



Teacher's First Choice Administrative Manual 2011-2012

Employer Benefits Guide

www.mprhealthplan.org

STRENGTH IN MEMBERS | QUALITY IN SERVICE

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INTRODUCTION

The Administrative Manual is designed to provide you with general guidelines regarding our benefit plans and the enrollment process of new employees, changes to existing coverage and termination of coverage. Whenever possible, contact names and numbers are provided for assistance.

- **Midwest Public Risk (“MPR”) provides** a variety of medical plans throughout the states of Missouri and Kansas. The MPR pool of entities like yours sponsors a partially self-funded program, and the contributions we receive are used to pay the claims and administrative costs of the benefits. Our primary objectives are to provide excellence in benefit plans, competitive rates and service to our members. Since we are self-funded, we approach every aspect carefully to safeguard your investment in MPR’s funds.

Oftentimes, we hear from a member that their provider has not heard of Midwest Public Risk. This may happen because providers are used to working with fully-insured health carriers and not with self-funded entities. When a provider is unfamiliar with MPR, you may want to tell them it is a self-funded plan and advise which network you are utilizing (see card for networks). As a non-profit public entity like yours, our staff is accountable to the MPR Board of Directors who is investing and using your contributions wisely and appropriately. The Board of Directors is made up of representatives from our entities who participate in the plans.

- **We offer** both Preferred Provider Organization (PPO) and Health Maintenance Organization (HMO) plans. The PPO plans have available networks for all locations in the 2-state area, and we provide a national wrap network for in-network PPO access outside Missouri and Kansas. The Humana HMO plan can only be offered in the Kansas City, Missouri metropolitan area and several surrounding counties in Kansas. Your entity may choose to offer one or more plans, if available in your geographical location.

All of our medical plans include New Directions Employee Assistance Program (EAP) at no extra cost.

- **We partner with** third party administrators to provide you with competitive benefit plans and responsive service providers for benefits and claims processing.

If your entity does not participate in all of our programs or plans, some of the detail in this guide may not be applicable to you.

We offer this manual as a guide and as with most things, it is subject to change. The Benefits staff at MPR is happy to support your needs and assist you with training for administrative procedures. Please feel free to contact us at any time.

EMPLOYER CONTACT INFORMATION

Contact	PPO Plans	Humana HMO	Delta Dental
Eligibility Billings COBRA Admin.	Angie Bailey (BMI) Tel: 877-627-2481 Fax: 620-793-1199 abailey@bmikansas.com		2015 16 th St. PO Box 1090 Great Bend, KS 67530
Send all payments to (Lockbox)	MPR of Missouri PO Box 410072 Kansas City, MO 64141		MPR of Kansas PO Box 414963 Kansas City, MO 64141
Customer Service Claims	877-627-2481 www.mprhealthplan.org	800-448-6262 www.humana.com	800-392-1167 (MO) www.deltadentalmo.com 800-234-3375 (KS) www.deltadentalks.com
Employee Packets	Bridgette McDaniel bridgette@mprisk.org Tel: 816-292-7524 Fax: 816-292-7599	Janice Nadolski jnadolski@humana.com Tel: 913-217-3340 Fax: 678-808-3717	Bridgette McDaniel bridgette@mprisk.org Tel: 816-292-7524 Fax: 816-292-7599
ID Cards	877-627-2481 (BMI)	800-448-6262 (Humana)	800-392-1167 (Delta Dental MO) 800-234-3375 (Delta Dental KS)
Escalated Issues* <small>Any claims issue that has not been resolved by calling Customer Service.</small>	Michelle Aiken* maiken@bmikansas.com Tel: 913-312-5672 Fax: 913-312-5650	Emily Lehn* elehn@humana.com Tel: 513-826-8170 Fax: 513-898-7526	Stacy Buckallew* stacy.buckallew@ddpmo.org Tel: 816-931-5114 Fax: 816-931-5588 Natalie Daney* ndaney@deltadentalks.com Tel: 913-327-3724 Fax: 913-381-8312
MPR Staff	816-292-7520 www.mprhealthplan.org Kelly Kilgore, Joan Wilson and Bridgette McDaniel kelly@mprisk.org joan@mprisk.org bridgette@mprisk.org		
MedTrak* PPO Pharmacy Services	Judy M. Bruegging jbruegging@medtrakservices.com 913-322-8463 or 800-894-0794		
Vision Service Plan	800-877-7195 www.vsp.com		
New Directions EAP	913-982-8398 or 1-800-624-5544 www.ndbh.com		
PPO Network/ Provider Info	913-685-6300 or 800-544-3014 www.phpkc.com		

***The above names and numbers are for benefit administrators ONLY and should not be given to employees.**

ELIGIBILITY GUIDELINES

Coverage for an employee and any covered dependents does not begin until they have satisfied the Eligibility Waiting Period established by your entity. However, it is helpful to begin the enrollment process within 30 days prior to their Effective Date of coverage so they will be entered into the system and Identification Cards issued on a timely basis.

Employees, spouses and dependents must all meet the Eligibility Definitions described in the Plan Documents and must fall within the Underwriting Guidelines established by Midwest Public Risk. *As Administrator, it is your responsibility to obtain and retain the required documentation and proof they meet these eligibility definitions prior to enrollment in our benefit plans.*

A child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependence or residency status with the Employee, or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month.

