FDLIC

Fond du Lac Insurance Company

IMPORTANT INFORMATION ON NETWORK OFFERINGS

As a full-time employee of the Fond du Lac Reservation you have the option to enroll in the Fond du Lac Medical Plan. The Fond du Lac Medical Plan has three options for provider networks; Open Access 200, Wilderness ACO and Preferred Health ACO.

Open Access 200 Network	Wilderness ACO	Preferred Health ACO
• Largest and most comprehensive network provided by Preferred One, our Third-Party Administrator for the Medical plan • Network includes 99% of clinics and 100% of hospitals in Minnesota • Monthly Premium of $252.00 broken into two monthly payments, deducted on a pre-tax basis	• Limited network of providers in Northern Minnesota • No cost to employee <u>Hospitals</u> • Community Memorial • Lake View • St. Luke's <u>Clinics</u> • CAIR • St. Luke's Internal Medicine Associated • St. Luke's Pediatric Associates • Duluth Family Practice Center • Planned Parenthood • Raiter Clinic • Cromwell Medical Clinic • Denfeld Medical Clinic • Miller Creek Medical Clinic • Min No Aya Win • P.S. Rudie Medical Clinic • Lake Superior Community Health Center, Duluth • Lakeview Medical Center • Lester River Medical Center • University of Duluth Health Services By choosing this network: • Only participating providers will be paid at 80/20 after you meet your deductible • If you go to a non-participating provider, claims will be paid as out of network at 60/40 If you are choosing this network, complete the Wilderness Authorization Form	• Limited network of providers in the Twin Cities Metropolitan area • Fairview Health Services, which includes all Health East locations and North Medical Memorial • The network includes 5,000 physicians, 1,300 clinics and 12 hospitals • No cost to employee By choosing this network: • Only participating providers will be paid at 80/20 after you meet your deductible • If you go to a non-participating provider, claims will be paid as out of network at 60/40

For full listing, please check website

If you have any questions on provider networks please call Preferred One Customer Services at 800-997-1750.

I,_____, have read the information provided and understand that my network selection can only be
Please sign

changed during Open Enrollment for the next plan year._____/_____/20_____
(Please date)

Fond du Lac Insurance Company
Benefit Enrollment Form

Section A

YOUR ENROLLMENT INFORMATION (To be Completed by the Employee)

Name (First, Middle, Last)	Social Security #	☐ Male ☐ Female
Address (Street, City, State, Zip Code)		Date of Birth (MM/DD/YYYY)
Phone #	Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner	

EMPLOYEE TRIBAL ENROLLMENT INFORMATION

Are you ☐ Enrolled in a Federally Recognized Tribe ☐ Child or Grandchild o fan Enrolled Member of a Federally Recognized Tribe ☐ Non-Tribal Affiliated

Enrollee Name (First, Middle, Last)

Name of Federally Recognized Tribe	Enrollment #

Section B

COVERAGE

	Employee Only	Family	Decline	
Medical	☐	☐	☐	Other _____
Dental	☐	☐	☐	Other _____
Basic Life	☒			

MEDICAL PLAN SELECTION

☐ **High Deductible Health Plan** – I understand by choosing this plan there will be no cost to me for Single coverage; Family coverage costs $281.00** per month. I understand that Medical Premiums (the amount I pay) will be deducted twice per month on a pretax basis.

Deductibles and Out of Pocket Maximum under the High Deductible Plan is:

Single Coverage	**Family Coverage**
$3,000 Deductible	$6,000 Deductible
$4,500 Out of Pocket Max	$9,000 Out of Pocket Max

☐ **Low Deductible Plan** – I understand by choosing this plan I agree to pay $112.00 per month for Single coverage; Family coverage costs $393.00** per month. I understand that Medical Premiums (the amount I pay) will be deducted twice per month on a pretax basis.

Deductibles and Out of Pocket Maximum under the High Deductible Plan is:

Single Coverage	**Family Coverage**
$1,000 Deductible	$2,000 Deductible
$2,400 Out of Pocket Max	$4,800 Out of Pocket Max

**These premiums are for Family medical only. If you choose Family Dental there is an additional monthly premium of $25.00.

