Welcome to the NN Employee Benefit Program/HMA's Work Session for Enterprise And LGA Chapter Benefit/Human Resources Representatives

Sheraton Airport Hotel and Conference Center
Albuquerque, NM
February 27 – 28, 2019

Navajo Nation Employee Benefit Plan Mission Statement

Our Mission… exists to provide unique, comprehensive and cost-effective benefits through quality management for the health and well-being of the plan participants.

Our Goal… to provide and administer employee benefit programs for non-occupational causes including life insurance, health care coverage and related medical, dental, and vision plans, disability income, and other benefit plans enacted by The Navajo Nation or federal legislation.

Our Foundation… the self insured Navajo Nation Employee Benefit Plan enacted in 1991 insures employees of the Navajo Nation, Enterprises and LGA Certified Chapters.

Overview of HMA, LLC

Mallory Gray – HMA
Account Manager

About HMA

- Founded in 1983; currently serve over 150,000 members
- March 2012, Health Management Associates, Inc. became Hawaii-Mainland Administrators, LLC (HMA). HMA has continued to offer all of its valued clients the same administrative services as before
- Headquartered in Tempe, AZ, Operations Centers in Cottonwood, AZ and Honolulu, HI
- Provides successful third party administration to the Navajo Nation for 21 years
- Thorough knowledge of the Indian Health Services/PL ‘638 facilities and Purchase Referred Care referrals

Responsibilities

- Third Party Administrator (HMA)
  - Claims Management (Health and Disability)
  - Customer Service
  - Account Management
  - Network Management
  - Health Services
  - Recovery Services
  - Other Services (Pharmacy, COBRA, Stop Loss Policies, Life Insurance, Voluntary Benefits)

What are the Benefits?

- Medical Program (includes Native Healing Benefits)
  - PPO Plan – Deductibles, Co-payments, Co-insurance
- Dental Program (includes Orthodontic Benefits)
  - Deductibles; Co-insurance
- Vision Program (includes Lasik Surgery)
  - $200 Calendar Year Max; $500 Lasik Lifetime Max
- Pharmacy Program – (WellDyne Rx)
  - $20 generic, $40 brand, $70 non-preferred brand
- Short Term Disability Program
  - 52 weeks Max

What are the Benefits? (continued)

- Stop Loss Insurance
  - Medical Claims exceeding $600,000 per insured member based on calendar year paid claims
  - Reimbursement to the Plan from the stop loss carrier

What are the Benefits? (continued)

- Basic and Accidental Death & Dismemberment Insurance (MetLife)
  - Employee (Annual Salary): $48,000 - $125,000
  - Dependent Spouse (Basic Only): $7,500
  - Dependent Child (Basic Only): $5,000
  - Elected Chapter Officials: $5,000 (Voluntary)

What are the Benefits? (continued)

- Voluntary Term Life Insurance (MetLife)
  - Employee: Min $10,000 up to Max 5x Annual Salary ≤ $300,000
  - Dependent Spouse: Min $5,000 up to 100% of Employee's amount, Max $100,000
  - Dependent Child: $5,000

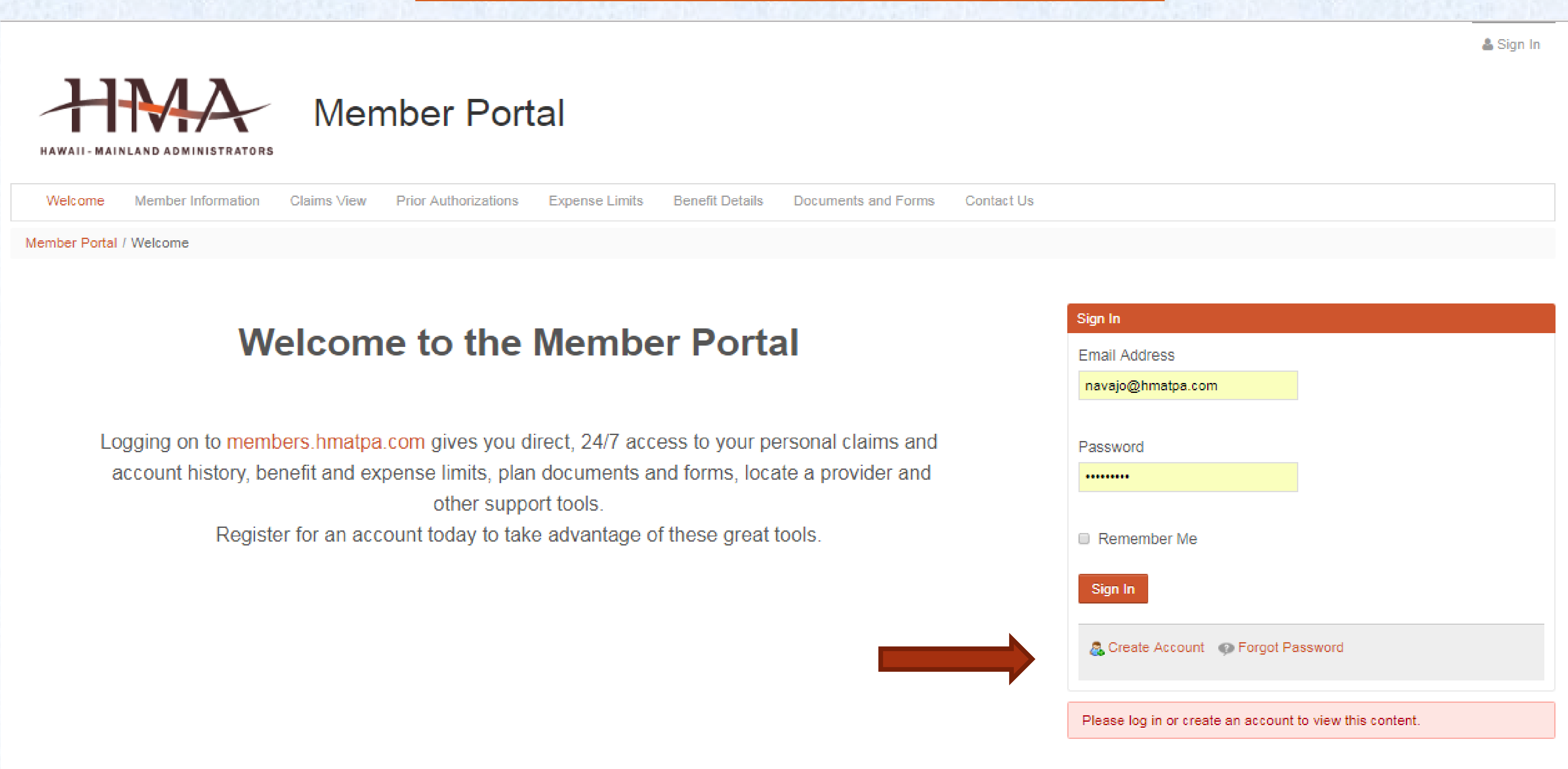
- Supplemental Insurance (optional – Colonial)

Website Orientation-Member Portal "Create Account"

Mallory Gray – HMA
Account Manager

How do I access the Member Portal?

https://members.hmatpa.com



Click on "Create Account" and follow the steps provided.

Welcome Page

My Sites 0

Member Portal

Welcome | Member Information | Claims View | Prior Authorizations | Expense Limits | Benefit Details | Documents and Forms | Contact Us

Member Portal / Welcome

WELCOME NAVAJO NATION EMPLOYEE BENEFIT PLAN MEMBER

What would you like to do?

Sign In

You are signed in as navajo test.

Locate Provider

Locate San Juan IPA Provider

Contact Us

Make Request

Member Information

Member Portal

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Member Portal / Member Information

View Dependent Information

Member Name: JOHN A SMITH SR **Member ID:** 99999999901
Employer ID: NNEBP **Member Type:** CONTRACT
Date of Birth: 1985-03-04 **SSN Last 4:** 6789
Address: 1234 ANY STREETAPT 12
City: ANY TOWN **State:** AZ **Zipcode:** 85321
Phone Number: 4805551234
Location:

Coverage: 710000

Rider Code: D1 **Description:** Dental **End Date:** 2017-04-30
Rider Code: L1 **Description:** Life **End Date:** 2017-04-30
Rider Code: M1 **Description:** Medical **End Date:** 2017-04-30
Rider Code: V1 **Description:** Vision **End Date:** 2017-04-30

Locate Provider

Locate San Juan IPA Provider

Contact Us

Make Request

View Dependent Information

Member Portal

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Member Portal / Member Information

Information for dependent children under 18 years of age with the same mailing address as the employee is automatically made available to the employee on this member portal. A spouse or a dependent child who is 18 years of age or older will need to create their own login. In order to access information for your spouse or other dependents under your login they will need to submit the HIPAA Authorized Representative Form. This form is available under Forms and Documents on this member portal or by clicking here.

Member ID: 99999999903 View Information
Dependent Name: JOHN A SMITH

Member ID: 99999999904 View Information
Dependent Name: JANET B SMITH

Member ID: 99999999905 View Information
Dependent Name: JANICE C SMITH

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Claims View

Member Portal

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Member Portal / Claims View

Note: Information related to sensitive Protected Health Information (PHI) is not available online. Sensitive PHI is protected health information related to the identity, diagnosis, prognosis, or treatment of any beneficiary in connection with reproductive health, substance abuse, HIV, rape, sexually transmitted diseases, mental health, and abuse (such as sexual assault and domestic violence). To discuss this information please contact our Customer Service Department.

