

DIOCESE OF WINONA-ROCHESTER
HEALTH AND DENTAL PLAN
Participation and Form Directions

Administered by BlueCross BlueShield of Minnesota and
Delta Dental

Eligible participants are those employees who work at least 20 hours a week or at least one-half academic load during the school year. Health and dental insurance starts on the first of the month coincident with or following the date of hire. **New employees have 30 days from their initial date of employment/eligibility to enroll. When the 30 days are over, employees are able to sign up at yearly renewal on September 1 or upon a qualifying event or special enrollment.**

FORM REQUIRED TO ENROLL AN EMPLOYEE:

Health/Dental Enrollment/Change/Waive form for Group Coverage Form A-1

PURPOSE: To initiate health and dental coverage by collecting required information.

- a. If taking coverage, employees should complete Section I, III, IV, and VI. Section V needs to be completed if the employee or dependents being covered are
 1. Continuing health coverage with another company **And/OR**
 2. If the employee or dependent being covered is enrolled in Medicare.
- b. Upon enrollment, provide the employee with a copy of the plan summaries. Each employee enrolling in the health/dental insurance can access the summary plan description booklets online at <https://www.dow.org/offices/human-resources/index.html>.

FORM REQUIRED TO WAIVE GROUP COVERAGE:

Health/Dental Enrollment/Change/Waive Form for Group Coverage Form A-1

PURPOSE: To prove the employee was offered the health/dental insurance and wishes to waive their right to this benefit.

If an employee does not wish to participate in the health/dental plan, they MUST complete Section I and II, including their signature and date.

FORM REQUIRED FOR CHANGES TO EXISTING EMPLOYEES:

Address Change – no form needs to be completed – location to notify Diocese by email

Health/Dental Enrollment/Change/Waive Form for Group Coverage Form A-1

PURPOSE: To change name with no coverage changed. This form must be completed within 30 days of change. The employee's signature is required.

- a. Employee should complete Section I and Section VI.
- b. Please write former name on the top of the form.

Health/Dental Qualifying Event Group Coverage Form A-2

PURPOSE: A Special Enrollment Period is a period during which the employee and employee's family has a right to up for new or make changes to existing health coverage. Special Enrollment Period qualifying or triggering events listed below.

- Loss of minimum essential coverage (does not include loss due to failure to pay premiums or rescission)
 - Loss of eligibility for employer-sponsored coverage
 - Termination of employment or reduction of hours
 - Legal separation or divorce
 - Loss of dependent child status
 - Death of employee
 - Move outside HMO service area
 - Exceeding the plan's lifetime maximum
 - Employer bankruptcy
 - Employee becomes entitled to Medicare
 - Loss of minimum essential coverage
 - Gaining or becoming a dependent due to marriage
 - Gaining a dependent due to birth, adoption or placement for adoption,
 - An individual gains or loses eligibility for Medicaid or MinnesotaCare (notice must be received within 60 days of the event).
- a. Notice period is 30 days except for Medicaid/SCHIP events.
 - b. Employee should always complete Section I. Depending on what changes the employee needs to make, Section III, IV, and V may need completion. The employee always needs to sign Section VI. The qualifying event or special enrollment notice must be included with enrollment form.

TERMINATING EMPLOYEES:

Notice of Employee Termination of Employment Form 001

PURPOSE: It is very important to complete and return this form promptly so that all COBRA regulations and MN Continuation laws are complied with. The Diocese of Winona-Rochester contracts with a third party administrator for COBRA administration on the health and dental plan. Please complete the Notice of Employee Termination of Employment form (found in Hire/Term tab of Employee Benefits Guide), and return it to the Employee Benefits Coordinator in Winona within five days of the employee's termination. The COBRA third party administrator will contact the employee directly regarding their option to continue this health and dental coverage.

NOTE – Upload ALL FORMS to Dropbox for processing. Location to maintain copy for their employee records.

GENERAL INFORMATION:

Health/Dental Group Numbers:

	<u>2018/19</u>	<u>Dental</u>
\$1,000 Deductible – Health:	10274582	00918
\$5,000 Deductible – Health:	10416258	00918

Renewal:

Annual renewal is September 1, with open enrollment occurring prior to the annual renewal. Employees may sign up or change deductible amounts only during open enrollment unless the employee has a qualifying event or special enrollment.

Single Health/Dental Coverage:

Single coverage is coverage for only the employee.

Family Health/Dental Coverage:

Family coverage is coverage for the employee and each member of the family.

- Employees may keep their adult children on the health/dental plan through age 26. After that time, COBRA is available.
- Employees enrolling in family insurance will receive their health insurance identification cards from Blue Cross; every member in the family will receive their own ID card. Delta Dental will provide cards with the employee's name only.

Insurance Address/Phone for Completing Special Enrollment:

- BlueCross BlueShield of Minnesota
PO Box 64560
St. Paul, MN 55164
651-662-8000
- Delta Dental of Minnesota
PO Box 9304
Minneapolis, MN 55415
877-268-3384