WEST VIRGINIA
MOUNTAINEER FLEXIBLE BENEFITS
BENEFIT COORDINATOR REFERENCE MANUAL

MOUNTAINEER
FLEXIBLE BENEFITS
FBMC BENEFITS MANAGEMENT, INC.

WEST VIRGINIA PEIA PUBLIC EMPLOYEE INSURANCE AGENCY

Table of Contents

I – Introduction

The Mountaineer Flexible Benefits Plan is sponsored by the West Virginia Public Employees Insurance Agency (PEIA) as both a vehicle to provide additional benefits to eligible state employees, and a method of providing tax savings to participating employees and the state. The Plan qualifies as a Cafeteria Plan authorized under Internal Revenue Code Section 125.

The Plan is made available to State Agencies, Universities & Colleges, participating Boards of Education, and participating Non-State Agencies. To participate each respective entity must execute a Joinder Agreement to the master contract and establish a written plan document consistent with the document established by state statute.

FBMC Benefits Management, Inc. (FBMC) is the contract administrator of the Mountaineer Flexible Benefit program and is a nationally recognized leader in the field. It has provided services to the state since 1992.

This manual was prepared by FBMC as a practical guide for Personnel Administrators, Benefit Coordinators and other state and county boards of education staff with responsibilities associated with the Mountaineer Flexible Benefits Plan.

The goal was to keep the content simple and provide the reader with a high level overview as well as the detail needed to understand his/her role. As such the manual communicates general information and procedures essential for implementation and ongoing administration of the Plan. It is important that staff at the state agencies, colleges and universities, county boards of education, non-state agencies and their counterparts at FBMC have a clear understanding of the interface necessary to administer the Plan and the role each party plays to assure its accuracy and success.

This Benefit Coordinator Reference Manual is not intended to be all-inclusive. If conflicts exist between this manual and the Internal Revenue Code or West Virginia Statutes or the Mountaineer Flexible Benefits Plan Summary Document, the Internal Revenue Code and the Statutes must be followed.

FBMC Key Contact Information

For Benefit Coordinators

FBMC Service Center - 844-55WVA4U (844.559.8248)

FBMC Charleston-based Account Management Team

Please send all email inquiries to: mtflexbenefits@fbmc.com

1. Kayla Horton, Account Manager 304.558.7850 Ext. 20329
   Email khorton@fbmc.com
2. Emily Hoffman, Regional Account Executive 304.558.7850, Ext.20333
   Email ehoffman@fbmc.com
3. Jodi Grady, Senior Account Representative 304.558.7850, Ext. 20331
   Email jgrady@fbmc.com

FBMC Facsimile Numbers by Transaction Type

1. For Active employees: ATTN: Enrollment Processing Fax # 850.514.5803
2. For Change in Status: ATTN: Change in Status Fax # 850.514.5803
3. For Retirees: ATTN: Direct Bill FAX # 866.836.9943

FBMC Correspondence Addresses by Transaction Type

1. Active Employee Correspondence:
   FBMC Benefits Management, Inc.; ATTN: Enrollment Processing
   P.O. Box 1878
   Tallahassee, FL 32302-1878
2. Retiree Correspondence:
   FBMC Benefits Management, Inc.; ATTN: Direct Bill
   P.O. Box 10789
   Tallahassee, FL 32302-2789
3. Payroll Reconciliation Reports (for manual payrolls)
   FBMC Benefits Management, Inc.; ATTN: Accounting-WV
   P.O. Box 1878
   Tallahassee, FL 32302-1878

For Employees/Participants

FBMC Service Center - 844.559.8248 or by email: *FBMCServiceCenter@fbmc.com*

- ✓ Toll-free bilingual Interactive Voice Response, 24/7
- ✓ Toll-free bilingual Service Center, 7AM to 7PM, Monday through Friday (excluding holidays)

On-line at www.myFBMC.com for Mountaineer benefit account information
On-line at www.payflex.com for FSA and HSA account and claims information
PayFlex Mobile® app for account and claims information and history

Important Note: FBMC follows very strict protocols when discussing and exchanging data with agency personnel consistent with the WV Executive Branch and State of WV Business Associate Agreements.

II Enrollment

Enrollment Overview

The key to a successful enrollment cycle is providing sufficient information and resources for informed benefit decisions to be made.