Sort by Date | Sort by Provider | View Older Claims | View Dependent Claims

Claim Number: 160211010530 View Details
Provider Name: JAMES DAY DDS **Date of Service:** 2015-10-30
Status: DENIED **Status Description:** Claim has not been paid for reasons included in remarks
Charges: 255.00 **Member Pays:** 0.00 **Plan Pays:** 0.00 **Deductible:** 0.00 **Out of Pocket:** 0.00

Claim Number: 160314010889 View Details
Provider Name: BISHOP OPTICAL **Date of Service:** 2016-03-01
Status: PAID **Status Description:** Claim has completed processing and has been paid
Charges: 200.00 **Member Pays:** 0.00 **Plan Pays:** 200.00 **Deductible:** 0.00 **Out of Pocket:** 0.00

Claim Number: 160411011198 View Details
Provider Name: NGHEIM T LE DDS **Date of Service:** 2016-04-01
Status: DENIED **Status Description:** Claim has not been paid for reasons included in remarks
Charges: 473.00 **Member Pays:** 0.00 **Plan Pays:** 0.00 **Deductible:** 0.00 **Out of Pocket:** 0.00

Claims View (continued)

Member Portal

Welcome | Member Information | Claims View | Prior Authorizations | Expense Limits | Benefit Details | Documents and Forms | Contact Us

Member Portal / Claims View

Claim Number: 16031401088901
Provider ID: 17050 **Provider Name:** BISHOP OPTICAL
Benefit Category: VISION - LENSES
Status: PAID **Status Date:** 2016-05-03
From Date: 2016-03-01 **To Date:** 2016-03-01
Charges: 200.00 **Allowed:** 200.00 **Ineligible:** 0.00 **Copay:** 0.00
Deductible: 0.00 **Coinsurance:** 0.00 **Plan Liability:** 200.00 **Coordination of Benefits:** 0.00
Member Deductible: 0.00 **Member Out of Pocket:** 0.00
Family Deductible: 0.00 **Family Out of Pocket:** 0.00
Remarks: Processed As An Indemnity Benefit

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Prior Authorizations

Member Portal

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Member Portal / Prior Authorizations

View Dependent Information

Referral ID: 88685
Status: APPROVE
Begin Date: 2015-03-17 **End Date:** 2016-03-16
Referring Entity: **Treating Entity:** LINCARE 201 W. SANTA FE AVE SUITE C GRANTS, NM. 87020
Benefit Category: DURABLE MEDICAL EQUIPMENT / SUPPLIES > $250

Referral ID: 89209
Status: APPROVE
Begin Date: 2015-02-21 **End Date:** 2016-02-20
Referring Entity: FLOR J CABALLAR-GONZAGA **Treating Entity:** SLEEP RX LLC, 7536 N. ST. LOUIS AVE, SKOKIE, IL 60076
Benefit Category: DURABLE MEDICAL EQUIPMENT / SUPPLIES > $250

Referral ID: 106299
Status: APPROVE
Begin Date: 2016-03-17 **End Date:** 2017-03-17
Referring Entity: **Treating Entity:** LINCARE INC - GRANTS
Benefit Category: DURABLE MEDICAL EQUIPMENT / SUPPLIES < $251

Referral ID: 112366
Status: APPROVE
Begin Date: 2016-10-11 **End Date:** 2017-01-11
Referring Entity: NICHOLAS LELAND HUGENTOBLER **Treating Entity:** ANIMAS SURGICAL HOSPITAL

Expense Limits

Member Portal

Welcome | Member Information | Claims View | Prior Authorizations | Expense Limits | Benefit Details | Documents and Forms | Contact Us

Member Portal / Expense Limits

View Previous Year | View Dependent Information

Service Year: 2017
Rider Code: D1 - Dental
Member has used 0.00 **of** 2000.00 **Annual Amount.**
Member has used 0.00 **of** 0.00 **Lifetime Amount.**
In Network
Member has used 0.00 **of** 100.00 **Deductible.**
Member has used 0.00 **of** 0.00 **Out of Pocket.**
Family has used 0.00 **of** 300.00 **Family Deductible.**
Family has used 0.00 **of** 0.00 **Family Out of Pocket.**
Out of Network
Member has used 0.00 **of** 100.00 **Deductible.**
Member has used 0.00 **of** 0.00 **Out of Pocket.**
Family has used 0.00 **of** 300.00 **Family Deductible.**
Family has used 0.00 **of** 0.00 **Family Out of Pocket.**

Service Year: 2017
Rider Code: D2 - Orthodontic
Member has used 0.00 **of** 0.00 **Annual Amount.**
Member has used 0.00 **of** 2000.00 **Lifetime Amount.**
In Network
Member has used 0.00 **of** 100.00 **Deductible.**
Member has used 0.00 **of** 0.00 **Out of Pocket.**

Benefit Details

Member Portal

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Member Portal / Benefit Details

View Dependent Information

Rider Code: D1 - Dental — View Details

Rider Code: L1 - Life — View Details

Rider Code: M1 - Medical — View Details

Rider Code: V1 - Vision — View Details

Benefit Details (continued)

Welcome | Member Information | Claims View | Prior Authorizations | Expense Limits | Benefit Details | Documents and Forms | Contact Us

Member Portal / Benefit Details

Back | View Previous Year

Service Year: 2017
Rider Code: D1 - Dental
Benefit Category: DENTAL - FULL MOUTH X-RAY **Benefit Limit:** 1 Visit Every 3 Plan Years
Of This Benefit You Have Used:
Days: 0 **Services:** 0 **Visits:** 0 **Amount:** 0.00
Service Date:

Service Year: 2017
Rider Code: D1 - Dental
Benefit Category: DENTAL - BITEWINGS **Benefit Limit:** 2 Visits Every Plan Year
Of This Benefit You Have Used:
Days: 0 **Services:** 0 **Visits:** 0 **Amount:** 0.00
Service Date:

Service Year: 2017
Rider Code: D1 - Dental
Benefit Category: DENTAL - FLOURIDE APPLICATION **Benefit Limit:** 2 Visits Every Plan Year
Of This Benefit You Have Used:
Days: 0 **Services:** 0 **Visits:** 0 **Amount:** 0.00
Service Date:

Service Year: 2017
Rider Code: D1 - Dental
Benefit Category: DENTAL - ORAL EXAMS **Benefit Limit:** 2 Visits Every Plan Year
Of This Benefit You Have Used:

Documents and Forms

Member Portal

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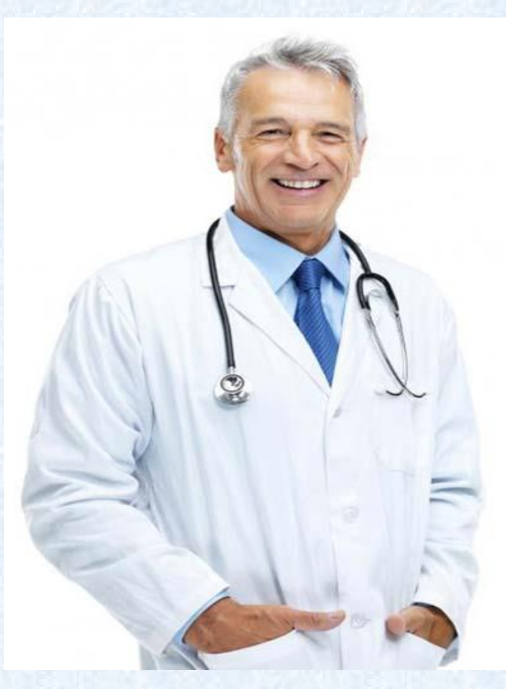
Member Portal / Documents and Forms

Helpful Documents and Forms	
WellDyne Rx Prescription Delivery Service	Download PDF
HMA & WellDyne Welcome Letter	Download PDF
NNEBP_SBC-Coverage Period_1-1-2017-12-31-2017	Download PDF
NNEBP Plan Document_revised 010114	Download PDF
WellDyne Rx Welcome Letter	Download PDF
SBC Glossary of Terms_English	Download PDF
SBC Glossary of Terms_Navajo	Download PDF
Medicare Part D Notice NN	Download PDF
Tribal Exemption Form	Download PDF
AMN RAN HMN Network Flyer	Download PDF

Website Orientation - Provider Search
In-Network Providers

Mallory Gray – HMA
Account Manager

Provider Search



AMN, RAN & HMN Networks

Please follow the instruction below to complete an in-network provider search:

- Go to www.hma-inc.com
- Select the logos on the back of your Member ID card

- Select either Provider Search or Personal Directory
- Fill out the Provider Search form
- Please be patient while a Provider Directory generates
- Receive services from the providers in the directory to receive in-network benefits

Or, call the number on the back of your ID card for further assistance:

(928) 634-2216 or (800) 448-3585

P.O. BOX 22009 Tempe, AZ 85285
(800) 448-3585| www.hmatpa.com

Where to conduct a Provider Search?

www.hma-inc.com

Welcome | Payers | Providers | Patients | Contact Us

Looking for HMA, Inc.?

MultiPlan acquired HMA, Inc. but sold its third party administrator business to a new company called Hawaii-Mainland Administrators, LLC.

MultiPlan continues to offer network solutions under the Arizona Medical Network (AMN), Rural Arizona Network (RAN), and Health Management Network (HMN) brand names. If you are looking for information on these networks, you're at the right place. Use the navigation bar above to learn more, or the button to the right to search the networks.

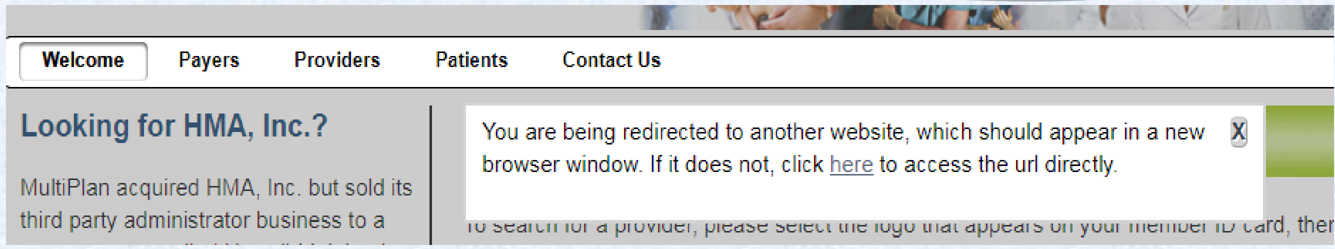
Click here to be redirected to Hawaii-Mainland Administrator's website.

Looking for the **MultiPlan** or **PHCS** networks? Click here

Search for a Doctor or Facility

To search for a provider, please select the logo that appears on your member ID card, then click the Continue button below.

My logo is not here



Provider Search

- Search for the doctors or hospitals near you.
- Check to see if your doctor or hospital is part of the network.
- Get a map showing the exact location of a doctor's office or hospital.

Personal Directory

- Print a personalized directory of the network doctors and hospitals in your area.

Every effort is made to ensure the accuracy of our data; however, we receive changes daily from numerous sources that must be verified. Therefore, some updates may not yet be included.

IMPORTANT:

This directory contains providers who, based on our records, participate in the AMN, RAN and/or HMN networks. Our website is updated on a weekly basis. We try to ensure the accuracy of the information in our directory; however, changes occur daily and may not yet be included in the directory. Therefore, it is possible that the provider you select is not currently participating in our network. Please confirm the provider's participation by calling the provider directly.

