# 2018 HEALTH CARE ASSISTANCE PLAN (HCAP) APPLICATION GUIDELINES

***Please keep the following items in mind as you complete the HCAP application.***

1. You must select the Accelerate Plan, the Access Plan, or decline coverage. Once you choose a plan, you cannot change plans during the policy year. If you decline HCAP coverage, you must attach a copy of your insurance card (front and back) as proof of coverage.

2. Sign and date the Employee Authorization and Certification form.

3. Complete Form A and select your plan option.

4. Complete Form B if you are covering your spouse whose annual earnings are less than $36,900.

5. Employed spouses who have health care benefits available from their employer (even at cost) must use those benefits as primary coverage, regardless of their earning level.

6. Employed spouses who cannot obtain or purchase health care coverage through their employer may be admitted to HCAP, **as long as an employer letter stating such is attached to the enrollment application.** There is a monthly fee based on if the spouse's annual earnings are under or over $36,900.

7. Dependent children may be covered until age 26.

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**Employee Name:** _____

# 2018 Healthcare Plan

**Check the box for one option below:**

## ☐ Accelerate Plan

The Accelerate Plan is designed to encourage and support the health and wellness of participating Plan employees and their family members. **For the 2018 plan year, there are no activity points required for the Accelerate Plan**. To qualify for the Accelerate Plan for 2019, you and your enrolled spouse are required to do the following in 2018:

- Participate in Care Management and/or Health Coaching Services if you or your spouse are identified by the health plan as someone who would benefit from these services.
- If you want to continue in the Accelerate Plan in 2019, you must complete certain requirements in 2018. See "All members" section below for the Accelerate Plan requirements for 2019.

By enrolling in the Accelerate Plan Program, you and your spouse are agreeing that you will satisfy the above requirements, along with wellness and activity point requirements. If you do not satisfy the requirements of completing the wellness assessment (60 points), biometric screening (60 points), and earning an additional 80 activity points for a total of 200 Ascend to Wholeness points in 2018, you and your spouse will be removed from the Accelerate Plan for 2019. Likewise, if your enrolled spouse does not satisfy the requirements of completing the wellness assessment (60 points), biometric screening (60 points), and earning an additional 80 activity points for a total of 200 Ascend to Wholeness points in 2018, you and your spouse will be removed from the Accelerate Plan for 2019.

If you or your spouse are identified as someone who would benefit from care management and/or health coaching and you do not meet the care management and/or health coaching requirements, then you and your spouse (and family) will not be eligible for the 2019 Accelerate Plan year.

## ☐ Access Plan

There are no wellness requirements to participate in the Access Plan. The Access Plan has higher deductibles, co-payments and co-insurance than the Accelerate plan. If you choose the Access plan now, you will not be able to move into the Accelerate Plan until 2019, even if you later choose to participate in the health-promoting activities outlined above.

## ☐ Decline Coverage — MUST ATTACH PROOF OF COVERAGE

I understand that I am an employee eligible to participate in the Ascend to Wholeness Healthcare Plans for Employees of the Seventh-day Adventist Church organizations working in the United States ("Plan"). By selecting this option, I hereby (1) decline coverage under the Plan; and (2) certify to my employer that I have health plan or health insurance coverage from another source, such as a health plan sponsored by the employer of my spouse or parent, or a federal plan, such as Medicare or Medicaid. I have attached proof of such other coverage to this application.

By declining coverage for myself as an employee, I understand that my spouse and dependent children ("Dependents") are not eligible for coverage under the Plan. I understand that my ability to enroll myself and my Dependents in the Plan at a later date may be restricted to certain time periods, such as (1) an open enrollment period of my employer; and/or (2) the special enrollment periods described in the Plan.

I also acknowledge, represent and agree that:

- Since I am eligible for Plan coverage, my tax dependents and I will not qualify for any federal subsidy (premium tax credit) available for health insurance purchased at a Health Insurance Marketplace (for more information about the Health Insurance Marketplaces, visit www.healthcare.gov);
- I am signing this form voluntarily and I am not required by my employer or the Plan to sign this application; and
- I have not been given and will not be given any incentive, reward or consideration by my employer or the Plan for signing this application.

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HEALTHCARE PLANS

# 2018 Healthcare Plan

## Employee Authorization and Certification

I have received a copy of the Health Plan Guide, Plan Comparison and have access to other documents concerning my benefits at http://ascendtowholeness.org I have read and understand the materials and my rights to choose the Plan I believe is best for me. I understand there is a medical Preferred Provider Organization (PPO) that must be used for non emergency situation in order for the Plan to respond. I recognize there are certain requirement for me and my covered spouse, if applicable, in the areas of enrollment, prior authorization and others. I recognize I have full access to the plan document at the http://ascendtowholeness.org website, and that it is my responsibility to be in compliance with the Plan.

I agree that my employer may withhold from my paycheck the employee contributions that are required for the plan coverages that I have elected. I understand that there may be employee contributions, for all plan coverages, including coverage for full time employees, and that I have been given access to employee contribution rates. I further understand and agree that my paycheck withholding authorization will continue into future years if I remain covered under my employer's group health plan.

I understand that if the information is not complete and correct, this coverage could be retroactively terminated.

I authorize all providers of healthcare to furnish all records pertaining to medical history, services, and rendered treatment given as pertains to evaluation of enrollment application and/or claims. This authorization will become effective immediately and will remain in effect as long as necessary to enable Adventist Risk Management, Inc. to process the application and/or claims.

I agree to notify my employer of any changes in family status or eligibility of family members. Failure to notify my employer of any status changes will authorize my employer to ask Adventist Risk Management, Inc. to deny payments of future claims and ask for collection of past paid claims for ineligible spouse or dependents.