FBMC's on-site team (Account Manager, Client Liaison, and Client Services Specialist) attend numerous Benefit Coordinator Workshops during March; Benefit Fairs are held throughout the State and utilize both group and one-to-one meetings with employees to facilitate enrollment in the voluntary benefits.

Detailed communication materials are produced and distributed; FBMC's primary communication objectives:

- Communicate the program in a straightforward, thorough manner to encourage employee understanding, appreciation, and participation in the State's benefit programs.
- Provide materials that employees can share with their spouses or dependents to better understand and make family benefit choices.

FBMC provides an online enrollment system for state agency employees during the annual Open Enrollment period, as well as a paper enrollment process for non-state agency employees.

Additional enrollment support is provided by FBMC via toll-free, bilingual access to its Service Center from 7:00AM to 7:00PM, Monday through Friday. (EST). Service Center Representatives are thoroughly trained prior to commencement of the enrollment and provide the following enrollment-related services for State employees:

- Answer questions about the available benefits;
- Provide enrollment meeting locations and times;
- Counsel employees on benefits, tax-savings analysis, and guide employees in completing forms or how to use the web-based enrollment system; and
- Assist employees to enroll via the online enrollment system.

During the development process, business rules are defined and edit checks for the online enrollment system are established. Employees will receive warning messages throughout their enrollment when required fields are missing or are not in the correct format. When eligibility information is available, employees are presented with a personalized form that contains their own demographic information and they are offered only those benefits for which they are eligible. Confirmations of Benefits (Welcome) Packets are provided to each participant post-enrollment.

At the conclusion of the open enrollment period, FBMC notifies the various insurance providers of enrollment elections through numerous data exchanges. Participating entities also receive enrollment election information in order to populate each entity's payroll system. On a payroll basis, FBMC reconciles and remits premiums to the applicable provider companies.

Important Note:

Access to and exchange of PII and PHI must follow state and federal requirements related to the security of information.

FBMC follows very strict protocols consistent with the WV Executive Branch and State of WV Business Associate Agreements.

Distributing Enrollment Material

Open Enrollment

FBMC produces comprehensive enrollment materials, customized separately for the active, retired and COBRA-eligible state employees. Active and Retiree Enrollment Guides and accompanying forms are available in electronic format on the PEIA website. COBRA materials are mailed directly to COBRA- eligible individuals and COBRA participants.

In addition, these enrollment reference guides and election forms are mailed by FBMC directly to most employees' home addresses prior to the start of the enrollment. However, for Non-State Agencies, materials are mailed directly to the agency for agency distribution.

New Hire Enrollment

FBMC maintains a small inventory of material for use throughout the year with new employee or new retiree enrollments. Below is the information needed to place an order with FBMC's representative; materials may be requested by email.

Required when placing an Order	FBMC's Contact Information
Agency Name: 4 digit Work Location #: ATTN: Address: Phone number: Number of enrollment packets: Type of packet: Active or Retiree:	Jodi Grady 1.304.558.7850, Ext 20331 jgrady@fbmc.com

Conducting the Annual Open Enrollment

The Mountaineer Flexible Benefits plan year is July 1st to June 31st of the following calendar year. Under Internal Revenue Code Section 125 regulations, employees must be given an opportunity to change elections every 12 months. These elections must be made in advance of the start of a new plan year during an "Open Enrollment" period. The Open Enrollment period for the Mountaineer Flexible Benefitsplan generally occurs during an April/May timeframe. Dates are announced well in advance.

Online Enrollment System

During the annual Open Enrollment period, most eligible employees may use the FBMC internet application to enroll online for benefits; employees log-in to www.myfbmc.com using their registered e-mail address and a password. All state agency employees, and any employees who are already enrolledin Mountaineer Flexible Benefits (regardless the type of agency) may use the online system.

The online system simplifies the enrollment process and reduces the role of the Benefit Coordinator during Open Enrollment. FBMC's online system manages employee eligibility and minimizes the likelihood of enrollment discrepancies.

A Confirmation Notice is provided to the enrolling employee at the conclusion of the online enrollment process.

Election information is automatically submitted to FBMC at the conclusion of Open Enrollment.

