the federal Omnibus Budget Reconciliation Act of 1993. The child must otherwise be available for adoption and the legal process must have commenced.
  - Step-children
- If a covered team member is the legal guardian of an unmarried child or children, these children may be enrolled in the health plan as covered dependents.
- Any child who is an alternate recipient under a qualified medical child support order shall be considered as having a right to dependent coverage under the health plan. Coverage of these children is in accordance with the requirements of the federal Omnibus Budget Reconciliation Act of 1993.
- Unmarried dependent children age 19 or over, unable to earn a living due to mental or physical disability and who depend on the covered employee for support.
- Foster children are ineligible to participate.

Enrollment Documentation

If you enroll or make changes in our health benefits plans, Human Resources may require proof of eligibility upon request through an independent auditing firm, to support proof of eligibility. The following documents may be requested by the auditing firm to enroll or maintain coverage for eligible dependents as defined above:

1. Legal Spouse - certified marriage certificate from the municipality in which you were married
2. Dependent Children - certified birth certificate, adoption papers and/or legal documentation from the court
3. Social Security Numbers of all dependents.
4. Proof of total disability for covered dependent who is disabled
5. Proof of student status - 12 credits for undergrad, 9 credits for graduate for dependents age 19 and over for dental and vision plans
6. Tax Records
7. Civil Union – Certificate of Civil Union, or certified Marriage Certificate

To maintain eligibility for a grandfathered domestic partner status, all documentation must prove to have been in effect for a minimum of six (6) months prior to the health insurance coverage effective date. All three (3) documents provided as proof must be selected from the separate groupings below - (one selection per group).

Three of the following documents evidencing the commitment of the relationship are required.

- Joint mortgage or lease
- Designation of the domestic partner as primary beneficiary in the team member's will, life insurance, or retirement contract.
- Durable power of attorney for health care or financial management.
- Joint ownership of a motor vehicle, a joint checking account or a joint credit card

- A relation or cohabitation contract which obligates each of the parties to provide support for the other party
- State of New Jersey Certificate of Domestic Partnership

To maintain eligibility in the medical plan for a grandfathered Civil Union partner status, a Certificate of Civil Union or marriage license must be submitted as proof evidencing the commitment of the relationship.
Please note: Child(ren) of grandfathered domestic partners or grandfathered Civil Union, are eligible dependents covered under the plans discussed in this policy. Tax treatment of the team member's contribution will be dependent upon whether the dependent is considered your qualified tax dependent under IRC Section 152. You may be asked to produce proof of tax dependency at least annually at the end of the plan year. If your dependent is not a qualified tax dependent, the value of the HMH provided medical coverage for the dependent will be treated as taxable income to you, a concept known as "imputed income".

Medicare Eligibility

Team members who are eligible for Medicare, actively working with HMH and age 65 or over, and/or their spouse is eligible for Medicare and age 65 or over, both the team member and the spouse must be aware that their benefits through HMH are their primary health benefits.
If team members are eligible for Medicare, and are not actively employed at age 65 or over, the benefits will be reduced to the extent that benefits for the services received are available under Medicare.
If team members are under 65 and disabled, the HMH benefits will be primary. Medicare will supplement these benefits.

Enrollment/Changes

At the time of hire/eligibility, the qualifying team member must access the Team Member Benefits Portal through MyWay - PeopleSoft. If the team member enrolls dependents, their coverage will become effective on the first day of the month following date of employment. All team members are still required to provide proof of eligibility upon request.
Team members going from benefit-ineligible to benefit-eligible will immediately be able to enroll in the appropriate benefits on the date of the job change if they have already satisfied the initial waiting period.

Qualifying Life Events

Team members who do not enroll themselves and/or their eligible dependents at the time of eligibility will not be eligible for coverage until a subsequent open enrollment period or a qualifying life status event as determined by the IRS occurs. Qualifying life status events include the following:

- Changes in the team member's legal marital status (marriage, death of spouse, divorce, legal separation (under state law), and annulment).
- Change in the number of team member's dependents (birth, death, adoption, placement for adoption).
- Change in the employment status of the team member, spouse, or dependent (termination/ commencement of employment, beginning or end of an unpaid leave of absence, change in work site. Also included is change in employment status that affects plan eligibility, such as changing from hourly to salaried status).
- Change in dependent status (dependent reaching contract termination age, marriage of the child). Change in residence of the team member, spouse or dependent. (When team member/dependent moves out of a plan's service area, i.e. an HMO.)
- The annual Cafeteria Plan open enrollment for a spouse's plan.

Human Resources must be notified within 31 days of a qualifying event. If you do not notify the Plan within 31 days of the event and your ineligible dependents continue to utilize services under the Plan, this will be considered fraud and will result in the termination of the team member's and the dependents' coverage.