The provider you select may not be available to all clients due to, for example, individual benefit plan or network restrictions. Additionally, the provider may not offer the contracted rate for all services. Please confirm your benefits by calling your Health Plan Benefit Administrator or Insurance Company.

Provider Search

To search for a doctor or hospital...

1 How do you want to search?

By Location

Find providers within 50 miles of this location:

Address — *Optional*

City — State

Zip 87301

Show providers on a map

It is suggested you start with a low mileage and increase the number as needed.

If you don't know the full address, enter at least the 'City' **and** 'State', or the 'Zip' code.

If you want a map of providers locations, check the box.

By Doctor Name

Last name

First name — State

Enter 'Last name' and 'State'. Add 'First name' or First initial to narrow search.

By Hospital or Facility

Name — State

Enter 'Name' and 'State'.

By Doctor Name

Last name

First name — State

Enter 'Last name' and 'State'. Add 'First name' or First initial to narrow search.

By Hospital or Facility

Name — State

Enter 'Name' and 'State'.

2 What type of providers do you want listed?

Search For Doctors

Specialty: Primary Care (FP,GP,IM)

Gender: No Preference

Click here for specialty definitions.

Search for Hospitals or Facilities

Type: All

Click here for facility definitions.

Search All

SEARCH CLEAR

For more help with this form click here

Search Results

Provider Search

Search Results

You selected **Primary Care (FP,GP,IM)** doctors or practitioners within **50.0** miles of the zip code **87301**.

Results 1-10 shown. Click here for results 11-20.

#	Doctor or Practitioner	Specialty	Gender	Office Location	Accepting New Patients?	Distance (miles)
1	KNEDLER, LINDA K., MD	Family Practice	F	2111 COLLEGE DR, GALLUP, NM 87301 (505)863-1820	Yes	1.7
	PATEL, NIYATI, MD	Internal Medicine	F	2111 COLLEGE DR, GALLUP, NM 87301 (505)863-1820	Yes	
	ANDRADE, AEDRA D., MD	Family Practice	F	2111 COLLEGE DR, GALLUP, NM 87301 (505)863-1820	Yes	
	ROBINSON, THOMAS E., MD	Internal Medicine	M	2111 COLLEGE DR, GALLUP, NM 87301 (505)863-1820	Yes	
	GONZALES, EDUARDO, CNP,NP	Internal Medicine, Nurse Practitioner	M	2111 COLLEGE DR, GALLUP, NM 87301 (505)863-1820	Yes	
	MACBRIDE, SAMUEL D., MD	Family Practice	M	2111 COLLEGE DR, GALLUP, NM 87301 (505)863-1820	Yes	
	ROBERTSON, GERALD R., MD	Medical Oncology, Internal Medicine, Hematology / Oncology	M	2111 COLLEGE DR, GALLUP, NM 87301 (505)863-1820	Yes	
	GONZAGA, CHRISTOPHER E., MD	Internal Medicine, Infectious Disease	M	2111 COLLEGE DR, GALLUP, NM 87301 (505)863-1820	Yes	
2	ERINLE, AYODELE O., MD	Internal Medicine, Nephrology	M	2240 COLLEGE DR, GALLUP, NM 87301 (505)863-7993	Yes	1.7
	WHITFIELD, JAMES W., MD	Internal Medicine, Nephrology	M	2240 COLLEGE DR, GALLUP, NM 87301 (505)863-7993	Yes	
3	ANDRADE, LAWRENCE, MD	Family Practice	M	517 E NIZHONI BLVD, GALLUP, NM 87301 (505)772-6603	Yes	1.7
	FRONTEROTTA, ADELFIO P., MD	Family Practice	M	517 E NIZHONI BLVD, GALLUP, NM 87301 (505)772-6603	Yes	

Search Results (continued)

Provider Search

Provider Details

Doctor or Practitioner	
KNEDLER, LINDA K., MD	
Medical school: Not Available	
Title: MD	
Member since: 06-22-2017	
Gender: Female	Year of birth: 1954

Specialties

Specialty: Family Practice, Board Certified

Office Locations

2111 COLLEGE DR
GALLUP, NM 87301-5600
Phone: (505)863-1820
Accepting new patients?: Yes

Map this location

Facility Privileges

Not available

Administrative Information

Profile Update

If you are a provider and wish to update your profile information, click here to find out how.

Search Again

Enrollment and Eligibility

Mallory Gray – HMA

Account Manager

Enrollment: Who is eligible?

- Employees actively working for the employer participants on a regular, part-time, or seasonal basis who are regularly scheduled to work at least 20 hours or more per week;
- Spouse including common-law marriage;
- Child (up to the age of 26);
- Newborn Child;
- Adopted Child;
- QMCSO (Qualified Medical Child Support Order);
- Developmentally or Physically Disabled Child

Enrollment: Who is ineligible?

- A spouse legally separated or divorced from a covered employee, unless the legal separation or divorce decree provides coverage;
- Domestic same sex partner;
- Persons in the military or like forces of any country;
- If both husband and wife are eligible as covered member, only one may carry dependent coverage;
- Any person eligible under the Plan may be covered as an employee or as a dependent, but not both;
- Any person living in the covered employee member's home, but not eligible as defined in the Plan Document
- Child born to the dependent member's child (grandchild)

How to enroll

- An eligible employee must complete an enrollment form for coverage under the Plan;
- The employee may enroll for individual coverage or family coverage;
- Employee coverage includes: medical, prescription drug, vision, dental, short term disability, and life;
- Dependent coverage includes: medical, prescription drug, vision, dental, and life;
- The enrollment must be completed within thirty-one (31) days after the employee or dependent becomes eligible for coverage

Member & Dependent Effective Dates

- Health - the first of the month following the date the employee completes a sixty (60) day waiting period;
- The date the employee becomes a member of an employment status eligible for coverage under the plan;
- If a late enrollee, on January 1 of the calendar year next following the annual open enrollment period

Reinstatement of Coverage

- Active Military Duty;
- Family Medical Leave Act;
- Change of location if break in coverage is less than thirty-one (31) days

Member Termination of Coverage

Coverage terminates at midnight on last day of the month in which:

- Employment ends due to a resignation, termination, retirement, layoff, or loss of life;
- Member is no longer eligible for coverage;
- Dependent child reaches the age of 26;
- Required contribution for coverage is not made;
- Member voluntarily terminates their coverage.
- Employee member engages in fraudulent conduct, deception, or misrepresentation relating to claims, enrollment, obtaining benefits or the use of an identification card;
- Coverage terminates for the class of employees to which the employee member belongs;
- Employee member becomes an active full-time member of the armed forces other than for scheduled drills or other training of less than thirty-one (31) days

Enrollment Form

HMA
HAWAII · MAINLAND ADMINISTRATORS

1600 West Broadway Road, Suite 300
Tempe, Arizona 85282
Phone: (888) 811-8944
Fax: (866) 814-3854

Employee Enrollment Form
Please complete all sections to prevent any delay in enrollment.
For questions regarding this form, email Enrollment@hmatpa.com.

SECTION A: QUALIFYING EVENT (Please Select One Option)

Employee	Dependent
☐ **New Hire/Open Enrollment**	☐ **Add/Delete Dependents** (Must Complete Section C)
☐ **Termination:** (Date) ____/____/______	Please Select Qualifying Event (Must Provide Documentation)
Reason for Termination: __________	☐ **New Birth** ☐ **Divorce** ☐ **Adoption** ☐ **Marriage**
☐ **Transfer of Coverage:** From __________	☐ **Other:** Please explain __________
☐ **Name Change:** From __________	Date of Qualifying Event: ____/____/______
☐ **Decline Coverage:** Reason __________	☐ **Termination** (Date) ____/____/______
☐ **Dual Coverage** ☐ **Reinstatement**	Reason for Termination: __________
☐ **New ID Card** ☐ **Salary Change**	☐ **Address Change**

SECTION B: EMPLOYEE INFORMATION

Employer Name | Position / Title | Employee Census Number
Social Security Number ___ - ___ - ___ | Employee First Name | Employee Last Name
Employee ID Number | Date of Birth ___/___/___ | Phone Number | Email Address
Home Address (Mailing) | City | State | Zip Code

Gender:	Marital Status:	Coverage Selected:	Coverage Desired:
☐ Male	☐ Single	☐ Employee Only	**Employee:** ☐ Health ☐ Life ☐ Disability
☐ Female	☐ Married	☐ Employee & Spouse	**Spouse:** ☐ Health ☐ Life
	☐ Common Law	☐ Employee & Family	**Child(ren):** ☐ Health ☐ Life
		☐ Employee & Child(ren)	
		☐ Dual Spouse	

SECTION C: DEPENDENT INFORMATION (ALL INFORMATION IS MANDATORY) ("A" Add, "C" Change, "D" Delete)

"A"	"C"	"D"	First Name, Last Name, M.I.	Census #	Social Security Number	Date of Birth	Gender	Grand-Child
☐	☐	☐	Spouse:				M F	Y N
☐	☐	☐	Child:				M F	Y N
☐	☐	☐	Child:				M F	Y N
☐	☐	☐	Child:				M F	Y N
☐	☐	☐	Child:				M F	Y N

If dependent coverage is elected, a photocopy of the Birth Certificate and Social Security card for each dependent must be submitted within 31 days from date of enrollment.

SECTION D: OTHER INSURANCE

Is there any other Group Insurance for you or your family members? ☐ **Yes** ☐ **No**
If yes, please list individuals covered and what type of coverage.

Employer Name: __________ **Insurance/TPA Carrier:** __________
Individuals Covered: ☐ Employee ☐ Spouse ☐ Child(ren) **Effective Date** ____/____/______

Type of Coverage: **Contract Holder Name:** __________
Employee: ☐ Medical ☐ Dental ☐ Vision **Contract Holder Date of Birth:** ____/____/______
Spouse: ☐ Medical ☐ Dental ☐ Vision
Child(ren): ☐ Medical ☐ Dental ☐ Vision **Plan/Policy Number:** __________

SECTION E: DISCLAIMER INFORMATION

I represent that all answers given are full, complete and true to the best of my knowledge, information and belief.
AUTHORIZATION TO RELEASE INFORMATION: For claim purposes, I give my permission to: any physician or other medical practitioner, hospital, clinic, pharmacy, insurance company, reinsurer, or any other drug organization to give my employer or HMA, LLC. all information on my behalf including findings on medical care, dental care, alcohol or drug abuse information, psychiatric or psychological care or examination, or surgery, as they apply to me or my dependents who are to be covered. I know that I have a right to a copy of this authorization. A photocopy will be as valid as the original.
AUTHORIZATION FOR PAYROLL DEDUCTION: I hereby authorize my Employer to deduct any health, life and disability insurance premium from my paycheck.