NETWORK SELECTION

☐ **Open Access 200**, $252 per month employee deduction This network is the largest and most comprehensive network to include 99% of clinics and 100% of hospitals in Minnesota.	☐ **Wilderness ACO**, No Employee Cost Network Limited Network in Northern Minnesota. **Check website for full listing* ☐ **Preferred Health ACO** Limited Network in the Twin Cities Metropolitan area. **Check website for full listing*

*****If you are electing Single coverage, skip to Section D*****

Section C

SPOUSE/DOMESTIC PARTNER INFORMATION

Name (First, Middle, Last) | Social Security # | ☐ Male ☐ Female

Address (Street, City, State, Zip Code) | Date of Birth (MM/DD/YYYY)

SPOUSE/DOMESTIC PARTNER TRIBAL ENROLLMENT INFORMATION

Is your spouse/domestic partner ☐ Enrolled in a Federally Recognized Tribe ☐ Non-Tribal Affiliated
☐ Child or Grandchild o fan Enrolled Member of a Federally Recognized Tribe

Enrollee Name (First, Middle, Last)

Name of Federally Recognized Tribe | Enrollment #

DEPENDENT INFORMATION

Name (First, Middle, Last) | Social Security # | ☐ Male ☐ Female

Address (Street, City, State, Zip Code) | Date of Birth (MM/DD/YYYY)

Relationship ☐ Child ☐ Step Child ☐ Grandchild | Reside with you? ☐ Yes ☐ No Do you claim on taxes? ☐ Yes ☐ No | Full time student? ☐ Yes ☐ No *If student, please provide school name below

School Name

DEPENDENT TRIBAL ENROLLMENT INFORMATION

Is your dependent ☐ Enrolled in a Federally Recognized Tribe ☐ Non-Tribal Affiliated
☐ Child or Grandchild o fan Enrolled Member of a Federally Recognized Tribe

Enrollee Name (First, Middle, Last)

Name of Federally Recognized Tribe | Enrollment #

DEPENDENT INFORMATION

Name (First, Middle, Last) | Social Security # | ☐ Male ☐ Female

Address (Street, City, State, Zip Code) | Date of Birth (MM/DD/YYYY)

Relationship ☐ Child ☐ Step Child ☐ Grandchild | Reside with you? ☐ Yes ☐ No Do you claim on taxes? ☐ Yes ☐ No | Full time student? ☐ Yes ☐ No *If student, please provide school name below

School Name

DEPENDENT TRIBAL ENROLLMENT INFORMATION

Is your dependent ☐ Enrolled in a Federally Recognized Tribe ☐ Non-Tribal Affiliated
☐ Child or Grandchild o fan Enrolled Member of a Federally Recognized Tribe

Enrollee Name (First, Middle, Last)

Name of Federally Recognized Tribe | Enrollment #

DEPENDENT INFORMATION

Name (First, Middle, Last) | Social Security # | ☐ Male ☐ Female

Address (Street, City, State, Zip Code) | Date of Birth (MM/DD/YYYY)

DEPENDENT TRIBAL ENROLLMENT INFORMATION

Is your dependent ☐ Enrolled in a Federally Recognized Tribe ☐ Non-Tribal Affiliated
☐ Child or Grandchild o fan Enrolled Member of a Federally Recognized Tribe

Enrollee Name (First, Middle, Last)

Name of Federally Recognized Tribe | Enrollment #

DEPENDENT INFORMATION

Name (First, Middle, Last) | Social Security # | ☐ Male ☐ Female

Address (Street, City, State, Zip Code) | Date of Birth (MM/DD/YYYY)

Relationship ☐ Child ☐ Step Child ☐ Grandchild | Reside with you? ☐ Yes ☐ No Do you claim on taxes? ☐ Yes ☐ No | Full time student? ☐ Yes ☐ No *If student, please provide school name below

School Name

DEPENDENT TRIBAL ENROLLMENT INFORMATION

Is your dependent ☐ Enrolled in a Federally Recognized Tribe ☐ Non-Tribal Affiliated
☐ Child or Grandchild o fan Enrolled Member of a Federally Recognized Tribe

Enrollee Name (First, Middle, Last)

Name of Federally Recognized Tribe | Enrollment #

DEPENDENT INFORMATION

Name (First, Middle, Last) | Social Security # | ☐ Male ☐ Female

Address (Street, City, State, Zip Code) | Date of Birth (MM/DD/YYYY)