Complete eligibility detail is included at the back of this guide under “**Dependent Eligibility Guidelines**” and “**Documentation Requirements for Dependent Eligibility**” and can also be found at our website www.mprhealthplan.org, Forms and Resources, Dependent Eligibility. Anytime a new dependent or spouse is added to a plan, proof of eligibility documentation should be maintained by the entity.

In most circumstances, you will retain all the documentation in your files except for proof of disabled dependent over age 26. *Send copies of physician's documentation to BMI/MPR at PO Box 1090, Great Bend, KS 67530 or fax to 620-793-1199.*

Upon occasion, we may choose to conduct random audits of eligibility.

SPECIAL ENROLLMENT ELIGIBILITY & OTHER LIFE EVENTS

Employees and dependents are eligible for a special enrollment period upon loss of medical coverage or if a person becomes a dependent through marriage, birth, adoption, placement for adoption or legal guardianship. The employee must request enrollment for the affected employee or dependent no later than 31 days after the loss of other coverage or the event. A special enrollee is not considered a late enrollee.

Adding Newborns – the child **must be added within 31 days** of birth. Coverage will be effective the date of the birth, assuming the form is received within 31 days of birth. Ask for a completed enrollment form showing the addition. To add the newborn within 31 days, obtain a copy of the hospital certificate of birth (to be followed up with the actual state-issued birth certificate when available).

Children adopted, placed for adoption, or for whom legal guardianship has been granted - may also be added within 31 days of the event. In order for grandchildren to qualify under the MPR plans, the employee *must have legal guardianship* of the minor granted through the courts.

Marriage - New Spouse - must be added within 31 days of the event. Coverage will be effective the 1st of the month following the marriage date. Documentation, usually a current official marriage certificate, is required and should be maintained in the employer file.

Common Law Spouse is based on the state in which a participant lives and is only allowed in Kansas. In addition to the enrollment application, a Common Law Affidavit is required before the Common Law spouse is covered. The affidavit can be found at our website www.mprhealthplan.org under Forms and Resources, Member Eligibility. The completed affidavit should be faxed to MPR at 620-793-1199 for approval.

QMCSO (Qualified Medical Child Support Order) - legal documentation must be submitted to BMI/MPR. If the employee is not enrolled for coverage at the time the order is received, they must enroll at that time in order for the child to be covered. If a dependent covered by QMCSO lives outside of the HMO service area, a PPO plan will be the only option for coverage.

Loss of Coverage - provided the person was covered under a group health plan and stated in writing that was the reason for declining enrollment, coverage will begin the 1st of the month following the loss of coverage date. Request must be submitted within 31 days of coverage loss. For full details, review the Special Enrollment section of the medical plan document.

Loss of eligibility for Medicaid or a State Child Health Insurance Program (SCHIP) - provided a request for enrollment is made within 60 days after the loss of eligibility.

Determined to be eligible for premium assistance by Medicaid or a SCHIP - including under any waiver or demonstration project conducted under or in relation to such a program, provided a request for enrollment is made within 60 days of the determination of assistance.

Leave of Absence or Layoff - coverage may continue for up to 90 days after the date in which the person last worked as an active employee (depending on the member entity's personnel policy) and runs concurrent with any FMLA continuation period.

FMLA - follow standard law for FMLA.

Disability - coverage can be continued following the latest of these dates: (1) for up to 90 days that next follows the date in which the employee last worked as an active employee, if allowed by the member entity's policy, or (2) the end of the period in which the person was entitled to regular pay as an active employee or through personal paid time off, sick leave, vacation time or other defined salary compensation of the Member entity.

ENROLLMENT – NEW HIRES & CHANGES TO EXISTING MEMBERS

Remember that changes to employee coverage can be done only during Open Enrollment for a July 1st effective date, except in the event there is a life status change in marital status, birth, adoption, legal custody of a dependent child, or in some cases, loss of employment/other coverage. Social Security Numbers are required for all participants and their dependents. These special enrollment opportunities are outlined in the previous section and the summary plan description.

Changes between medical plans can only be done during Open Enrollment.

If your group has a section 125 Premium Only Plan or FSA, then additional limitations on changes and terminations may be applicable. Consult your section 125 administrator for details.

BMI, our third party administrator, is responsible for maintenance of all eligibility. Questions regarding the status of eligibility should be addressed to our MPR team at BMI at 877-627-2481. This includes COBRA and Retirees.

Customized Enrollment Form – The MPR Enrollment/Change Form can be used to enroll all lines of coverage --- Medical PPO, HMO, Vision and Dental. New employees should complete the customized Enrollment/Change Form within 31 days after becoming eligible, and provide proof of dependent eligibility for any covered dependents. The Administrator should then check to verify the correct hire date, effective date and social security numbers are on the form and that plan selections are made. For HMO, you will want to make sure the employee has indicated a Primary Care Physician's (PCP) name and PCP number for themselves as well as for any family members.

This same Enrollment/Change Form is used to make changes to existing coverage as well, including Terminations. The applicable action to be taken should be indicated and reason/date of event completed.

Enrollment for medical PPO or HMO automatically enrolls the covered person(s) in their prescription drug program and the New Directions EAP (Employee Assistance Program).

As Administrator, you are encouraged to enroll and enter changes, additions and terminations online at www.mprhealthplan.org under the Participant Center / Employer Login. A tutorial "Online Enrollment Guide" can be found on the website under Forms & Resources, Download Forms and Documents. Although you will be entering the information online, for changes in coverage, such as deletions, terminations or additions, we recommend that you always retain the employee's signed and dated form for your files.

