Spousal Medical Coverage Provision

Legacy Health Services' medical coverage contains a "Spousal Coverage" provision. This provision is designed to require other employers to pay their "fair share" of health care costs.

If you are married and your spouse is employed and eligible for healthcare coverage from his/her employer, then he/she is no longer eligible for the Legacy Health Services health plan, unless the cost to obtain the other employer's single coverage is more than $160 per month. This provision also applies to an employee's spouse that has retired and is eligible for health care coverage through his/her former employer.

If your spouse is self-employed and does not have access to group health coverage, or if your spouse is not working or is not eligible for coverage through their employer, then he or she is eligible to participate in the Legacy Health Services health plan. If your spouse must complete a waiting period to enroll for coverage under his/her employer's health plan, during that waiting period he/she will be eligible to participate in the Legacy Health Services health plan.

If your spouse has a change in his or her employment status and becomes eligible for group health coverage, he/she must enroll in that coverage as soon as he/she is eligible. You are responsible for notifying Human Resources within 31 days when this situation occurs.

Note

Every employee (whether married or single) who is eligible for medical insurance is required to complete the Spousal Coverage Questionnaire on the following pages and return it to Human Resources. If the Questionnaire is not returned, your spouse's claims will not be paid until the information is received.

You will need to indicate whether your spouse is eligible for other employer-sponsored health coverage. You will be asked to certify that your spouse has health coverage and to provide information about that coverage, or to certify that his/her employer does not offer health coverage. If you do not respond, provide false information, or fail to notify Human Resources of any required information, you will become personally liable for any benefits paid by Legacy Health Services on behalf of your spouse that would not have been paid had Legacy Health Services had accurate information. In addition, your insurance may be terminated and/or your employment may be terminated.

Spousal Coverage Questionnaire, Page 1

Failure to complete this form will result in a denial of payment of your spouse's healthcare claims and no reimbursement of payroll withholding amounts.

SECTION A – Marital Determination

Legacy Health Services Employee Name _____

Social Security Number _____-_____-_____

Are you married or legally separated (but not yet divorced)? ☐ Yes ☐ No

If NO: Complete Section E of the form and turn it in to Human Resources.
If YES: Complete Section B if your spouse does not have other coverage available.
If your spouse does have other coverage available, complete Section D.
If your spouse is an employee of Legacy Health Services, please complete Section D.

SECTION B – No Other Coverage Available

Spouse's Name _____

Spouse's Social Security Number _____-_____-_____

This is to certify that my spouse does not have the option of other healthcare coverage. Please check the situation that applies.

I _____ My spouse is not employed and does not otherwise have access to a group health plan.

II _____ My spouse is employed/retired and does not have access to a group health plan.

If you checked option I, your spouse can be covered under the Legacy Health Services health plan. Please complete Section E.

If you checked option II, complete Section E, and have Section C completed by your spouse's Human Resources Department.

SECTION C – Spouse's Employer Response

Dear Employer:

Legacy Health Services has adopted a spousal eligibility rule that requires the spouse of a Legacy Health Services employee to enroll for single coverage in the health plan offered through their employer, unless the cost of coverage exceeds $160 per month. See Section E for employee release.

As a reminder, HIPAA regulations require a special enrollment period for individuals who previously declined coverage for themselves and their dependants without having to wait until the plan's next open enrollment period. A special enrollment period occurs if a person with other health coverage loses that coverage.

☐ We offer health insurance. Date coverage will begin ____/____/____
☐ The cost of single coverage exceeds $160/month. Monthly cost $_____
☐ This employee is not eligible to enroll because _____
☐ We do not offer health insurance

Employer Name _____ Phone _____

Signature of Company Benefits Rep _____ Date_____

SECTION D – If Your Spouse Has Coverage Available

Spouse's Name _____

Spouse's Social Security Number _____-_____-_____

☐ My spouse is covered by Legacy Health Services' health benefits. Please complete Section E.

This is to certify that my spouse is/will be enrolled in healthcare benefits through his/her employer.

Effective date of coverage _____/_____/_____

Type of Coverage: ☐ Employee Only ☐ Employee & Spouse
☐ Employee & Children ☐ Family

Insurance Carrier Name _____

Group Number _____

Employer Name _____

Phone Number _____

SECTION E – Employee Certification/Spousal Release

I understand it is my responsibility to notify Legacy Health Services Human Resources within 31 days in the event that any changes occur in my marital status or the employment/eligibility status of the above named spouse.

I understand that I am personally liable for any benefits paid should any of the above information be inaccurate.

I understand that any willful misrepresentation of facts on this enrollment form will be grounds for discharge from employment and termination of benefits as well as insurance fraud.

I hereby certify that the foregoing information is true and correct.

Employee Signature_____ Date_____

If your spouse must take this form to his/her employer, please have him/her sign here:

Spouse's Name _____

I authorize my employer to release to Legacy Health Services the information requested in this form.

Signature of Spouse _____ Date _____