Paper Enrollment Process

PEIA recognizes that not all employees are able or want to use an internet-based enrollment system; thus, FBMC also provides a paper-enrollment option. Forms are available on the PEIA website. Paper enrollment forms must be submitted to the employee's Benefit Coordinator when completed, no later than the designated due date. Forms submitted after the due date will generally be rejected. See SectionV for appeals process exceptions.

Q/A 1. Must all employees complete an electronic or paper enrollment form during open enrollment?

There are several ways to comply with the IRS requirement to make available an annual open enrollment. An employer may require all employees to complete a new form during this time, or may require only employees who want to change existing elections to complete a form. A participating employee who does not wish to make changes may let the benefits "Evergreen" (continue unchanged).

Typically the Mountaineer Benefit Plan open enrollment is conducted using the latter approach also referred to as "changes only" enrollment. Employees who are currently enrolled and who do not wish to make changes, are not required to complete a new form during Open Enrollment. However, a form must be completed if enrolling for the first time, if adding or deleting coverages, or changing coverage types (i.e. family coverage to single coverage or vice versa). If at any time the type of enrollment changes, this information will be prominently displayed in all enrollment communiques and will be a focus of Benefit Fairs and any other enrollment trainings or meetings.

An employee may submit more than one form during the Open Enrollment period; the second form is referred to as a supersede form. Supersede forms are discussed below in more detail.

Collecting Paper Enrollment Forms

During Open Enrollment employees must turn in completed paper enrollment forms to their Benefits Coordinator no later than the close of business the last day of Open Enrollment. The dates of open enrollment are determined by PEIA and dates are noticed in all enrollment communications provided to employees.

Benefit Coordinators play a crucial role in reviewing the forms for accuracy and completion prior to forwarding the forms to FBMC in Tallahassee, Florida. This review process ensures timely creation of accurate employee payroll deduction files, and assures accurate accounting and compliance reporting.

Q/A 2. After paper enrollment forms are collected, what tasks must be completed by the Benefit Coordinators?

Confirm Eligibility. The employee must be eligible to participate in the Mountaineer Flexible Benefits Plan. If not, the form should be rejected and the employee notified according to standard agency procedure.

Complete "For Benefit Coordinator Use Only". This section is located in the bottom right corner of the enrollment form. The importance of completing this section cannot be overstated. When this section is not completed, FBMC must question eligibility to participate since it could be too easy for an ineligible employee to avoid scrutiny by sending directly to FBMC. The form is placed in a pending status awaiting consultation with the Benefit Coordinator. This could cause elections to be delayed and double deductions to occur so we stress to complete this section.

Provide copy of completed enrollment form to each employee.

Bundle and send forms to FBMC. Forms must be bundled and forwarded to FBMC weekly during open enrollment. At the conclusion of Open Enrollment all remaining forms must be sent by the final date specified on the enrollment form to:

Actives: Enrollment Processing - PO Box 1878 -Tallahassee, FL 32302-1878 or FAX 850.514.5803

Retirees: Direct Bill – PO Box 10789 – Tallahassee, FL 32302-2789 or FAX 866.836.9943

Include Transmittal Notice with all bundled forms. The following information is key to include on the transmittal:

Agency Name: Sender Name: Date:

Number & Type of Forms Attached: (i.e xx active enrollment forms; xx supersede forms; xx retiree forms)

Addressing Paper Enrollment Form Discrepancies

Enrollment form errors or discrepancies may be detected manually by FBMC's data entry specialists or electronically by the edit checks in FBMC's Common Remitter system. Sometimes the discrepancy is key information missing from the form. Regardless the type of discrepancy each must be resolved quickly before the final enrollment data is generated and provided to PEIA and the various insurance providers. This will generally require consultation with the appropriate Benefit Coordinator.

FBMC's Standard Procedure:

Contact Benefit Coordinator by phone to resolve discrepancy. If employee-completed information is missing, FBMC will make multiple attempts to contact the Benefit Coordinator. In the interim the form remains in a pending status.

Modify the form based on Benefit Coordinator input; or if the Benefit Coordinator cannot be reached, modify to meet plan requirements or to match coverage level to premium amount notated on form. This is done in red ink and the change is initialed by the FBMC processor.

Return unprocessed any/all enrollment forms where employee is determined to be ineligible.