If you enter information on-line, you do not need to send the forms to BMI (Exception: Disabled Dependent verification paperwork does need to be faxed or mailed to BMI.)

Changes can also be mailed or faxed to BMI, PO Box 1090, Great Bend, KS 67530, fax 620-793-1199.

If you do not have Employer Login access to BMI's Participant Center, you can request an Employer Access Agreement from Michelle Aiken, 913-312-5672 or maiken@bmikansas.com.

CENTRALIZED ELIGIBILITY

BMI, our third party administrator located in Great Bend, Kansas, maintains all employee and dependent eligibility. Any questions regarding a person's eligibility should be addressed to BMI at 877-627-2481.

BMI electronically sends membership enrollments and changes to MedTrak for the PPO prescription plans, Vision Service Plan for vision, Humana for the HMO medical and prescription plan and Delta Dental for the dental benefits. Most of these data feeds occur weekly. In the event there is an urgent need to manually update a person's eligibility for services, please contact BMI for assistance at 877-627-2481. This might occur when a person is late in enrolling and needs to use the services right away, especially for prescriptions.

Identification cards and welcome packets are mailed to the employee's home within 10 business days. BMI will mail cards for the PPO plans and cards are triggered twice per week (or upon special request); Humana and Delta will mail cards for the HMO and dental plans respectively. There is no ID card for VSP but you can request a supply of VSP benefit reminder wallet cards by calling MPR or the member can print one online at www.vsp.com.

CENTRALIZED BILLING

BMI handles all billing statements for PPO, HMO, Vision and Dental plans. These consolidated Statements typically go out by the 25th of the preceding month. All changes must be entered on-line or received at BMI by the 15th of the month in order to be processed for the subsequent billing.

As employer representative, you can access your entity billings online at www.mprhealthplan.org, Participant Center, Employer Login. Once you are signed in, look for Billing. This allows you to look at past and current statements, view detail as a pdf file or download to Excel.

We ask that you please PAY AS BILLED. Adjustments, including terminations, status changes, additions, address changes, etc. should be communicated under separate cover and not included with your premium payment. Enrollments, terminations, status changes and personal information changes can be managed online through the employer log-in at www.mprhealthplan.org, or through fax or U.S. mail submission. BMI has available a manual Adjustment Report if you prefer manual submission.

All billing questions and/or discrepancies should be directed to BMI's Billing Department at 877-627-2481. Please send your premium remittance to our lockbox:

MPR of Missouri
PO Box 410072
Kansas City, MO 64141

MPR of Kansas
PO Box 414963
Kansas City, MO 64141

Direct billing to COBRA and Retirees is handled by BMI. Please see the COBRA and Retiree Sections of this manual for additional details regarding this process.

CLAIMS, BENEFIT QUESTIONS & CUSTOMER SERVICE

Our service partners have trained claims examiners to ensure members receive assistance with claims and benefit questions. Members or their providers may call the customer/member services phone number on their identification cards for interpretation of their detailed benefits, how to use their benefits, for help in locating providers, and with claims.

Although BMI processes claims and benefits for the PPO Plans, the HMO claims and benefits are processed by Humana. Likewise, Delta processes dental, and Vision Service Plan (VSP) handles vision claims and questions. For PPO prescription drugs, MedTrak Services provides the professional advice and benefit plan details to members and pharmacies.

Claims submitted due to accidents or injuries will trigger an accident inquiry form to be mailed to the member and a copy to the provider. The claim is pended until the accident form is completed and returned. If BMI or Humana does not receive the completed form back from the member within 20 days, all related claims will be denied. Denied claims will be reviewed for reprocessing if the form is received at a later date.

For active employees, MPR health plans are considered their primary coverage. For dependent spouses and children that also have other health coverage, different rules apply to determine which plan is primary and which plan is secondary. We coordinate claims payments with any other primary coverage. Inquiries to determine if other coverage circumstances have changed and if they have obtained other primary coverage may occur at any time and especially each new plan year for the initial claim on a dependent spouse or child. It is very important that other insurance inquiries be returned in a timely manner, as claims will be denied if primary and secondary assignment cannot be determined. Claims will be reconsidered for payment once the information is received.

Please refer any employee questions regarding claims or benefits to the appropriate service partner. Much information, including access to claim details, is available to employees on-line at the partner websites.

WEBSITE RESOURCES

Our website www.mprhealthplan.org provides most of the information needed to do business with Midwest Public Risk. It contains many helpful resources including Forms, Plan Documents, links to partner websites, Wellness Information and general MPR information.

Encourage employees and dependents to register on-line with the service partners so they can obtain detailed claim and benefit information, access provider listings and maintain their individualized health data. Since these websites are available 24/7, members can access and print information from any computer. Each of the websites listed below have easy registration instructions. Any problems with registering should be referred to the Customer/Member Services phone number on their ID cards.