Employee Signature: __________ **Date:** ____/____/______

FOR HR USE ONLY – DO NOT WRITE BELOW THIS LINE

Annual Salary: | **Date of Hire:** | **Effective Date:** **Health:** ____ **Life:** ____ **Disability:** ____

Employer/Administrator Signature: __________ **Date:** ____/____/______

White Copy – HMA   Yellow Copy – Human Resource   Pink Copy – Employee   ENRL_FT_068_V_0_1

Section A: Qualifying Event

Employee (left)

- Must make proper selection based on the qualifying event
- New Hire or Open Enrollment, etc.

Dependent (right)

- If the add/delete dependents is selected you must provide the date of the qualifying event; if not provided this form is incomplete and returned back to HR representative

Section B: Employee Information

- Ensure that the Employer Name/Location is clearly indicated;
- Employee Census #: if the employee is Native American, providing this number helps HMA process claims properly for visits to federally funded healthcare facilities;
- The phone number and/or email address is beneficial for member outreach and communications;
- Martial Status: If marriage or common law is selected proof of legal documentation must be provided which is the responsibility of HR to obtain and validate;
- Coverage Selected: If dual spouse is selected, Section D: Other Insurance, must be completed;
- Coverage Desired: Select all lines of coverage since the benefit is offered as a package.

Section C: Dependent Information

- Proof of eligibility documentation must be furnished to the employer to verify marriage and dependent eligibility within thirty-one (31) days from enrollment;
- Ensure one box is selected Add/Change/Delete;
- Census #: If the dependent is Native American, providing this number allows HMA to process federal funded healthcare facility claims properly;
- Social Security Number: This is a **mandatory** field and the dependent(s) with missing SSN will **not** be enrolled and a copy of the form will be returned back to HR;
- Date of birth must be accurate and verified with birth certificate
- Newborn may be assigned a temporary SSN of 999-99-9999 until such time an SSN is assigned by SSA; all efforts must be made to obtain the SSN from the employee to complete enrollment

Section D: Other Insurance

- A selection of Yes or No **must** be indicated;
- This section is completed if the member and/or dependents have other health insurance coverage other than I.H.S. or Medicaid;
- This section should be completed in it's entirety to allow HMA to coordinate benefits properly;
- If a copy of the ID card for the other coverage is available, please attach it with the enrollment form.

Section E: Disclaimer Information

- Employee signature and date is required for all changes other than the following:
  - Termination of employment;
  - Address change;
  - Salary update.

For HR Use Only

- Annual Salary: This is required to calculate life insurance premiums;
- Date of Hire: This is the date the employee begins their regular status employment (not temporary);
- Effective Date:
  - Health - The first of the month following a 60 day waiting period or the date of a qualifying event;
  - Life – The date of eligibility;
  - Disability (employee only) – The date of eligibility;
- Employer/Administrator Signature: This is a required field and if not complete, it will be returned back to HR

Enrollment Form Key Points

- Make sure the enrollment form is completed in its entirety, legible and you include:
  - Employer ID
  - Effective date of enrollment or the termination and reason for termination
  - Effective date of full-time hire
  - SSN
  - Census number, if applicable
  - Employee member's salary
  - Other insurance

New ID Cards 2019

NAVAJO NATION EMPLOYEE BENEFIT PLAN

Plan #: 710000 Employer #: ##AltIns ID##

Employee Name: ##emp_full##
Employee ID: ##employee_id##

Member Services: (888) 479-2000
Pharmacy Help Desk: (888) 886-5822
TTY: (800) 900-6570
RxBIN: 008878 RxGRP: HMATPA
Pharmacy Copays: Generic $20 / Brand $40/ Non-Preferred $70

WellDyneRx
www.welldynerx.com

Each Person is a Cardholder, Replace Last 2 Digits with Code

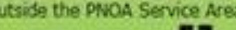
##Dep1 Poode##Dep1 Full Name##
##Dep2 Poode##Dep2 Full Name##
##Dep3 Poode##Dep3 Full Name##
##Dep4 Poode##Dep4 Full Name##
##Dep5 Poode##Dep5 Full Name##
##Dep6 Poode##Dep6 Full Name##
##Dep7 Poode##Dep7 Full Name##
##Dep8 Poode##Dep8 Full Name##
##Dep9 Poode##Dep9 Full Name##
##Dep10 Poode##Dep10 Full Name##
##Dep11 Poode##Dep11 Full Name##
##Dep12 Poode##Dep12 Full Name##

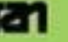
This card is intended for use by the insured individual named hereon and any eligible dependents. CARD POSSESSION DOES NOT CERTIFY ELIGIBILITY FOR BENEFITS.

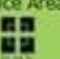
For Benefits, Eligibility, Claims and Pre-Certification, please call:
(928) 634-2216 or (800) 448-3585

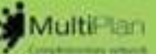
(Failure to contact HMA for Pre-Certification of certain services may result in a reduction of benefits or no benefits payable.)

SEND CLAIMS TO: HMA, Attn: Navajo Nation Employee Benefit Plan
P.O. Box 22009, Tempe, AZ 85285-2009
www.hmatpa.com









Enrollment Forms

- Send all completed enrollment forms to the Enrollment Department at HMA via:
  - Mail: 1600 West Broadway Rd., Suite 300
    Tempe, AZ 85282
  - Phone: (888) 811-8944
  - Fax: (866) 814-3854
  - E-mail: enrollment@hmatpa.com

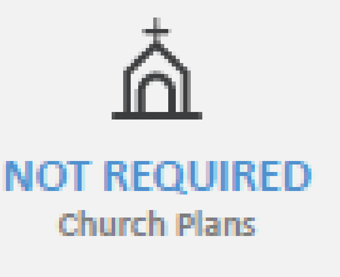
INFINISOURCE
BENEFIT SERVICES

COBRA COMPLIANCE OVERVIEW

WHO MUST COMPLY

© 2018 Infinisource Benefit Services

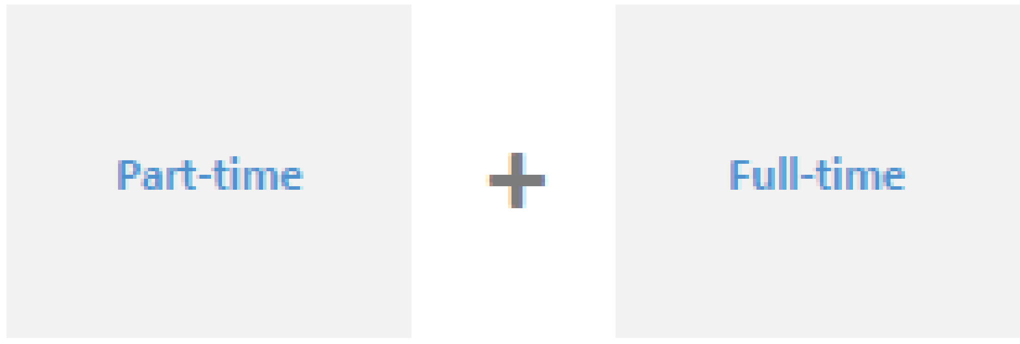
WHO MUST COMPLY



Refer to Plan Document, page 74

EMPLOYEE COUNT

When counting employees, employers MUST include:



Regardless of their eligibility for the group health plan

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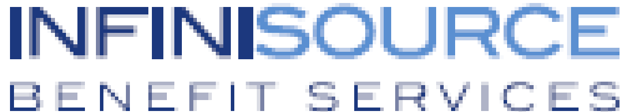
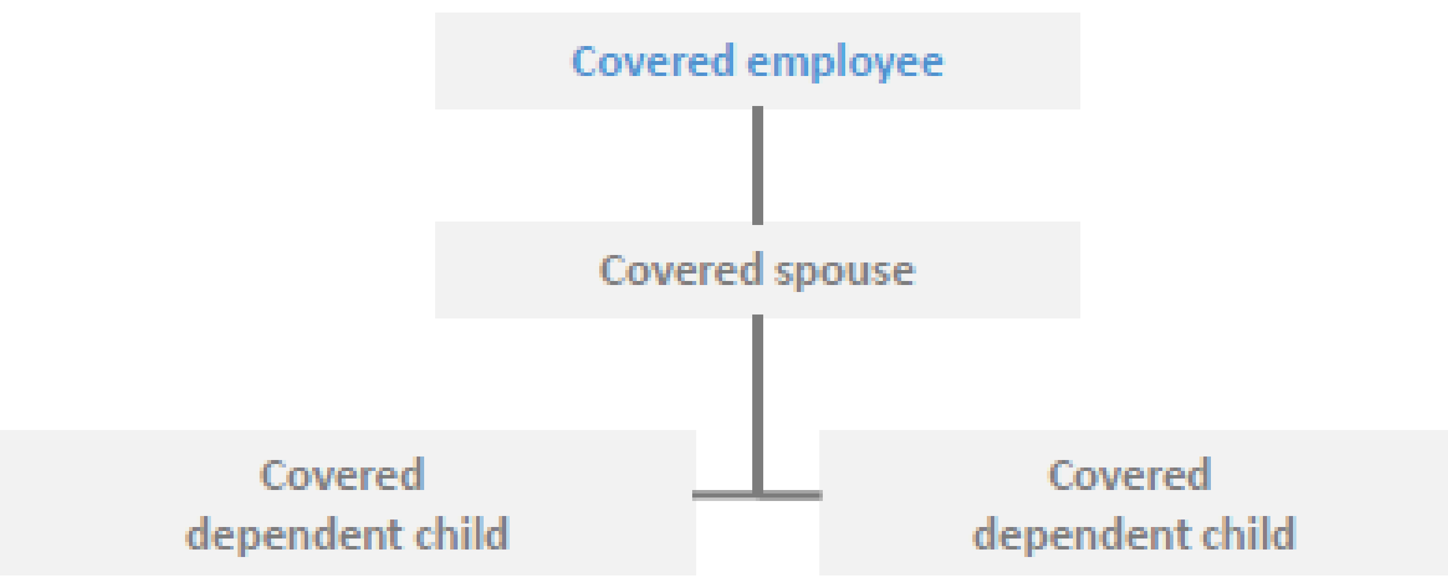


QUALIFIED BENEFICIARIES

© 2018 Infinisource Benefit Services

QUALIFIED BENEFICIARIES



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QUALIFYING EVENTS

© 2018 Infinisource Benefit Services

EVENT

+

LOSS OF COVERAGE

=

COBRA QUALIFYING EVENT

© 2018 Infinisource Benefit Services

18-MONTH QUALIFYING EVENTS

- Voluntary termination
- Involuntary termination
  (gross misconduct exception)
- Reduction of hours
  (strike, layoff, leave of absence, loss of full-time status under ACA)

Refer to Plan Document, page 75

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36-MONTH QUALIFYING EVENTS

- Death of the employee
- Medicare entitlement
- Divorce or legal separation
- Dependent child ceasing to be a dependent

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- Voluntary termination
- Involuntary termination
- Reduction of hours
- Death of the employee
- Medicare entitlement

Employer's responsibility to submit TIMELY notification to the Plan through the submission of a Termination form.