We take your privacy and confidentiality seriously

As your health plan administrator, Adventist Risk Management and its partners adhere to all HIPAA privacy regulations. No personally identifiable health information will be shared with your employer, including the Human Resources department, managers, supervisors or other non-health plan employees. Your employer receives only aggregated statistics, stripped of identifying information.

PRINT NAME: _____

EMPLOYEE SIGNATURE: _____ DATE (MM/DD/YYYY): _____

FLORIDA CONFERENCE of SEVENTH-DAY ADVENTISTS
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# 2018 EMPLOYEE HEALTH CARE ENROLLMENT APPLICATION

# FORM A

Must be returned within 30 days of your hire date
or you will not be eligible for coverage
until 1/1/2019

## EMPLOYEE INFORMATION:

| Group # : **752-200** | Social Security Number: | | Employee's E-Mail Address: |
|---|---|---|---|
| Have you been at this address more than 12 months? ◯ Yes ◯ No | First Name: | M. I. | Last Name: |
| Address | | | Work Location:<br>Work Phone:<br>Home Phone: |
| City | State | Zip | |

| Sex | Birthdate | Hire Date | Effective Date: | Marital Status |
|---|---|---|---|---|
| ◯ Male<br>◯ Female | MO DA YR | MO DA YR | | ◯ Married ◯ Separated ◯ Widowed<br>◯ Single ◯ Divorced |

## SPOUSE INFORMATION:

| Spouse First Name: | M.I. | Spouse Last Name: |
|---|---|---|
| Spouse Birthdate: MO DA YR | Spouse's Social Security Number: | Spouse's Employer Name & Phone # |

| Other Insurance: | Medicare Eligible: | Dependents Covered: | Is Spouse Employed: | Is Spouse a Student: |
|---|---|---|---|---|
| ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No |

| Name of Insurance: | Policy Number: | Effective Date: |
|---|---|---|
| | | |

## DEPENDENT INFORMATION (OMIT IF NOT INCLUDING ON YOUR HEALTH CARE):

| Relationship | First Name | Last Name | Birthdate | Child's SS # |
|---|---|---|---|---|
| ◯ Son ◯ Daughter | | | | |
| ◯ Son ◯ Daughter | | | | |
| ◯ Son ◯ Daughter | | | | |
| ◯ Son ◯ Daughter | | | | |
| ◯ Son ◯ Daughter | | | | |
| ◯ Son ◯ Daughter | | | | |

# PLAN OPTIONS

OPTION A ☐ Employee only. Monthly cost: $120

OPTION B ☐ Employee and dependent children. I am a single parent.
Monthly cost: 1 child, $180 2 children, $240 3+ children, $300

## SELECT IF SPOUSE'S ANNUAL EARNINGS ARE LESS THAN THE ANNUALIZED RATE OF $36,900.

OPTION C ☐ Employee and spouse. My spouse is unemployed or has no health care benefits available from employment. Monthly cost: $240

OPTION D ☐ Full family coverage, my spouse is unemployed or has no health care coverage available from employment. Monthly cost: employee, spouse, and children: $300

OPTION E ☐ Employee and dependent children. My spouse has benefits available from employment.
Monthly cost: 1 child, $180 2 children, $240 3+ children, $300

## SELECT IF SPOUSE'S ANNUAL EARNINGS ARE MORE THAN THE ANNUALIZED RATE OF $36,900.

OPTION F ☐ Employee and spouse. My spouse is unable to acquire benefits through employment.
Monthly cost: $420

OPTION G ☐ Employee, spouse, & dependent children. My spouse is unable to acquire benefits through employment.
Monthly cost: 1 child, $450 2 children, $480 3+ children, $510

OPTION H ☐ Employee and dependent children. My spouse has benefits available through employment.
Monthly cost: 1 child, $240 2 children, $300 3+ children, $360

**NOTE 1.** Dependent children may be covered until age 26.

**NOTE 2.** If your spouse is eligible for health care coverage and his/her annual earnings are less than $36,900, you must **complete FORM B on the back of this application and attach the required documentation.**

**NOTE 3.** If your spouse is employed, and health care benefits are not available through their employer, **a letter from the employer stating such must be attached with this enrollment application, along with required documents (see FORM B).**

# HEALTH CARE ASSISTANCE PLAN
# FORM B

**(TO BE COMPLETED FOR SPOUSE'S COVERAGE WHOSE ANNUAL EARNINGS ARE LESS THAN $36,900)**

**Part I: EMPLOYMENT AND INCOME VERIFICATION**

**Attach a copy of your most recent IRS form 1040 (front page only) and copies of the relevant W-2, if any, for your spouse. (*You MUST attach form 1040 whether or not spouse was employed or had income*).**

**If spouse is self-employed, please attach their 1099 MISC form/s with Schedule C, along with your IRS 1040 (front page only).**

**If you do not wish to attach IRS form 1040, you may, as an alternative, attach a statement from an attorney or CPA certifying that your spouse's earned income was less than $36,900.**

**PART II: SPOUSE INFORMATION**

Name_____

*Employment Status:*

- ☐ Not employed
- ☐ Self-employed
- ☐ Employed part-time
- ☐ Employed full-time **(see note 3 on previous page)**

*Medical Benefits Available from Employment:*

- ☐ None
- ☐ Partial
- ☐ Full

Income during tax year 2016 $_____

Expected income for current tax year 2017 $_____

Expected income for calendar year 2018 $_____

**EMPLOYEE SIGNATURE** **DATE SIGNED**

(Revised September, 2017)