PPO Plans - www.mprhealthplan.org "Participant Center"

PPO Prescription Drug Plans - www.medtrakservices.com

PPO Provider Listings - www.phpkc.com

HMO Plan - www.humana.com and www.myhumana.com

Delta Dental - www.deltadentalmo.com (Missouri) or www.deltadentalks.com (Kansas)

Vision Service Plan - www.vsp.com

New Directions Employee Assistance Program - www.ndbh.com

CERTIFICATE OF CREDITABLE COVERAGE (COC)

BMI is the COBRA administrator and as such mails all required certificates of creditable coverage (COCs). Please refer all requests for the HIPAA COCs to BMI. Certificates are mailed direct to the member and as appropriate for the circumstance:

- Upon termination of coverage as an active employee and/or dependent
- Upon termination of COBRA coverage
- Upon termination of Retiree coverage
- Upon request

COBRA

BMI administers COBRA for our MPR-sponsored plans. If you have other COBRA-eligible plans **not** sponsored by MPR, you will need to send your own COBRA notices for those plans.

When a new employee enrolls in any MPR plan, an Initial Notice of COBRA Rights and Responsibilities will be sent to the employee and spouse/dependents by BMI.

After a termination notice is received, the eligibility department will terminate coverage on the member and/or family member(s) and generate the appropriate COBRA notification. In order to comply with COBRA regulations, notices must be sent within 14 days of the loss of coverage or receipt of notice of termination, whichever is later. **Please ensure you are processing terminations on a timely basis.**

If the member is eligible for COBRA, a COBRA Election Notice is prepared which advises the recipient of their rights and responsibilities. The upper portion of the Election form is pre-populated and the bottom portion is for the member to complete and return when electing COBRA. In order to elect COBRA, the member must return the completed election within 60 days of the mailed date. The member then has an additional 45 days to pay all premiums due.

BMI has access to all PPO, HMO, Vision and Dental eligibility including new employees, terminations, and other qualifying changes. BMI then sends out required notices.

After receipt of the election form, BMI's eligibility department will invoice the COBRA participant for the premium each month. The member has a choice of payment methods: direct pay by check or preauthorized bank withdrawal. ACH forms can be found on our website www.mprhealthplan.org under the "COBRA & Retiree" section. Upon termination or expiration of COBRA, the appropriate notifications are mailed to the member. As the COBRA administrator, BMI will conduct billing, premium collection and determine length of COBRA availability on the member.

When COBRA expires, the participants may be entitled to medical Conversion Coverage (available through Celtic Life Insurance Company). The participant will be notified of their options by BMI. Further details regarding this option are contained in the plan document or they should contact BMI for information.

RETIREES

Eligibility Requirements for Retiree Coverage:

MPR will follow the state statute pertaining to retirees to determine eligibility.

For Missouri, eligible retirees can remain covered until they choose to terminate provided timely payments continue. Nonpayment of premium will result in termination of coverage. Once coverage is terminated, it is not eligible for reinstatement.

The participating Retiree pays the same premium rate as active employees.

The retiring employee and any dependents will also be notified of COBRA rights at the time of separation.

Plans Available to Retirees

Upon entitlement to Eligible Retiree coverage, the retiree may elect to move from one plan to another plan. At open enrollment, the eligible Retiree will have the same rights as any active employee including the right to choose between MPR health plans offered by their entity.

If a retiree does not elect medical or dental at time of their retirement or within the next 12 months, they are not eligible to participate in the future.

How to Enroll a Retiree

The MPR entity is responsible for providing the retiree with the appropriate information and forms for retiree coverage. Use the same form as for an active employee but indicate “retiree”. As the member entity, you have the responsibility of determining the member’s initial eligibility for retiree coverage, and notifying BMI of their termination due to retirement.

Thereafter, as the Retiree administrator, BMI will provide billing, premium collection and determine length of coverage availability for the member.

Retirees have a choice of payment methods: direct pay by check or preauthorized bank withdrawal, ACH Forms can be found on our website www.mprhealthplan.org under “COBRA & Retirees”.

Medicare Options for Medicare Eligible Retirees

MPR has partnered with Humana to offer a Humana Group Medicare Employer PPO plan to any Retirees who are Medicare eligible. This Group Medicare plan provides a wide range of medical services including a prescription drug plan. If you are familiar with Medicare plans, it is technically termed Medicare Part C, or oftentimes is referred to as a “Medicare Advantage” plan. The cost for this PPO plan is very low as compared to other Medicare options and supplements. The MPR Medicare PPO plan has no annual deductible, primary care office visit copay of \$15, specialist copay of \$35 and various other copays for emergency, and inpatient and outpatient hospital care. To participate, the person must also enroll in Medicare Part A and Part B.

Contact Humana for Group Medicare plan information. Humana representatives are available to explain the plan in more detail. They can be reached at Humana Group Medicare Customer Care at 1-800-824-8242 (TTY: 711), Monday - Friday 7:30 a.m. to 4:00 p.m. Central. Please instruct them to mention “MPR” when they call.

We urge you to share this information with any of your employees who are soon to be retired, or are currently retired, and are also Medicare eligible. To obtain a packet or a supply of packets, please contact an MPR employee benefits staff member by calling 816-292-7520 or email the retiree’s mailing address to joan@mprisk.org.

PPO - MEDICAL AND PRESCRIPTION PLANS

PPO Plans:

All claims should be mailed to the address on the back of the identification card or submitted electronically by the provider. Remember that it may take up to 60 days from the actual date of service until the claim is processed and paid. An Explanation of Benefits (EOB) will be mailed to the employee and provider after each claim is processed. Deductible and out of pocket maximum are tracked on the EOBs. We encourage all members to use our website www.mprhealthplan.org to view up-to-date information about their benefits, claim history and to obtain copies of an EOB. Providers can also call BMI directly.