Document FBMC's records with the details of the discrepancy situation via the Service Center Inquiry screen. This provides a permanent record so that should the employee or Benefit Coordinator call FBMC, the Service Center representative or the Account Management Team has all pertinent information available to discuss the discrepancy and the solution, and assist the employee with any other needed adjustments.

Assist in documenting agency records with letter of explanation to Benefit Coordinator and copy of the revised form.

Q/A 3. What are Supersede Forms and how are they handled?

An employee may change his/her mind about benefit selections during the open enrollment period after they have submitted an enrollment form. The Plan permits a change to be made as long as the employee submits a new enrollment form during the Open Enrollment period.

The second form is referred to as a Supersede Form and it must be submitted to the employee's Benefit Coordinator. To avoid any confusion at FBMC, the Employee or Benefit Coordinator must write SUPERSEDE across the top of the enrollment form. The Benefit Coordinator reviews the form, all pertinent information is added as previously specified (see Q/A 2), and the form is forwarded to FBMC.

Note: The number of supersede forms forwarded to FBMC should be clearly specified on the Transmittal Notice that accompanies all forms. See also Q/A 2.

When a supersede enrollment form is received from the Benefit Coordinator, FBMC replaces selections from the first form with selections indicated on the supersede form.

Confirmation Notices

The Confirmation Notice itemizes the benefits selected and the per pay amount to be deducted from the employee's paycheck. The text of the Confirmation Notice instructs employees to carefully review the Notice and ensure the benefit coverages are in keeping with what the employee meant to select; any discrepancies are to be immediately brought to FBMC's attention by contacting the FBMC Service Center.

Online Enrollment System. Every employee who enrolls using the online system during Open Enrollment will be prompted to print his/her own Confirmation Notice at the conclusion of the enrollment session.

After Open Enrollment, Benefit Coordinators will see a link on myFBMC.com which will direct them to any changes that their employees made online during open enrollment.

Paper Enrollment Process. Every employee who completes a paper enrollment form receives a Confirmation Notice from FBMC. Confirmation notices are printed and distributed by mail daily to employee home addresses.

Benefit Coordinators should make copies of any paper enrollment forms that they receive during open enrollment after completing and signing the benefit coordinator section. This is to make sure you're keeping track of paper enrollment forms that are sent to FBMC during open enrollment.

Note: The insurance plan certificates and guides for all products may be accessed on www.myfbmc.com.

Special Enrollment Events

New Hire & Certain Agency Transfer Enrollments.

The online enrollment system is not available mid-year. New Hires that wish to enroll in Mountaineer Flexible Benefits must do so using the Paper Enrollment Process (described previously) and submit the completed form to his/her Benefit Coordinator no later than two months following the month of hire (this is a plan document requirement).

Certain Transfer Employees are treated as a new hire. This happens when an employee transfers from an agency that does NOT participate in the Mountaineer Flexible Benefits Plan to an agency that does participate.

The effective date for the above categories of employees is the first of the month following enrollment and the employee is responsible for the full month's premium.

The Benefit Coordinator confirms the employee's eligibility and completes the Benefit Coordinator section in the lower right comer of the form. The completed enrollment form is then forwarded to FBMCvia FAX: 1.850.514.5803 ATTN: Enrollment Processing.

Change in Status (CIS).

The online enrollment system is not available mid-year. Any change in employee status that results in changes to Mountaineer Flexible Benefits must be processed via the Paper Enrollment Process. Benefit Coordinators must mark the CIS box (top right corner of the form) and include the appropriate supporting documentation with the CIS request to prevent processing delays. Forms must be faxed to 1.850.514.5803 ATTN: CIS. Detailed information on processing CIS forms to assure consistency with IRS regulations and the Mountaineer Flexible Benefits plan document is provided in Section III of this manual.

III Plan Administration & Maintenance

Administration Overview

FBMC's Account Management Team located in Charleston, and the Tallahassee-based Benefits Administration staff work closely with Benefit Coordinators throughout the state to administer the Section 125 Mountaineer Flexible Benefits program. Each play an important role in plan administration and ongoing plan maintenance. PEIA sponsors and FBMC participates, in ten benefit coordinator training sessions held throughout the year. In addition trainings are held just prior to open enrollment. For specific dates, contact PEIA.