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EMPLOYEE OR OTHER QUALIFIED BENEFICIARY

must inform the employer of:

- Divorce or legal separation
- Dependent child ceasing to be a dependent
- Social Security disability
- Secondary events

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COBRA COVERAGE

© 2018 Infinisource Benefit Services

COBRA COVERAGE

COBRA applies to:

Medical
Pharmacy
Dental
Vision

COBRA does not apply to:

Life insurance
Disability
HSAs
Long-term care plans

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NOTICES

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QUALIFYING EVENT ELECTION NOTICE

- To inform Qualified Beneficiaries of their right to elect COBRA
- Sent with PROPER language, generally within 44 days
- Sent by first class mail to employee and spouse (documentation of mailing recommended)

Notifications are handled by Infinisource once HMA sends a file of newly hired or added members to the Plan.

© 2018 Infinisource Benefit Services

- Sent to all COBRA Continuees
- To inform Continuees of a plan change (benefits, rates, etc.)
- Sent within 60 days after the change has been adopted by the plan

Notifications are handled by Infinisource once HMA sends notification of changes to benefits and rates.

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NOTICE OF EARLY TERMINATION

- If an individual is terminated from COBRA prior to the end of the 18, 29 or 36 month period:
  - A notice must be sent explaining why the coverage was terminated, and
  - Rights to any other coverage they might have

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ELECTION PERIODS AND TIME FRAMES

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44 DAYS	60 DAYS	45 DAYS	30 DAYS
Notice from ER/PA to Qualified Beneficiaries	COBRA Election Period	Retroactive Premium Payment Period	Prospective Premium Payment Period

© 2018 Infinisource Benefit Services

Loss of Coverage date

Date of Election

All retroactive Premiums due

JANUARY 31

APRIL 5

MAY 3

© 2018 Infinisource Benefit Services

Qualified Beneficiaries entitled to
18 months of COBRA coverage
from the loss of coverage date

JANUARY 15, 2017

Employee quits

JANUARY 31, 2017

Qualifying event date and loss of coverage date

JULY 31, 2018

COBRA expires

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COBRA ENDING EVENTS

© 2018 Infinisource Benefit Services

AT THE END OF 18 MONTHS

- Voluntary termination
- Involuntary termination
- Reduction of hours

© 2018 Infinisource Benefit Services

AT THE END OF 29 MONTHS

- Social Security disability determination
  - Voluntary termination
  - Involuntary termination
  - Reduction of hours

© 2018 Infinisource Benefit Services

AT THE END OF 36 MONTHS

- Employee death
- Divorce or legal separation
- Dependent ceasing to be a dependent
- Medicare entitlement

© 2018 Infinisource Benefit Services

COBRA TERMINATES

-FOR FAILURE TO MAKE TIMELY PAYMENT*

-After the date you elect COBRA you become covered by another group health plan

-After the date you elect COBRA, you become entitled to Medicare

-Cancellation of **ALL** group health plans

-First of month 30 days **AFTER** being deemed no longer disabled

**Insignificant premium payment*

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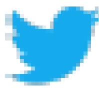
INFINISOURCE
BENEFIT SERVICES

www.infinisource.com

Follow us!



We will continue in 15 minutes…

Navajo Nation Retirement Services

Delphine Martinez – NN Retirement Services

Retirement Officer

We will reconvene at 1:00 p.m.

Enjoy…

EMPLOYEE ASSISTANCE PROGRAM

Enterprise and LGA Chapter
Benefit/Human Resource
Representative
Work Session

Albuquerque, NM

February 27, 2019

What is Employee Assistance Program (EAP)?

It is a prepaid benefit program that provides free confidential and comprehensive counseling services to support the wellness, safety and efficiency of Navajo Nation employees, Enterprise, and Chapter employees and their immediate family members

EAP

It provides consultation and guidance to Supervisors, Program Managers, and Personnel as they address individual employee performance issues, behavioral issues, group work effectiveness and organizational challenges

Mission Statement

The EAP is committed to making a positive impact in the workplace and to help Navajo Nation employees and their immediate family members who may develop social, behavioral or health related problems that could affect their work performance.

What are the objectives of the EAP?

- assists to reduce issues in the workplace
- retain our valued employees

Confidentiality

- Confidentiality is maintained in accordance with Navajo Nation Privacy Act
- Duty to warn - We are required by law to inform third party or authorities if a client threatens him or herself or another identifiable individual.
- We are also required to call authorities if a child or elder has been abused.

TYPES OF REFERRAL

Self Referral

Informal Referral

Formal Referral

Family Referral

Navajo Nation Employee Assistance Program

P.O Box 1360

Window Rock, AZ 86515

Phone: (928) 871- 6530

Mobile: (928) 206-7533

Fax: (928) 871- 6408

rondaroan@navajo-nsn.gov

EAP is located in Administration Building 1 on the 2nd floor in Window Rock, AZ

Monthly Premium Billing

David Appel – HMA
VP, Finance

INVOICE

Group Name: SAMPLE	Group # 7100XX

Invoice Date		Stmt Date	Premium Due Date
From	To		
2/1/2019	2/28/2019	2/15/2019	2/28/2019

CONTACT: Account Payable

Enclosed is the monthly premium billing for the month of February 2019 . This billing also includes any enrollment changes that have occurred since the last billing statement. All payments are due by the last day of the month. It is important that you pay as billed each month.

Please submit all eligibility changes as soon as possible each month. All changes must be received by HMA, LLC. at least 5 working days prior to the end of the month to insure that they are included on next month's premium billing statement.

Billing Summary

Prior month Balance		$	4,498,476.54
Adjustments		$	(8,098.60)
Amount Received	Jan-19	$	(2,763,878.83)
Current Month	Feb-19	$	3,004,350.41
Life premium credit (Jan & Feb)		$	(4,814.66)
Employee Benefit User Fee		$	60,012.27
Total Amount Due		**$**	**4,786,047.13**

`

Please submit all billing payments to:

Navajo Nation Employee Benefit Plan
Cashiers Section
Attn: Roberta Holyan

PO Box 3150
Window Rock, AZ 86515

If you have any questions regarding your billing statement, please call HMA Finance Department at (480)-921-8944.