Our PPO plans provide both in and out of network benefits and include the following components:

- PPO Networks managed by Preferred Health Professionals (PHP)
- Pharmacy Benefits managed by MedTrak Services Inc.
- Claims adjudication, Benefit Questions, Member Billing and Eligibility by Benefit Management, Inc. (BMI)
- New Directions Employee Assistance Plan

PPO Networks

Some of the most significant drivers of our cost increases are large claims and those claims for which members seek care outside of our established networks. Because we lease PPO networks from PHP, we receive excellent in-network discounts on services. This helps both the member and MPR's overall plan costs. Our networks are:

- Freedom Network Select - services 48 county area in & around Kansas City metro area including 5-county service area in KS
- HPK (Health Partners of KS) - services outside Freedom Network Select in Kansas
- HealthLink or HealthLink OA III - services outside Freedom Network Select in Missouri
- PHCS - national network for services outside of MO & KS
- Midland's Choice (select groups only) - services in NE & IA

The applicable PPO logos appear on the member's ID cards. Provider lookup can be found at www.phpkc.com. Employees who do not have access to the web should call PHP directly at 913-685-6300 or 800-544-3014.

PPO Pharmacy Benefits

MedTrak Services manages the prescription drug benefits for the PPO plans. MedTrak is located in Overland Park, KS. Their service hours are 8:00 a.m. – 9:00 p.m. Monday-Friday as well as Saturday from 9:00 a.m. – 6:00 p.m. Prescription questions can be directed to MedTrak customer service at 800-771-4648 during regular service hours.

In addition to the 34-day supply at a participating MedTrak retail pharmacy, our members can also obtain up to a 90-day supply at a participating MedTrak-90 pharmacy.

Our Walgreen's Mail order program for 90-day maintenance prescriptions is available through MedTrak. Mail order forms, claims detail and tracking are available on MedTrak's website www.medtrakservices.com.

While on MedTrak's website, a registered member can:

- Access MedTrak's mail order pharmacy and place their order online
- Locate a pharmacy, including address, phone number and directions
- Download claim forms and drug formulary list
- Price prescription drugs, price lower cost alternative drugs and options
- Review prescription claims history
- Access consumer information and sponsored programs

PPO Claims & Benefits

We have a dedicated customer service team at BMI. When a member or dependent calls 1-877-627-2481, they will have the option for "Benefit Information or Claims" or "Enrollment or Premium Billing". The MPR Team at BMI answers most questions upon the first call and is happy to assist with benefits, claims and provider questions, including network questions.

"Enrollment or Premium Billing" would be the option to use for questions related to who is covered on a plan, which benefit plan they have, ID Cards for the PPO plans or billing/payment for COBRA and Retirees.

BMI records 100% of phone calls. This allows us to review the calls and information given if needed.

HMO - MEDICAL AND PRESCRIPTION PLAN

Midwest Public Risk partners with Humana for access to their HMO network of providers and for administration of benefits and claims. The Humana HMO Premier network offers approximately 1,984 primary care physicians, 2,924 specialists and 36 hospitals. It can only be offered in the Kansas City, Missouri metropolitan area and Douglas, Johnson, Leavenworth, Miami and Wyandotte counties in Kansas.

As with other Health Maintenance Organizations (HMO), members are required to access care from Humana HMO Premier providers or they do not have any benefits. **There is no out of network benefit except for treatment of serious, life-or-limb threatening situations.** If it is considered life-threatening, then members should seek care from the nearest provider.

Each member designates their Primary Care Physician (PCP) and each covered dependent in the family can select a different PCP. The PCP number is required for enrollment and can be obtained online at www.humana.com, Provider Search, Details, Offices and Affiliations or by calling Humana Customer Service. Physicians in Family Practice, General Practice, Internal Medicine or Pediatricians are classified as Primary Care Physicians. Some PCPs are not accepting new patients so the member will want to contact the PCP before they enroll. If they are currently a patient, it should not be an issue.

The PCP can be changed by the member/dependent as many times as they want. Changes that occur **prior to** the 15th of the month will be effective on the first of that month. If the PCP change is requested **after** the 15th of the month, then the change will become effective the first of the **following** month. You will not be able to request a PCP change for an employee. The member or dependent will need to contact Humana at 1-800-448-6262 to make the change or the member can change it online if they are registered at www.myhumana.com.

After the initial consultation, **referrals to a Specialist must be obtained from the PCP**, and it is the member's responsibility to make the call to the PCP or ensure the referral has been done. Specialist services received without a referral will be at the member's cost. The only exceptions to referrals are for an annual well woman exam with a participating gynecologist or for some chiropractic services.

The Humana HMO plan includes the following components:

- HMO Premier network
- Pharmacy Benefits managed by Humana including RightSource mail order program
- Claims adjudication and Benefit Questions, PCP Changes by Humana
- New Directions Employee Assistance Plan

DENTAL

MPR partners with Delta Dental of Missouri and Delta Dental of Kansas to administer its comprehensive dental program. Participants have access to two national networks of dentists – *Delta Dental PPO and Delta Dental Premier*.

Using a provider in the smaller **PPO network** will enable the participant and the plan to receive deeper discounts on services. These added savings are passed along to participants who use the **PPO network** of dentists through increased coverage so that out-of-pocket expenses for basic and major care are reduced. Refer to the *Summary of Dental Benefits* document for more details on the differences in benefit coverage between the two networks.