Plan Administration and Maintenance kicks into gear beginning with the first payroll of the new plan year. In advance of the first payroll (at the conclusion of the Open Enrollment) FBMC's administrative system master files and all provider system files are established. FBMC notifies the various insurance providers of enrollment elections through numerous data exchanges. Data exchange also populates the various agency payroll systems.

On an established frequency, (monthly or per payroll) FBMC receives data from each participating agency and conducts a thorough reconciliation prior to posting premiums and/or contributions to each participant-level account, and prior to forwarding premium to insurance providers. Reconciliation is the process of comparing "expected" master file election information to "actual" payroll deductions.

State agencies provide data electronically; reconciled records are usually posted to FBMC's master files within one to two days of receipt. Non-state agencies and Boards of Education provide data using a paper billing; reconciled records are usually posted within five days of receipt. FBMC's Benefits Administration staff is solely responsible for the reconciliation and posting of participant payroll deduction data.

Plan maintenance is the dynamic process of managing benefits for a changing workforce. New hires, terminations, agency transfers, leave of absence events, employee family changes,and retirements must be addressed taking into account both plan and IRS requirements. Various forms are available on the PEIA website for employees and Benefits Coordinators to help facilitate plan administration and maintenance. A screen shot of the website is provided at the end of Section III.

This section addresses the key plan administration and maintenance issues that Benefit Coordinators may face with the Mountaineer Flexible Benefits program.

Important Note:

Plan administration and maintenance of information containing PII and PHI must follow state and federal requirements related to the security of information. FBMC follows very strict protocols when exchanging data with agency personnel consistent with the WV Executive Branch and State of WV Business Associate Agreements.

Payroll Reconciliation

State Agencies, Universities and Colleges

Information is received electronically from each state agency on a per payroll basis and reconciliation is handled via electronic comparison of expected to actual on a per payroll basis.

West Virginia University and Marshall University report through their respective payroll systems; all other agencies and campuses report through OASIS.

Participating Boards Of Education & Non-State Agencies

Reconciliation of these payroll deductions is handled monthly and is a manual process for FBMC and the Benefit Coordinator. A monthly invoice ("Bill of the Month") is electronically remitted by FBMC to each county board or non-state agency approximately 10 business days prior to the beginning of the month in which deductions will be taken.

Bill of the Month consists of three parts:

Bill for the Month. It identifies each participant's social security number, name and other critical plan benefit information. Note: the bill contains space to be used as a worksheet to identify by participant any changes needed.

Adjustment Form for the Month. This form is used to consolidate the changes from the worksheet and to communicate changes or adjustments to FBMC. This form is to be used by the Benefit Coordinator to communicate any/all changes in employment status, clearly specifying the employee name/ID, and type of status change (termination, retirement, deceased, etc. and date of event). A link to the digital copy of the form may be located under the Remittance Summary Form cover sheet.

Remittance Summary Form. As the name implies, this form summarizes changes. The total remittance amount from this form should equal the actual deductions taken for the month, adding or subtracting any adjustments.

Q/A 4 What are the specific steps the non-state agency Benefit Coordinator must take to complete the Bill of the Month reconciliation?

Step one. After all payrolls have been generated for the month, total the actual deductions taken for all benefit categories and pay cycles.

Step two. Compare the employee totals to those on the Total Bill line on the Remittance Summary Form.

Step three. Either proceed to step four or six as follows: In most cases, the totals should agree. If the two totals are equal, the payroll system is balanced to the bill and the reconciliation is complete. The Benefit Coordinator may complete the remittance and reporting process as shown in step six. If the two totals are not equal, proceed to step four.

Step four. Verify that all employees who have deductions for the month are listed within the main sections of the bill. Also verify that the amount actually deducted for Dependent Care Flexible Spending Accounts and other miscellaneous deductions match what is on the bill. Note: The monthly amount listed on the bill should equal the total monthly deduction taken.

Identify and document. When an individual discrepancy between the bill and the actual deduction is identified, the discrepancy must be documented on the FBMC adjustment form as described below. The adjustment form requires the following information for each employee with a deduction change:

SSA Number - the employee's Social Security number
Subscriber Name - the employee's last name followed by first name or first initial
Plan Date - the effective date of the change
CHG CD - any one of the change codes shown at the bottom of the adjustment form
PAY / YR - the number of payrolls during which Plan deductions are taken (10, 12, 18, 20, or 24 pay cycle)
Plan Code - The plan code for each type of deduction (e.g. DEPR for Dependent Care accounts, MISC for miscellaneous)
Comments - space provided for any additional explanation not covered by the change codes shown on the form
Employee Amount - the contribution from the employee to the Plan
Employer Amount - Not Applicable

Note: If there are multiple entries for an employee, the Social Security number and name does not need to be repeated.