Relationship ☐ Child ☐ Step Child ☐ Grandchild | Reside with you? ☐ Yes ☐ No Do you claim on taxes? ☐ Yes ☐ No | Full time student? ☐ Yes ☐ No *If student, please provide school name below

School Name

DEPENDENT TRIBAL ENROLLMENT INFORMATION

Is your dependent ☐ Enrolled in a Federally Recognized Tribe ☐ Non-Tribal Affiliated
☐ Child or Grandchild o fan Enrolled Member of a Federally Recognized Tribe

Enrollee Name (First, Middle, Last)

Name of Federally Recognized Tribe | Enrollment #

Section D

CURRENT SECONDARY AND PREVIOUS COVERAGE

Do you or any covered family member listed on this application have current, secondary health coverage or had prior health coverage within the last 63 days? ☐ Yes ☐ No If **YES**, complete following section

MEDICAL PLAN SELECTION

Starting with the employee, list each family member applying for secondary coverage and include information for all current and previous coverage in effect during the last 18 months.

Member Name	Insurance Company (Name and Claim Adress)	Policy Number	Coverage Dates	Reason for Coverage Termination

MEDICARE INFORMATION

Are you or your spouse/domestic partner covered by Medicare? ☐ Yes ☐ No If **YES**, complete following section

Employee:	***Spouse/Domestic Partner***:
Part A Effective Date: _____	Part A Effective Date: _____
Part B Effective Date: _____	Part B Effective Date: _____
Part D Effective Date: _____	Part D Effective Date: _____

I understand that providing false information in this application may result in the denial of claims or cancellation of coverage.

Sign Here

_____	_____	_____
Signature of Employee	*Print Name*	*Date Signed (MM/DD/YYYY)*

THIS PART TO BE COMPLETED BY BENEFITS OFFICE

Employee date of full-time employment	Hourly wage	Hours worked per week	Group Number **PKA20381**

Reason employee is enrolling for coverage

☐ New Employer ☐ Rehire (length of layoff) _____ ☐ Return from leave of absence (length of absence) _____

☐ Previously waived coverage ☐ Change from part-time to full-time ☐ Other _____

Date of Event _____ ☐ Verified CHS Eligibility _____

I certify the above information to be true and correct

Benefit Clerk Signature	*Date*

DIVISION

☐ 100 - Programs ☐ 600 – FDLTH ☐ 700 – BBC ☐ 800 – BBH ☐ 900 - BBG

☐ New Enrollment Effective _____	☐ Change Effective _____
☐ Add Dependent Effective _____	☐ Cancel Dependent Effective _____
☐ Other Changes Effective _____	

WILDERNESS HEALTH

Partners advancing rural health

Authorization for Wilderness Health ACO and Wilderness Health Network Providers to Share Your Health Information

Because you are an enrollee in the **Wilderness Health ACO** option under the group medical plan sponsored by your or your family member's employer, Wilderness Health ACO and the providers described below, would like to share your Health Information so that they can better manage your health conditions and diseases, if any, and/or coordinate and improve the quality of care that you receive from them and from any other health care providers that you see.

Your "Health Information" includes, but is not limited to your "protected health information" or "PHI" as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and your "health record" as defined by Minnesota Statutes section 144.293, and includes your past, present and future health records, which include but are not limited to, medical and pharmacy claims and related case notes. These specifically include, if we have them, claims and case notes about HIV/AIDS, mental health and psychotherapy, substance use, and/or chemical dependency treatment.

By executing this Authorization I, the enrollee, for myself and any minor dependents, or, if applicable, I the spouse or dependent age 18 or older, understand and agree as follows:

1. **Authorization**. Wilderness Health ACO may disclose my Health Information to Bigfork Valley Hospital, Community Memorial Hospital, Cook Hospital, Fairview Range Medical Center, Grand Itasca Clinic and Hospital, Lake View Hospital, Mercy Hospital, North Shore Health, Rainy Lake Medical Center and St. Luke's Hospital and their respective affiliates, and any other provider participating in the Wilderness Health ACO option (each a "Wilderness Health ACO" and collectively the "Wilderness Health Providers"), in their role as health care providers and with respect to their status, if any, as accountable care-type organizations; and the Wilderness Health Providers may disclose my Health Information to PreferredOne so that individually and collectively they can better manage my overall health status and my specific health conditions and diseases; for general care coordination and quality improvement purposes; for disease management purposes; and for payment purposes. This Authorization specifically allows PreferredOne and the Wilderness Health Providers to share my Health Information about care I have received or may receive in the future from them, as well as from other providers ("Other Providers"). This Authorization is effective notwithstanding any other authorizations or revocations of authorizations that I enter into or have already entered into with a Wilderness Health Provider or with any of my Other Providers. Health Information disclosed in compliance with this Authorization may be re-disclosed by the recipient and no longer be protected by HIPAA or other laws. This Authorization, and any expiration or revocation thereof, does not affect or change the routine sharing of my Health Information by or between PreferredOne and any provider that is permitted or required under HIPAA or applicable state law.
2. **Duration**. This authorization is effective for 10 years from the date I sign it or such longer period that is allowed by Minnesota state law, unless Ielect an earlier date here (optional)_____/_____/20_____or revoke it in writing as described in paragraph 3, below.
3. **Revocation**. I may prospectively revoke this authorization at any time and can only do so by notifying Wilderness Health ACO in writing. I can obtain revocation directions from Wilderness Health ACO's Customer Service Department at (763) 847-4477 or toll free at 1-800-997-1750. Any such revocation will not apply to any previously shared data, which will remain with the recipient.
4. **Voluntary Authorization; Rights**. I am not required to sign this form and am doing so voluntarily. My treatment, enrollment in a health plan, or eligibility for benefits is not conditioned upon signing this Authorization.
5. **Modifications to Form are not Allowed**. I am not permitted to modify the terms of this form. If I do, the authorization form will not be effective.

ENROLLEE: <MEMBER NAME>_____<MEMBER ID WITH SUFFIX> _____

Complete the following, sign and date the form, and return it to your Human Resources department or send by mail to: Wilderness Health ACO at 6105 Golden Hills Drive, Golden Valley, Minnesota 55416, Attention: Enrollment Department. **Or you may FAX to:** 763-847- 4004, Attention: Enrollment Department

Enrollee's Email Address: _____

Enrollee's Phone Number: _____ ☐ **HOME** ☐ **WORK** ☐ **CELL**

Enrollee's Signature:_____ **Date:** _____

***** *PreferredOne means PreferredOne Insurance Company, PreferredOne Community Health Plan, and PreferredOne Administrative Services, Inc.*

Domestic Partnership Eligibility Verification

Under penalties of applicable law and as provided under the Plan, including but not limited to reimbursement of the Plan for all amounts paid in error due to the Plan relying on the information provided herein, I hereby attest that all of the facts concerning the person(s) named below are true and correct:

Facts:

Employee Name _____ ID # _____

Name of Domestic Partner _____

Domestic Partner Date of Birth _____

Domestic Partner Social Security # _____

Check the applicable statements below if they are true and correct in your situation:

- ☐ Is in a committed and mutually exclusive relationship, jointly responsible for the domestic partner's welfare and financial obligations.
- ☐ Is at least 18 years of age and unmarried.
- ☐ Resides with the domestic partner in the same principal residence and intends to do so permanently.
- ☐ Is not a blood relative of the domestic partner.
- ☐ Is mentally competent.

I understand that the Fond du Lac Employee Health Plan is a Section 125 Plan and that I am only allowed to change, add or drop my healthcare coverage if I have a Qualified Change of Event or during Open Enrollment. I also understand that this form covers domestic partnership under Cigna/New York Life benefits; Supplemental Life and AD&D insurance, Critical Illness and Accident Insurance. I am responsible for contacting Fond du Lac Insurance Services and reporting the change in writing within 30 days of the date the change occurs.

_____ _____

Employee Signature *Date*

_____ _____

Domestic Partner Signature *Date*

This area reserved for Notary Public

STATE OF MINNESOTA

County of _____

Sworn and subscribed before me this _____ day of _____, 20_____.

_____

Notary Public

(Seal)

Employee must complete this form and have it notarized. Any expenses incurred relating to the completion of this form is the employee's responsibility and no reimbursement under the Plan is available for that purpose. Please send this completed and notarized form to the Fond du Lac Insurance Services Office for processing.