Delta Dental always gives you the freedom to visit the dentist of your choice and to select any dentist on a treatment by treatment basis. It is important to remember that your out-of-pocket expenses may vary depending on your choice. Fees charged by non-participating dentists may exceed Delta Dental's maximum plan allowance. When you receive services from a non-participating dentist, you are responsible for any amount that exceeds Delta's maximum plan allowance.

Dentists in each of the two networks agree to charge reduced fees for their services along with many other special provisions. You can reduce your out-of-pocket expenses by accessing care within these networks.

Claims/Customer Service

Delta's customer service staff is highly trained and able to assist with any claims or benefit questions Monday through Friday from 7 a.m. until 5 p.m. cst. Experienced representatives are able to answer over 95 percent of all questions during the initial phone conversation. If the question requires further research, the customer service representative will call back no later than the next business day with either a response or an update on the progress made.

Questions can also be e-mailed to Delta Dental's customer service department by visiting Delta Dental's web site, www.deltadental.com, select the *About Delta Dental* section, and then select *Delta Dental Member Companies* and choose your state on the map.

Employees can access their own claims history and benefits, and order ID cards, at www.deltadental.com. Delta Dental's toll free number will also take you to the automated response system that provides eligibility, benefits, claims status and a means to request a dentist directory 24 hours a day, seven days a week.

VISION SERVICE PLAN

MPR partners with Vision Service Plan (VSP) to administer vision coverage. VSP offers 35,864 Provider Access Points Nationally. All VSP providers have a dispensary on site (one-stop-shop approach). Although VSP providers are private practitioners, VSP does not dictate the location where a provider leases or owns their space. VSP Network Locations include major retail malls and shopping centers, medical building or office complex and rural and suburban locations. Summaries are included in the MPR plan documents and in the employee handout “A Guide to Your Health Care Benefits”. VSP’s website gives detailed information on exam and materials eligibility. Refer employees to www.vsp.com or 1-800-544-1415.

Services received from non-VSP providers can be filed for reimbursement. Patients should call VSP at 1-800-877-7195 for the filing procedure. The claim form can also be found at www.mprhealthplan.org.

Participants do not receive an ID card from VSP. Contact MPR if you would like a supply of wallet cards, or employees can print a personalized ID card at www.vsp.com.

NEW DIRECTIONS

For short term counseling needs, the MPR medical plans include three free visits to a mental health professional for all covered participants through New Directions Employee Assistance Program. For an additional charge, MPR member entities can take advantage of a group discount and subsidy amounts for New Directions’ short term model EAP for up to 6 free visits, formal management referral and training hours.

BMI submits electronic eligibility to New Directions monthly. Employees are encouraged to call 913-982-8398 or 800-624-5544. Many resources are available at www.ndbh.com by clicking “For EAP Members” and using the login code MPR.

DEPENDENT ELIGIBILITY GUIDELINES

Who is ELIGIBLE for MPR healthcare coverage?

- ❖ **Your Spouse**
 - The person is currently your legal spouse.
- ❖ **Your Common-Law Spouse**
 - The person is currently your common-law spouse under the laws of the state where you live. (Missouri does not recognize common law.)
- ❖ **Your Unmarried Dependent Child(ren)**
 - under age 26, or
 - mentally or physically disabled child as long as proof of disability has been submitted to MPR within 31 days of the date coverage would otherwise terminate and is dependent upon you or your spouse for support, and is not able to hold a self-sustaining job due to his or her disability.
- ❖ **Eligible Dependent children include:**
 - birth child(ren) of the employee or the employee's spouse;
 - legally adopted child(ren) of the employee or the employee's spouse;
 - a child placed under the legal guardianship of the employee or the employee's spouse;
 - a grandchild **if legal guardianship has been established**; and
 - a child for whom the employee has the legal responsibility to provide health care pursuant to a Qualified Medical Child Support Order.

Who is NOT ELIGIBLE for MPR health care coverage?

- Your spouse from whom you are legally separated.
- Your former spouse after the final date of divorce.
- Your children who have reached the limiting age.
- Foster children.
- Grandchildren for whom legal guardianship has not been established.
- Any dependent who is in active duty of the Armed Forces of any country for longer than 90 days.

DOCUMENTATION REQUIREMENTS FOR DEPENDENT ELIGIBILITY

Spouse

- ✓ Copy of your 1040 tax return filed for the prior year* (page 1 only) which lists the names of the dependents you are covering and shows a “married” filing status. *Please conceal any financial information, OR*

If you **acquired a spouse during the current year** due to marriage, you must submit the following:

- ✓ Copy of an official marriage certificate.

Common-law Spouse

You must submit a Common-law Affidavit and at least **two** of the following:

- ✓ Copy of a mortgage or rent agreement in both names.
- ✓ Copy of a bank loan in both names.
- ✓ Copy of a vehicle title or registration in both names.
- ✓ Copy of a checking/savings account in both names.

Birth Child of you or your spouse

- ✓ Copy of your 1040 tax return filed for the prior year* (page 1 only) which lists the names of the dependents you are covering. *Please conceal any financial information, OR*

If the child was born to you in the current year, you must submit the following:

- ✓ To add the newborn within 31 days, a copy of the hospital certificate of birth (to be followed up with the state-issued birth certificate when available).
- ✓ Copy of a state-issued birth certificate (not a hospital certificate of birth) naming you as a parent, **OR**

If you do not claim the dependent on your tax form, you must submit the following:

- ✓ Copy of a state-issued birth certificate (not a hospital certificate of birth) naming you or your spouse as a parent.