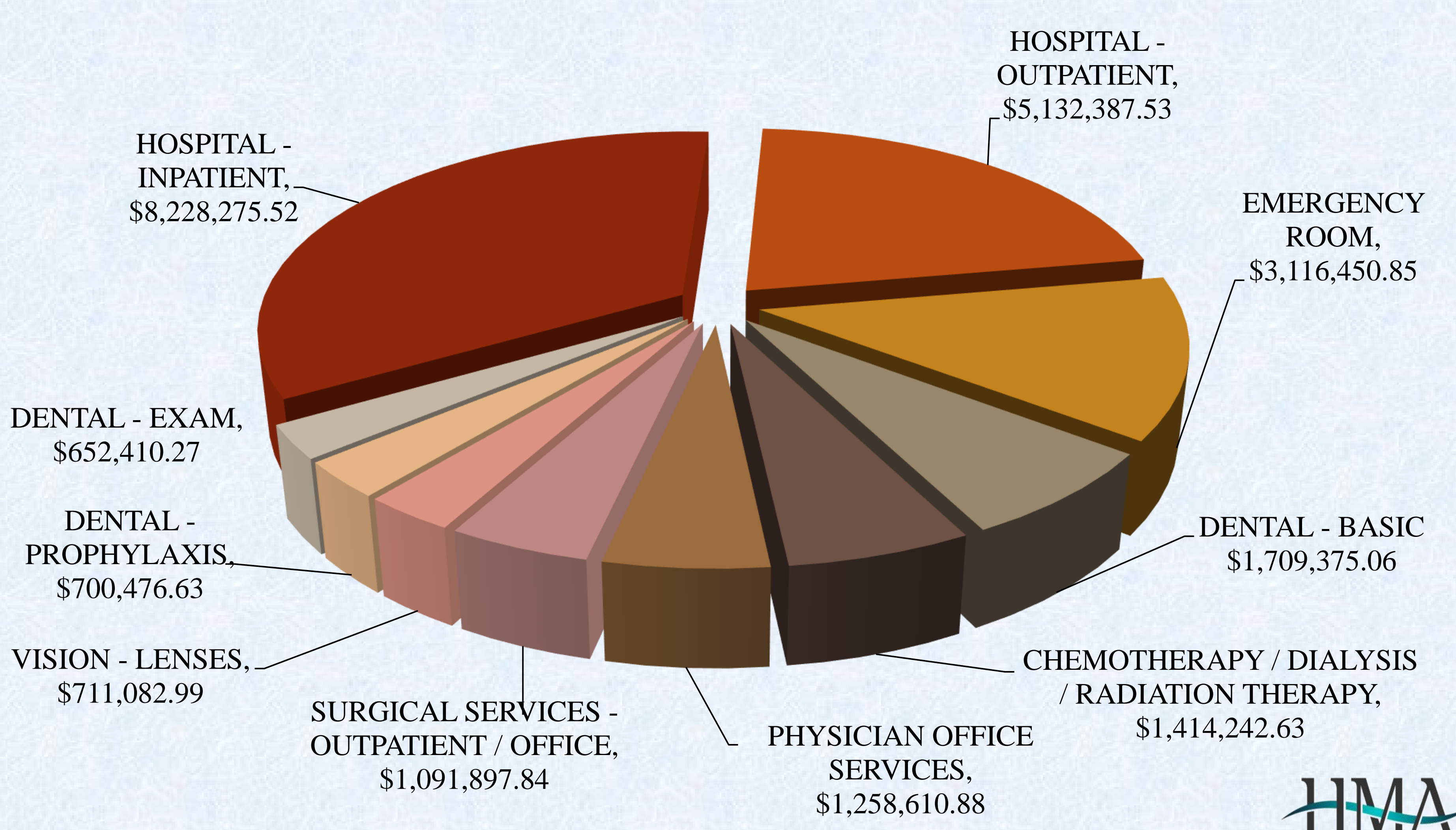
Billing Detail

transaction	location id	member name	member id	group	year month	gender	cc	sc	life amount	employee rate	dependent rate	emp. agg amt	dep. agg amt	employee life	dependent life	admin fee	pcori fee	Total
CURRENT	Sample	Sample	Sample	ACTIVE	201902	M	E	1	125000	8.48	-	329.35	-	37.45	-	21.24		396.52
CURRENT	Sample	Sample	Sample	ACTIVE	201902	F	F	1	125000	8.48	18.24	329.35	509.27	37.45	3.16	21.24		927.19
CURRENT	Sample	Sample	Sample	ACTIVE	201902	M	E	1	125000	8.48	-	329.35	-	37.45	-	21.24		396.52
CURRENT	Sample	Sample	Sample	ACTIVE	201902	M	E	2	90000	8.48	-	329.35	-	26.96	-	21.24		386.03
CURRENT	Sample	Sample	Sample	ACTIVE	201902	M	E	1	125000	8.48	-	329.35	-	37.45	-	21.24		396.52
CURRENT	Sample	Sample	Sample	ACTIVE	201902	M	E	1	125000	8.48	-	329.35	-	37.45	-	21.24		396.52
CURRENT	Sample	Sample	Sample	ACTIVE	201902	M	E	2	90000	8.48	-	329.35	-	26.96	-	21.24		386.03
CURRENT	Sample	Sample	Sample	ACTIVE	201902	F	E	2	90000	8.48	-	329.35	-	26.96	-	21.24		386.03
CURRENT	Sample	Sample	Sample	ACTIVE	201902	F	EC	2	90000	8.48	18.24	329.35	509.27	26.96	3.16	21.24		916.70
CURRENT	Sample	Sample	Sample	ACTIVE	201902	M	E	2	90000	8.48	-	329.35	-	26.96	-	21.24		386.03
CURRENT	Sample	Sample	Sample	ACTIVE	201902	M	E	3	80000	8.48	-	329.35	-	23.97	-	21.24		383.04
CURRENT	Sample	Sample	Sample	ACTIVE	201902	F	E	1	125000	8.48	-	329.35	-	37.45	-	21.24	-	396.52
	Current Total									**101.76**	**36.48**	**3,952.20**	**1,018.54**	**383.47**	**6.32**	**254.88**	**-**	**5,753.65**
ADJUSTMEI	Sample	Sample	Sample	ACTIVE	201901	F	F	1	125000	8.48	18.24	329.35	509.27	37.45	3.16	21.24		927.19
ADJUSTMEI	Sample	Sample	Sample	ACTIVE	201901	F	EC	2	90000	8.48	18.24	329.35	509.27	26.96	3.16	21.24		916.70
ADJUSTMEI	Sample	Sample	Sample	ACTIVE	201901	F	E	2	90000	(8.48)	-	(329.35)	-	(26.96)	-	(21.24)		(386.03)
	Adjustment Total									**8.48**	**36.48**	**329.35**	**1,018.54**	**37.45**	**6.32**	**21.24**	**-**	**1,457.86**

Utilization Reports/Benefit Categories/ Form 1094 & 1095

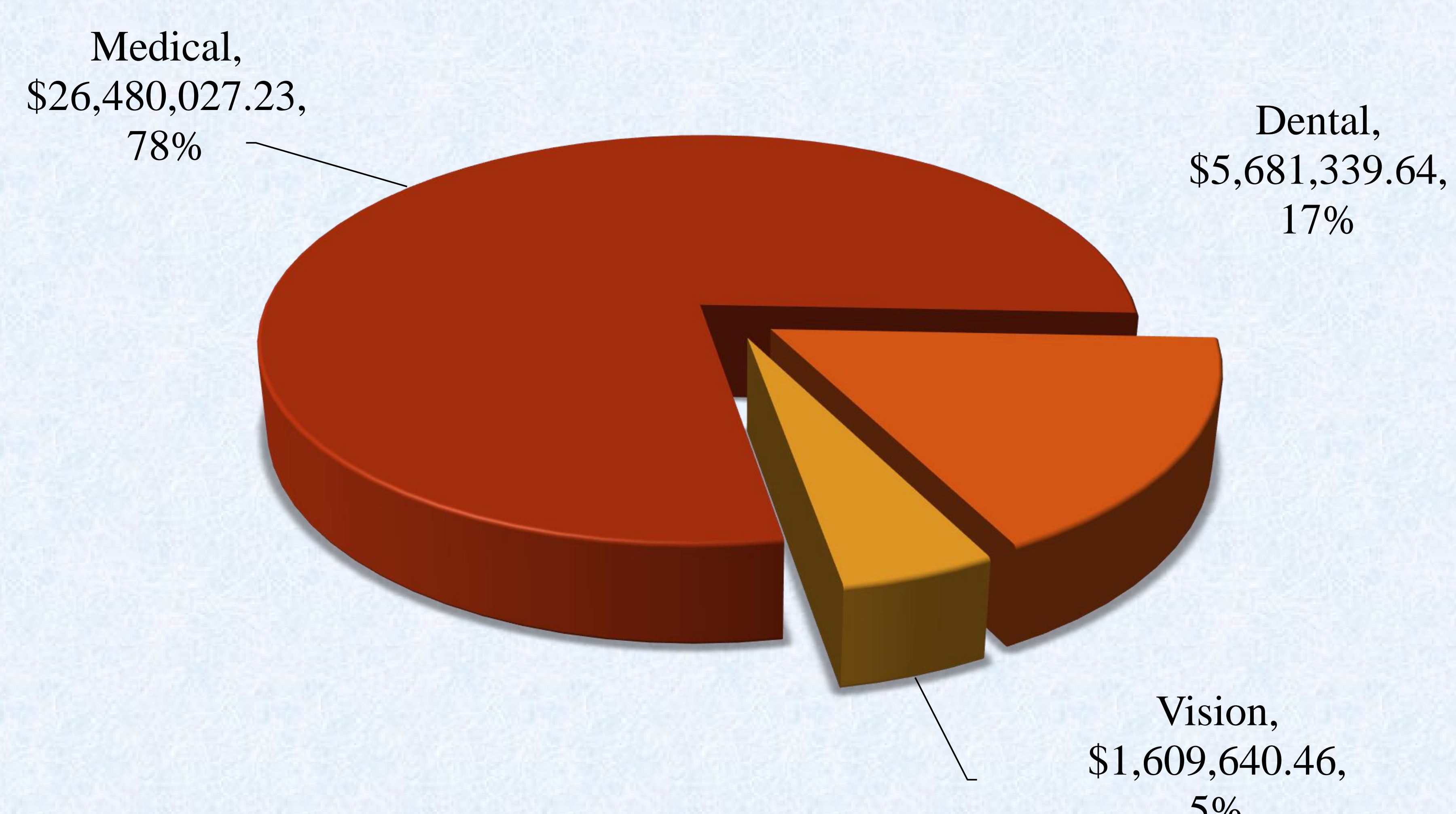
David Appel – HMA
VP, Finance

2018 Top 10 Benefit Categories by Paid Amounts

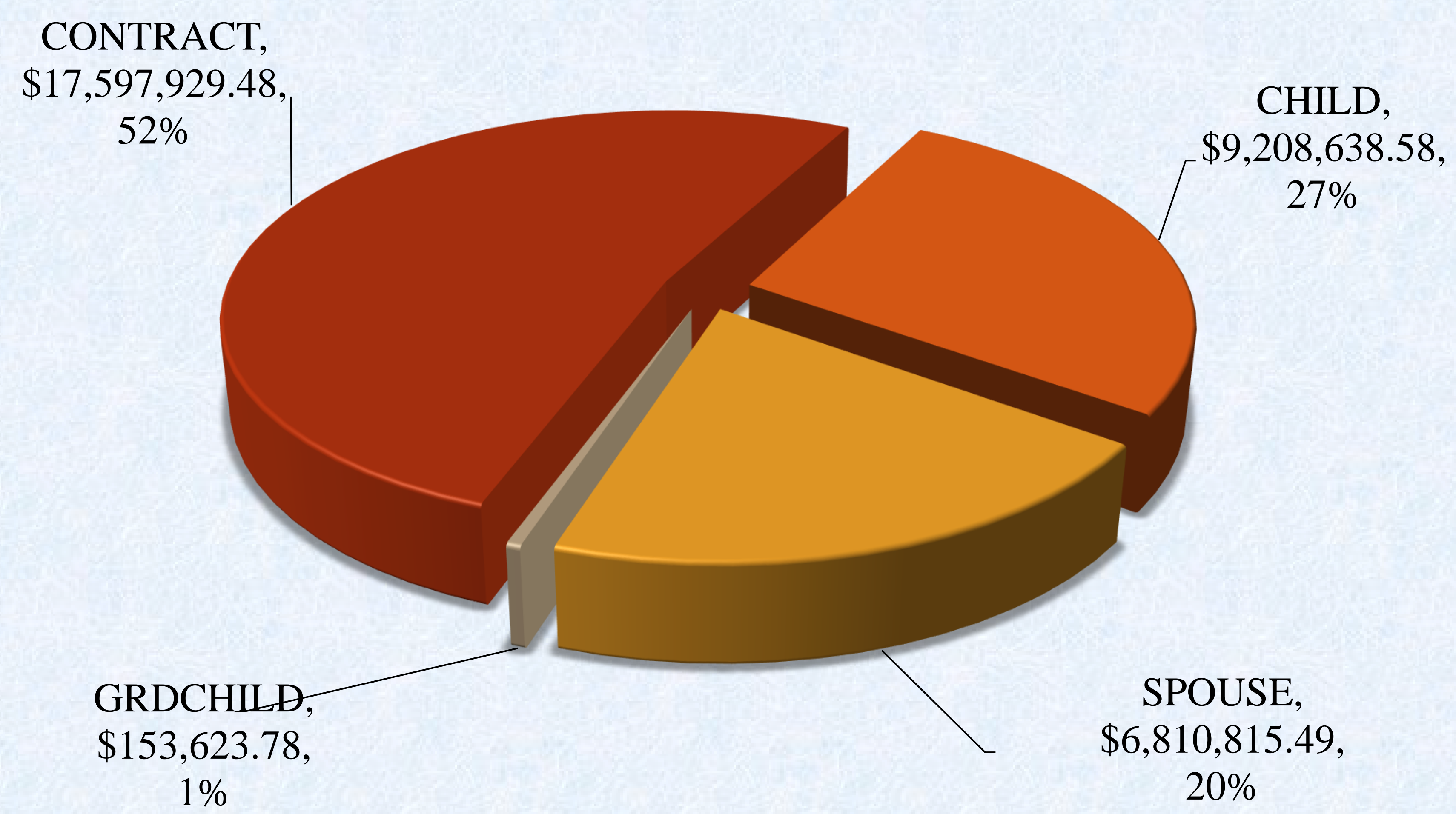


HMA
HAWAII - MAINLAND ADMINISTRATORS

2018 Claims Paid by Line of Coverage



2018 Plan Utilization By Member Type



IRS form 1094 & 1095's

- Form 1095-B (Transmittal of Health Coverage Information Returns) will be filed by insurance companies & TPA's to report individuals covered by insured employer-sponsored group health plans.
- Form 1095-C (Employer-Provided Health Insurance Offer and Coverage) and Form 1094-C (Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns) will be filed by applicable large employers (more that 50 FTE's).
- 1095 forms for 2018 must be sent out by March 4, 2019
- Employee's do not need to wait to receive the form before filing their taxes

Short Term Disability

David Appel – HMA
VP, Finance

Short Term Disability

- Short Term Disability benefits are available to "covered employee members only" beginning on their date of hire.
- If as a result of a non-occupational injury or illness the covered employee member becomes totally disabled, short term disability benefits will be paid following any applicable waiting periods, subject to all requirements, conditions that apply to qualification for and continuance of payment for the benefit.