Enrollment into the benefits plan is not automatic; the team member must access the Team Member Benefits Portal through MyWay - Peoplesoft. Team members have 31 days to make a change after a qualifying life event.

Team members will be mailed identification cards for their medical, dental, vision and prescription coverage. These cards should be carried at all times and presented to the hospital or physician whenever employees or eligible dependent(s) receive medical/prescription or dental services.

Online Resources

The benefit plan carriers' offer 24/7 online access to claims statements, Explanation of Benefits (EOB), provider selection information, and other member tools. You can visit www.teamHMH.com for more information.

**COVERAGE**

The health plans offered are described in detail in the various Summary Plan Descriptions (SPDs) available on the Team Member Benefits Portal. Team members are encouraged to review the SPDs to become familiar with their coverage tiers, deductibles, and co-insurance charges. After reviewing the SPDs, if employees still have questions regarding their coverage, they may contact the plan carriers through the member services contacts found on www.teamHMH.com.

The team member's portion of the health, dental and vision premiums are deducted bi-weekly, from their paychecks.

**Prescription Plan**

HMH offers onsite pharmacies created so team members can conveniently fill prescriptions for themselves and their families. In House pharmacies accept OptumRX cards and other third-party insurance plans. In-house pharmacies also provide team members with the opportunity to obtain 90-day supplies of maintenance medications. The percentages of costs and maximums for the 90-day supply of maintenance medications are more favorable out-of-pocket through In-House Pharmacy vs Mail-order for 90-day supply.

Specifics regarding coverage tiers, deductibles, and co-insurance charges under the prescription plan are available at the Team Member Benefits Portal.

Team members must fill their maintenance medications through any in-house pharmacies or through mail order with OptumRx.

If a generic is available and the pharmacy fills it with the brand name drug for any reason, the team member will pay the difference between the generic and the brand, as well as the generic co-pay.

**Dental Plan**

HMH offers a comprehensive dental plan administered by Horizon Blue Cross Blue Shield of NJ. Eligibility for the dental plan is on the 1st day of the month following date of employment. Dependent children are covered to age 19, 23 if full-time college students. More specifics regarding dental coverage are available at the Team Member Benefits Portal.

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**Vision Plan**
A vision plan through Horizon Blue Cross Blue Shield of NJ is offered to benefit eligible team members.
NOTE: Proof of full-time student status for the fall and spring semesters are required to obtain or maintain coverage. Failure to submit proof of student status will result in dis-enrollment of the dependent child(ren) from the dental and vision plans.

**TERMINATION OF HEALTH COVERAGE**

When a team member terminates or becomes ineligible due to a reduction of hours, coverage ceases on the day in which the change occurs. Coverage ceases for dependent children the end of the month in which they reach the limiting age of 26 for medical, the actual day your dependent reach age 19, or 23 if full-time college student, for dental or vision coverage. Excluded from age limits are children physically or mentally disabled and incapable of earning their own living.

Should HMH terminate the benefits plan, coverage for all team members will end on that date.

**COBRA**
With the passage of the Consolidated Omnibus Reconciliation Act of 1985, team members are required to offer former team members, retirees, spouses and dependent children the right to continue health coverage.
HMH is mandated by law to notify the Plan Administrator (Horizon BCBS of NJ) of a qualifying event within 30 days of a team member's termination, reduction in hours, death or entitlement to Medicare. Qualified beneficiary must notify HMH within 60 days of divorce, legal separation or child ceasing coverage.
Under COBRA, team members and their eligible dependents may elect to continue group health coverage if their coverage would have otherwise ended as a result of the following events:

- Voluntary or involuntary termination Reduction in the number of hours Medicare entitlement
- Divorce or legal separation
- Death of coverage employee
- Loss of dependent child status
- Social Security disability

If coverage is to continue, the team member and/or eligible dependents will be responsible for paying 102% of the premium for that coverage. Coverage will be identical to the health care coverage for the group and would be extended as follows:

| Qualifying Events | Beneficiary | Coverage |
| --- | --- | --- |
| Termination | Team Member | 18 Months |
| Reduced hours | Spouse/Dependent Child | 18 Months |
| Team Member entitled to Medicare, Divorce/Legal Separation or death of Team Member | Spouse/Dependent Child | 36 Months |

| Loss of Dependent Child Status | Dependent Child | 36 Months |
| --- | --- | --- |
| Social Security Disability | Team Member/Spouse | 29 Months |

HMH expressly reserves the right, in its sole and absolute discretion, to change, modify or delete the provisions of this policy in whole or in part, at any time or for any reason without notice. The employment terms set out in this policy work in conjunction with, and do not replace, amend, or supplement any terms or conditions of employment stated in any applicable collective bargaining agreement. Wherever employment terms in this policy differ from the terms expressed in the applicable collective bargaining agreement, team members should refer to the specific terms of the collective bargaining agreement, which will control.

Any questions regarding this policy and procedure may be referred to Human Resources.