If the child is the birth child of your spouse and your spouse is not covered under the MPR health and/or dental or vision plan(s), or you do not claim the dependent on your tax form, you must submit the following documentation:

- ✓ Copy of your 1040 tax return filed for the prior year* (page 1 only) which lists the names of the dependents you are covering and shows a “married” filing status. *Please conceal any financial information, AND*
- ✓ Copy of a state-issued birth certificate (not a hospital certificate of birth) naming your spouse as a parent.

Adopted Child or Child placed for adoption with you or your spouse

- ✓ Copy of your 1040 tax return filed for the prior year* (page 1 only) which lists the names of the dependents you are covering. *Please conceal any financial information.*

If you did not claim the dependent on your tax form or the child was placed with you for adoption in the current year, you must submit the following:

- ✓ Copy of official adoption records naming you as a parent.

Grandchild

- ✓ Copy of your 1040 tax return filed for the prior year* (page 1 only) which lists the names of the dependents you are covering. *Please conceal any financial information, AND*
- ✓ Copy of the court decree granting you or your spouse legal guardianship. A notarized affidavit **WILL NOT** be accepted as legal guardianship.

If the guardianship was established in the current year, a copy of the court decree granting you or your spouse legal guardianship will suffice.

Legal Guardianship

- ✓ Copy of your 1040 tax return filed for the prior year* (page 1 only) which lists the names of the dependents you are covering. *Please conceal any financial information, AND*
- ✓ Copy of court decree naming you or your spouse as legal guardian. A notarized affidavit **WILL NOT** be accepted as legal guardianship.

If the guardianship was established in the current year, a copy of the court decree granting you or your spouse legal guardianship will suffice.

Child of a Qualified Medical Child Support Order

- ✓ Copy of the QMCSO as executed by the court.

Handicapped child over the age of 26

- ✓ Copy of the physician's documentation of mental or physical handicap, **AND**
- ✓ Copy of your 1040 tax return filed for the prior year* (page 1 only) which lists the names of the dependents you are covering. *Please conceal any financial information.*

UNDERWRITING GUIDELINES EFFECTIVE 7-1-11

PURPOSE

The purpose for implementing underwriting guidelines is to:

- Protect Midwest Public Risk Members from adverse selection
- Clarify “informal” rules
- Provide for some eligibility rules for prospective Members
- Provide some detail for guidelines for options Members may provide, e.g. cash back, waiving coverage, employee contributions, etc.

RATES

Rates may vary when new members join. Each new member will be underwritten and rated on their own individual experience. At MPR’s option, employee health statements may be required. Members receive the same renewal percentage increase/decrease.

Midwest Public Risk shall retain the right to individually underwrite any member who has submitted their notice of withdrawal, who later determines to remain with Midwest Public Risk, based on their own individual utilization, experience and/or loss history. Any surcharge is to be reviewed after two years. Rates will not be less than the pool rates.

Each Midwest Public Risk employee benefit plan (A, B, R, HMO, TFC, HDHP, Dental, Vision) is rated independently.

PLAN PARTICIPATION

No other group medical plan may be offered to Member employees other than Midwest Public Risk. The employer must contribute at least 50% of the employee only coverage toward the premium cost for each plan offered to eligible active employees. In addition, 75% of the total eligible employees must enroll in a Midwest Public Risk health plan. If at any time during a plan year, the Member entity fails to meet this standard, Midwest Public Risk may terminate coverage with 30 days notice.

A prospective Member with less than 10 eligible full-time employees will be underwritten as part of the small entity group. All benefits-eligible employees who decline/waive coverage will count towards minimum participation requirement of 75% of total benefit eligible full-time employees. At Midwest Public Risk’s option, employee health statements may be required.

WITHDRAWAL

Members must give 90 days prior notice and withdraw on anniversary (July 1st). MPR will continue to process and pay claims for 90 days following termination. Claims received but not processed and paid by September 30th will be the responsibility of the withdrawing Member. MPR will charge an administrative fee per employee per month for the three month period to process run-out claims. Claims charges will be paid by MPR.

EMPLOYEE CONTRIBUTIONS/OPT OUTS

Employees may decline to enroll in the health plan if they show written proof of other comparable group (not individual) coverage. The Member will retain a copy of the documentation. Employees who decline medical coverage must complete a Midwest Public Risk enrollment waiver form.

Members may offer employees cash back if the employee provides proof of other group (not individual) medical coverage, as long as the maximum amount is under \$3500/year.

ELIGIBILITY Midwest Public Risk has adopted general eligibility rules for coverage. Specific details as to who qualifies, contribution levels, etc. are determined by each individual employer within Midwest Public Risk guidelines and as defined in the plan documents.

Midwest Public Risk's general eligibility guidelines include:

A. Who is eligible:

- Active Full Time Employees as determined by Member
- Covered employees on Military leave for 90 days or less (including dependents)
- Part Time employees as determined by Member provided employee works at least 1,040 hours for the Member and Member pays at least 35% of the contribution
- Legally Married Spouses
- Dependent Children of the employee or employee's spouse under age 26
- Legally adopted children of employee or employee's spouse under age 26.
- Children for whom the employee or employee's spouse was awarded legal guardianship
- Disabled children (doctor's authorization required)
- Child for whom the employee has legal responsibility to provide healthcare pursuant to a Qualified Medical Child Support Order
- Elected Board/Council Member – 100% participation required; waivers for other group coverage including Medicare are permitted
- Retirees (must have 10 years of continuous Full time service with Midwest Public Risk Member)
- Qualified COBRA beneficiaries
- Common law spouses (Kansas residents only; state documentation required.)
- For Teacher's First Choice Members Only: Part-time employee hourly requirement is equal to an average of 20 hours per week. For school districts only, Midwest Public Risk will prorate the 1,040 hours to a 9-month schedule for a minimum of 780 hours.
- Retirees who have continuous coverage can rejoin the plan as an active employee if they meet benefit eligibility requirements. Upon subsequent retirement, if not Medicare eligible, they can return to Retiree coverage.