Short Term Disability Benefits

Waiting Period	Accident – None Illness – 7 days
Weekly Benefit Amount	60% of weekly wage $400 maximum per week
Maximum Benefit Period	Up to 52 weeks per period of disability

Short Term Disability (continued)

- A covered employee member qualifying for short term disability benefit payments must:
  - Be totally disabled while covered under the benefits and must remain covered by these benefits continuously throughout the waiting period;
  - Be under a physician's care;
  - Exhaust all available sick leave (if employer does not have sick leave accrual, then the sick leave exhaust date must be the last day worked); and
  - Satisfy the requirements for filing a claim.

Short Term Disability (continued)

- The covered employee member must obtain and complete the short term disability claim form with all details of the extent and nature of the disability for which the claim is being filed;
- The claim form must be returned to their HR department;
- The covered employee member must file the claim within 31 days after the employee member ceases to be actively at work;
- A proof of claim must be submitted to the their HR department within 90 days after the waiting period.

Short Term Disability (continued)

- The short term disability claim form is submitted/faxed to the STD coordinator at HMA (1-866-814-3852) via the Plan Administrator or their HR department;
- The STD coordinator reviews the claim form and determines if claim was submitted within 31 days;
- If claim was submitted past 31 days, a denial letter is sent to the covered employee member and the Plan Administrator or their HR department.

Short Term Disability (continued)

- If the claim was submitted within 31 days, the STD coordinator determines whether the claim is a maternity claim, an illness, or a non-occupational injury claim;
- If claim is for maternity leave, the STD coordinator will approve for appropriate timeline for the disability up to a maximum of six weeks from date of delivery.

Short Term Disability (continued)

- If the claim is for an illness or an injury, the STD coordinator sends the claim to our Health Services department for review;
- Health Services department will review the disability and make a determination of the claim;
- If the claim is approved, timelines are included with the approval;
- Upon Health Services determination of the claim, the STD coordinator will mail a letter to the covered employee member and the Plan Administrator or their HR department with the determination of the claim;
- If the claims was approved, the STD coordinator will calculate the payment that will be made to the covered employee member and send an approval letter.

Short Term Disability (continued)

- The payment to the member is 60% of the employee member's weekly wage, not to exceed $400.00 per week;
- If the disability lasts part of a week, the Plan pays one-seventh (1/7) of the amount that is otherwise payable for that week for each day of disability;
- Payments are processed and paid every two weeks;
- Benefits are taxed and reported on a W-2 at the end of the year.

Short Term Disability: Termination of Benefits

The total disability ends;

- The maximum benefit period ends;
- The covered employee member fails to provide the required proof of disability;
- The covered employee member refuses to submit to a medical examination by a physician that the Plan Administrator requires;
- The covered employee member is no longer under the care of a physician;
- The covered employee member becomes eligible for any other group short term disability income plan;
- The covered employee member has a loss of life; or
- The date the covered employee member's coverage ends.

(Inter-office Use Only)

Total Paid ______________________

# of Days______________

(Inter-Office Use Only)

__________ Opened

__________ Closed

__________ Reopened

__________ Closed

Navajo Nation Employee Benefits Program

Report by Employer of Leave Status for Employee

Member ID ____________________________ (Inter-Office Use Only)

Employee's Name______________________________________ Social Security No_______________

Mailing Address_____________________________ City_________________ State______ Zip_______

Date Last Worked_______________ Date Returned to Work_______________

Date Sick Leave Exhausted_______________

(If Sick Leave is not accrued, date would be the same date as Date Last Worked.)

Date Employee is anticipated to return to work?____________________

Employee must be totally disabled, be under a physician's care for the disability, exhaust sick leave hours, and satisfy all provisions and requirements for filing a claim. A seven (7) day waiting period applies for all non-occupational illness/maternity; no waiting period for a non-occupational injury. All information is subject to verification.

Dept/Prog________________________________ Dept No_____________

Completed by (Print Name)_____________________________ Tele No___________ Date_________

Please attach a current job description for insured employee

09/10

Employee Completes

Addt'l Fed Tax W/H (Automatic 7.65% FICA)

Employer Completes

NAVAJO NATION EMPLOYEE BENEFIT PLAN
PRELIMINARY STATEMENT OF DISABILITY-STD

P.O. Box 2069
Cottonwood, AZ 86326

THIS SECTION TO BE COMPLETED BY EMPLOYEE (Please Print) — Plan Number 710000

Full Name (Last, First, M.I.)	Social Security No.	Date of Birth
Mailing Address	Employer	Home Phone ( )
City	State	Zip
Occupation	Gender ☐ Male ☐ Female	Type of Disability ☐ Accident ☐ Illness ☐ Maternity

Describe how and where accident occurred or list symptoms of illness.

Is your injury or illness related to your work? ☐ Yes ☐ No — Date claim filed with Workers' Compensation Program

Complete if your claim is for an accident:

Date accident occurred____________________________________

How and Where? ____________________________________

Date symptoms first noticed________________________________

Date first treated____________________________________

Complete if your claim is for an illness:

Date symptoms first noticed________________________________

Date first treated____________________________________

List symptoms of illness________________________________

If Workers' Compensation denied your claim, attach copies of denial letter, original claim filed, and Employee's Claim Petition

I have been unable to work because of the disablity since (m/d/yr):	☐ I returned to work Part Time on (m/d/yr)	☐ I returned to work Full Time on (m/d/yr)
Date first treated for illness or injury	Doctor name and address	Hospital name and address

Have you had same or similar conditions in the past? ☐Yes ☐ No	If so, when?	Doctor name and address	Hospital name and address

Describe any other income you are receiving or are eligible to receive as a result of your disability: (Examples: Social Security, Workers' Compensation, State Disability, Pension Disability, etc.)

Describe Source	Amount of Income	Date Income Began	Date Income Ended

If your request for benefits is approved do you want us to withhold amounts from each benefit check for Federal Income Tax purpose? ☐ Yes ☐ No

If "yes", enter amount $__________ (Amount per week $20.00 minimum) __________ Signature

AUTHORIZATION TO RELEASE INFORMATION- Must be signed and dated to validate the claim.

To: Any licensed physician, medical practitioner, hospital, clinic, or other medical related facility, insurance company, employer, or consumer reporting agency.

(1) I authorize you to release the following to HMA, Inc., their reinsurers, or any consumer reporting agency on their behalf for purposes of determining disability benefits: full information, including copies of records, concerning medical examinations, history and treatment, occupation, income, and financial status.

(2) I have a right to receive a copy of this authorization upon request. A photocopy of this authorization shall be considered as valid as the original. This authorization shall be valid for a period of one year from the date of signature.

DATE____________ SIGNATURE OF EMPLOYEE________________________

THIS SECTION TO BE COMPLETED BY EMPLOYER (Please Print)

Employee's Name	Last Day Worked	Reason for Stopping Work	Date Returned Full Time	Date Returned Part Time

Date Hired	Occupation at Time of Disability	Work Schedule at Time of Disability Days/wk: Hrs/day:	Basic Annual Earnings as of Last Day Worked $

By any Employer-Employee, Labor Management, Union Welfare Plan or any State Disability, will (or has) Employee file(d) for Unemployment Compensation or for Disability provided? ☐Yes ☐No If yes, please specify:

Is Employee eligible for Workers' Compensation? Amount $ Carrier ☐Yes ☐No

Employer Address

Telephone	Title	Date	Signature

Physician Completes

Verify non-occupational

Length of Disability

Limitation of Work Duty

Licensed Physician (MD)

NAVAJO NATION EMPLOYEE BENEFIT PLAN
PRELIMINARY STATEMENT OF DISABILITY – STD

PO BOX 2069
COTTONWOOD, AZ 86326

ATTENDING PHYSICIAN'S STATEMENT OF ACCIDENT OR ILLNESS

1. Patient's Name | Date of Birth

2. Nature of injury or illness (Describe complications, if any):

3. When did accident happen or symptoms first appear? (m/d/yr)

4. When did patient first consult you for this condition? (m/d/yr)

5. Is condition due to injury or sickness arising out of patient's employment?
Yes No If yes, explain:

6. Has patient ever had same or similar condition?
Yes No If yes, state when and describe:

7. Describe any other disease or infirmity affecting present condition:

8. Date and nature of surgical or obstetrical procedure, if any. Describe fully:

9. Give dates of treatment:
OFFICE________________
HOME________________
HOSPITAL________________

10. If patient is hospitalized give name and address:
HOSPITAL________________
ADDRESS________________
CITY, STATE, ZIP________________
Date admitted__________ Date Discharged__________

11. How long was or will patient be continuously totally disabled. (Unable to work)?
From__________20____Through__________20______

12. How long was or will patient be partially disabled?
From__________20____Through__________20______

13. If due to pregnancy:
LMP Date__________EDC Date__________
Date Delivered:________________
Complications, if any:

14. Is this patient competent to endorse checks and direct the proceeds with a clear understanding of the nature of his/her acts? Comments.
Yes No

(*As defined in Federal Dictionary of Occupational Titles)

Class 1 - No limitation on functional capacity; capable of heavy work* No Restrictions. (0-10%)
Class 2 - Medium manual activity* (15-30%)
Class 3 - Slight limitation of functional capacity; capable of light work* (35-55%)
Class 4 - Moderate limitation of functional capacity, capable of clerical/administrative (sedentary*) activity. (60-70%)
Class 5 - Severe limitation or functional capacity; incapable of minimum (sedentary*) activity (75-100%)

REMARKS:

Attending Physician's Name (Please Print) | Degree

Mailing Address | City | State | Zip

Telephone ( ) | Date | Signature

We will continue in 30 minutes…

Appeals/Grievances/Third Party Liability/Subrogation/Coordination of Benefits

Jody Harris – HMA

Senior Manager ,Claims

Appeals/Grievances

- When a covered member is not satisfied with the way a claim was processed, the covered member, his/her authorized representative, or health care provider has the right to appeal the processing of the claim.
- The appeal must be submitted in writing within 180 days of the date on the Explanation of Benefits (EOB) requesting the reconsideration of the claim in question.
- They should submit any other documentation or facts that will assist in the review of their appeal.
- The Grievance, Appeals and Disputes (GAD) department is responsible for all appeals received at HMA and is responsible for managing all communications between the plan and the party filing the appeal.