B. Who is not eligible:

- Covered employees on Military leave for more than 90 days (including dependents); USERRA rules apply
- Grandchildren for whom legal guardianship has not been established
- Children for whom the employee has not been awarded legal guardianship or custody
- Foster Children
- Parents or grandparents

- Ex-spouses once a final decree has been issued or legal separation has been obtained
- Common law spouses (Missouri residents)
- Same sex partners

School Districts that currently have part-time employees enrolled on their medical plans that do not meet the minimum requirements will be allowed to continue participation provided the district pays a minimum of 35% of the contribution. Any new part-time employees will not be eligible unless they meet the minimum hourly requirement of 780 hours. In addition, any school district that provides 100% of the contribution for part-time medical coverage, we require 100% participation of the part-time employees. To determine participation level, any eligible part-time employee that waives coverage because they have other medical insurance will not count against the Member.

ENROLLMENT

New employees must enroll for coverage to begin at the first of the month following employment or after satisfying the minimum waiting period established by the Member. Coverage always terminates on the last day of the month.

All Members must establish an annual open enrollment period of at least one week duration prior to June 1st. Changes submitted during this period are effective on July 1.

Exceptions may be requested; however, they will be considered based on unusual circumstances (such as a new Member joining Midwest Public Risk in midyear) and must not represent an underwriting risk to Midwest Public Risk. A midyear change in employee contributions will not cause Midwest Public Risk to approve an additional “open enrollment” period.

During open enrollment, employees may switch health plans or add/drop dependents.

- Employees/dependents who do not enroll during the open enrollment period may not enroll until the following year’s open enrollment unless a qualifying change in life status occurs. Upon such qualifying change, the enrollment form or change form must be submitted by the employee to the Member within 31 days of the life status change. Obtaining individual coverage does not qualify as a change in life status to terminate coverage during the year.

Newly married spouses will be eligible the first of the month following the date of marriage if the enrollment/change form is submitted to the employer within 31 days of the date of marriage. Proof of marriage (marriage certificate or KS Common Law for Rev 01-03) will be required to add a spouse at all times. Examples of accepted documentation include marriage certificate and most recent tax return.

The Member must validate eligibility for spouses, common law spouses, and dependent children by reviewing verifiable documents and maintain copies for audit purposes.

Employees or Dependents who enroll after the 31-day deadline will not be covered until the next open enrollment period (July 1).

Employees may drop dependents during the year only when the following conditions are met:

- Dependent no longer meets eligibility definition
- Dependent has acquired other coverage
- Other change in life status as defined by Section 125 plan
- Change must be made within 31 days

Otherwise, change must be made at open enrollment.

DENTAL

- Cash back may not be offered to employees who decline only dental coverage.
- Open enrollment rules apply for dental plans.
- The employer must contribute at least 50% of the employee only coverage toward the premium cost for each plan offered to eligible active employees and 35% for part-time employees.
- The employee must share in the cost of the dental plan per Health Care Reform.

VISION

- Open enrollment rules apply for vision plans.
- The employer must contribute at least 50% of the employee only coverage toward the premium cost for each plan offered to eligible active employees and 35% for part-time employees.

The employee must share in the cost of the vision plan per Health Care Reform.

UNDERWRITING ASSUMPTIONS

- Refer to the “Midwest Public Risk By-laws” regarding Member rights and responsibilities.
- Membership is subject to approval by the Board of Directors.
- The contract period is July 1 through June 30.
- Payment is due on the first of the month. All payments received after the 30th may be charged interest.
- Non-payment of premium can result in claims being held or denied. The Member may be responsible for the cost of health care provided for any month with lapsed coverage.
- MPR will make a refund adjustment not exceeding 60 days when a Member has made contribution errors. This provision shall not apply if claims have been made that exceed the adjustment level.

- Members are required to administer COBRA according to state and federal regulations for any coverage not provided by Midwest Public Risk. The Member is responsible for any penalties relating to non-compliance. Only individuals meeting the eligibility requirements specified by the Member may be covered. Former employees may not be offered coverage beyond the Member's policies relating to COBRA and retirees.
- Former spouses are always ineligible, regardless of court orders, except for their rights under COBRA. (effective July 1, 2007 for new employees; current employees upon audit)
- Missouri and Kansas law do not recognize same sex partners and neither does Missouri law recognize common law marriage. Hence no health benefits are offered for these individuals. Kansas law does recognize common law marriage and Midwest Public Risk will offer dependent health benefits provided that the individuals have filed the State of KS, Dept of Social & Rehabilitation Service Form 01-03, "Statement of Common-Law Marriage".
- Midwest Public Risk will report claims experience to the entire Membership at the pool level, not the Member level. Midwest Public Risk will release limited data related to wellness programming in compliance with HIPAA.