Third Party Liability/Subrogation Rights

- The NNEBP is at risk for paying claims that may be eligible for reimbursement by a third party. In order to minimize the amount Plan spends on claims that may be subject to third party payments, the NNEBP has Subrogation Rights/Right to Reimbursement provision within the Plan Document.
- The provision allows for recovery of payments made by the Plan for claims that are a result of an injury or illness caused by a third party.

Third Party Liability/Subrogation Rights (continued)

What is considered a third party? Here are some examples:

- Auto Insurance – An injury that occurred from a motor vehicle accident.
- Medical Malpractice – Misdiagnosed illness or improper medical treatment.
- General Liability Insurance – An injury/illness on commercial property or an acquaintance/friends house.
- Products – An injury/illness caused by a product.

Third Party Liability/Subrogation Rights

- The identification of potential TPL is based on a series of diagnosis codes that indicate motor vehicle accidents (MVAs), non-MVA accidents, poisoning, assaults, and product liability, etc.
- The claim is marked that the condition is related to an auto accident or other accident;
- Medical records indicate such;
- Claims are then reviewed to determine the potential third party liability;
- Upon notification of potential TPL, a TPL questionnaire and lien/loan agreement are sent to the member

Coordination of Benefits (COB)

- A member indicates on their enrollment form there is other coverage;
- A claim is marked for other coverage by the provider;
- The claim is submitted with the EOB from the primary coverage then the claim is processed as secondary;
- The claim is submitted without the EOB from the primary coverage then the claim is denied requesting this information;
- A COB questionnaire is sent to the member requesting the primary coverage information;
- Once the questionnaire has been returned the member’s file is noted so future claims will be processed accordingly

Health Services (Pre-Authorization/Case Management)

Jody Harris – HMA
Senior Manager, Claims

Health Services Functions

- Prior Authorization
- Concurrent Review
- Discharge Planning
- Retrospective Review
- Care Coordination
- Case Management
- Short Term Disability Review
- Special Case Claim Review

How We Work

- Team of Staff
  - Prior Auth Techs
  - Nurses
  - Physician Advisors
- Information Received via Fax, Internet
- Clinical Decision Support Criteria
- Approvals and Denials

Goals – Health Services

- To work with the members, providers, facilities, and community to coordinate, monitor, and evaluate options and services to meet an individual's health care needs.
- Empower the membership with the tools and resources to take care of themselves
- Create a culture of wellness

Goals – Case Management

- Engagement
- Participation
- Successful Clinical Outcomes

Objectives

- To provide a system for monitoring and evaluating the:
  - Medical necessity
  - Appropriateness
  - Timeliness
  - Efficiency and
  - Cost effectiveness of the care and services provided to the membership.

Prior Authorization

- Inpatient and Outpatient services
- Determined by Group
- List is in Plan Document
- Member has ultimate responsibility
- Penalties for No Prior Authorization
- In-Network versus Out-of-Network
- Indian Health Services (IHS) and other federally-funded healthcare facilities

Concurrent Review

- Inpatient Hospital Stays
- Work with Hospital Case Manager
- Consult with Physicians
- Decision Support Criteria
- Discharge Planning begins at Admission

Retrospective Review

- Occurs when Provider or Member fail to prior authorize services that require medical review
- Extenuating circumstances may be a factor and are considered
- Penalty is usually applied

Discharge Planning

- Member / Family Outreach (before, during, after hospitalization)
- Utilize preferred Home Care and Durable Medical Equipment (DME) Companies
- Services often not covered by IHS
- Post Discharge follow up calls
- Opportunity for “teachable moment”

Care Coordination

- Collaborative process to promote quality cost effective outcomes
- Identifying best practices to assist member with decisions regarding care
- Awareness and Availability of resources
- Communication
- Evaluation of effectiveness of interventions

Case Management

- Proactive member outreach based on "trigger list"
- Assistance with "best utilization" of benefits
- Motivational coaching
- Member empowerment
- Protect Privacy

Health Claim Processes/Member Reimbursement/Explanation of Benefits

Jody Harris – HMA
Senior Manager, Claims

Angelina Lozano - HMA
Claims Manager

Claim submission process

- Provider submits a HCFA 1500 (physician charges), ADA (dental charges) or UB (facility charges) claim form for potential reimbursement.
- Member submits a receipt for potential reimbursement on services paid directly to the provider.

Claim received in Tempe office

- The claim is date stamped, scanned and then data entered into the claims data base.
- The claim will go through validation edits to check for the following:
  - Is member eligible on the plan?
  - Is the diagnosis and procedure codes valid?
  - Does member I.D. and date of birth billed on the claim match the enrollment?

Invalid claim information

- If the claim is not submitted with valid information the claim is sent to a data correction queue.
- The data correction Supervisor conducts a thorough review of the of claim.
- If the data is invalid the claim is rejected and written notification is sent to the provider.
- If the data is valid the claim will continue to next step in the adjudication process.

Claims process

- Claims that do not require manual intervention will be automatically processed by the system (auto adjudicate).
- Claim that require manual intervention will be assigned to a claims processor for review.
  - I.H.S. involvement
  - E.R. claims
  - Inpatient claims

Traditional Healing Claims

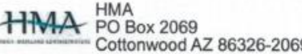
- Member obtains a traditional healing claim form from the benefits office.
- The form is completed by member and the Native Traditional Practitioner must sign and date the form.
- The original copy is submitted to the benefits office.
- The information is validated by the benefits office and the claim is sent to HMA for reimbursement.
- All reimbursements are sent directly to the policyholder unless the services were received by the spouse or a dependent over age 18.

Funding process

- Claims which have completed adjudication are set in a payment batch every Friday.
- A prepayment register is generated.
- Prepayment register is sent to the Navajo Nation for review and approval for funding.
- Once the prepayment register has been approved it is released to generate the reimbursement checks and explanation of benefits (EOB).

Explanation of Benefits (EOB)

- For provider reimbursements: a check and EOB will be sent to the provider and an EOB is sent to the member.
- For member reimbursements: a check and EOB will go to the member.



HMA
PO Box 2069
Cottonwood AZ 86326-2069

Provider Explanation of Benefits

[EP-EP]

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

Forwarding Service Requested

J1D1 1

DR. SAMPLE
123 MAIN STREET
ANYTOWN CA 12345

Customer Service

For Claims Inquiries:
LOCAL (928)634-2216
TOLL FREE (800)448-3585
FAX (866)293-9649

Plan: GROUP ABC
P.O. BOX 22009
TEMPE AZ 85285-2009

Provider: DR. SAMPLE
Provider ID: 11111111
Process Date: 05/09/2017

Adjustment to Payments

Beginning Balance: $0.00
Adjustment: $0.00
Ending Balance: $0.00

Zelis™ Payments is our ePayment vendor for expediting payment and remittance transactions, as well as complying with PPACA Section 1104. To sign up for ePayments using ACH or Virtual Payment Cards, as well as electronic remittances (835, Excel, PDF), please visit ZelisPayments.com, email membership@zelispayments.com, or call Zelis Payments Membership Department at 1-877-828-8834.

Patient Name:JOE COMMON

Reference No: 123456789
Account No.: 789
ID No.: 987654321

Line No	Date Of Service From Thru	Remarks	Service Code	Charges	Allowed Charges	Member Liability Ineligible	Co-Pay	Deductible	Co-Ins	Total	Pay To	Plan Pays
001	02/27/2017	4F 4K 5J 6C	99214	$160.00	$130.49	$29.51	$0.00	$129.62	$0.44	$159.57	PR	$0.43
002	02/27/2017	4K 5J 6C	G0442	$21.00	$21.00	$0.00	$0.00	$0.00	$10.50	$10.50	PR	$10.50
003	02/27/2017	4K 5J 6C	G0444	$21.00	$21.00	$0.00	$0.00	$0.00	$10.50	$10.50	PR	$10.50
004	02/27/2017	4K 5J 6C	81002	$10.00	$4.20	$5.80	$0.00	$0.00	$2.10	$7.90	PR	$2.10
005	02/27/2017	WU 4K 5J 6C	3016F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	PR	$0.00
006	02/27/2017	71 4K 5J 6C	G8510	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	PR	$0.00
			TOTAL	$212.00	$176.69	$35.31	$0.00	$129.62	$23.54	$188.47		$23.53

Statement Totals

Charges	Allowable	Ineligible	Co-pay	Deductible	Co-Ins	Total	Plan Pays	Voucher Number
$212.00	$176.69	$35.31	$0.00	$129.62	$23.54	$188.47	$23.53	00001918

Service Code/Description

3016F PHYSICIAN SERVICES - IN OFFICE
81002 LABORATORY - NON-HOSPITAL BASE
99214 PHYSICIAN OFFICE VISITS - SPEC
G0442 ALCOHOL MISUSE SCREENING AND C
G0444 DEPRESSION SCREENING (ROUTINE)
G8510 PHYSICIAN SERVICES - IN OFFICE

Remark Code/Description

4F Deductible not satisfied; member responsibility.
4K Processed in accordance with the plan document/COC
5J This claim was processed without a network contract with your provider.
6C Reimbursement based on reasonable and allowed charges
71 This service is included in the basic service.
WU Item is not reimbursed per fee schedule.