Step five. After all adjustments to the bill have been entered on the Adjustment Form(s), transfer the employee totals from the Adjustment Form(s) to the Remittance Summary Form.. Calculate the total remittance amounts on the bill's Remittance Summary Form and verify that the amounts match the total employee deductions remitted. Make a copy of the payroll deposit (check) that will be forwarded to FBMC, keep for your records, and verify the deposit amount matches the total employee deductions remitted.

Step six. Mail, all Adjustment Forms and the Remittance Summary Form no later than the 10th of the following month to the address provided below. Check(s) should be made out to WV-Mountaineer Flexible Benefits.

FBMC
ATTN: Accounting-WV
P.O. Box 1878
Tallahassee, FL 32302-1878

Agency Transfers

When an employee transfers from one agency to another, benefits must be carefully addressed. Unless eligibility is impacted by the change benefits will generally remain the same. However, there are separate procedures for addressing major medical coverages and Mountaineer Flexible Benefits. This section will address the latter.

The enrollment materials state that it is the employee's responsibility to provide current benefits to the new agency. If unsure the employee is instructed to contact the old agency to confirm coverage. In addition the employee may contact the FBMC Service Center, or log onto www.myfbmc.com. However, Benefit Coordinators are encouraged to question transferring employees who may not understand that benefits do not automatically transfer.

Q/A 5. Are all agency transfers treated the same? What is the Benefit Coordinator's role?

Type of Transfer	*Change Permitted*	*Action Needed*
Old and new agency both participate in Mountaineer Flexible Benefit Program	*Existing Mountaineer Benefit coverages must continue without change; if employee is not currently enrolled in Mountaineer coverages he/she must wait for the next open enrollment to enroll (unless another qualifying event occurs (i.e. CIS)*	*Employee completes new paper enrollment form with existing coverages and marks it "Transfer" (in the top right corner of the form. Benefit Coordinator completes the "Benefit Coordinator Use Only" box (on the bottom right corner of the form) and sends via FAX: 1.850.514.5803 ATTN: Enrollment Processing*
Old agency did not participate but new agency does	*Employee is treated as a new hire for purposes of Mountaineer coverages.*	*Employee completes new paper enrollment form with current coverages and marks it "New Hire" (in the top right corner of the form. Benefit Coordinator completes the "Benefit Coordinator Use Only" box (on the bottom right corner of the form) and sends via FAX: 1.850.514.5803 ATTN: Enrollment Processing*
Old agency did participate but new agency does not.	*Employee's Mountaineer coverages cannot continue.*	*Benefit Coordinator follows agency procedure for terminating employee benefits.*

Changing Employee Demographic Information

Keeping demographic information up to date is important to assure timely and accurate flow of information between FBMC, Benefit Coordinators, and Mountaineer Flexible Benefit plan participants.

An employee may update demographic information via the Demographic Change Form located on the myFBMC website. Please note: No changes to benefits will be made using this form.

The type of changes that may be made with the form include:

- Change of Address
- Name change ONLY
- Phone number
- Email address

Upon completion, the employee submits the form to FBMC as follows:
Enrollment Processing - PO Box 1878 -Tallahassee, FL 32302-1878 or FAX 850.514.5803 ATTN: Enrollment Processing

Correcting Spouse or Dependent Demographic Information

Any time a dependent's information is incorrect with FBMC, the Benefit Coordinator will need to fax a copy of the enrollment form to 850.514.5803 Attn: Enrollment Processing. Please notate the type of correction being made on the FAX cover sheet (I.e., per the form, please update DOB).

Permitted Mid-Year Election Changes

Under IRS regulations, once an election is made it is generally irrevocable for the duration of the plan year. However an Employer may permit changes to occur under limited circumstances. This section describes the changes that the Mountaineer Flexible Benefits program permits mid-year.

Administrative Error

An administrative error is not of the employee's doing and may not easily or immediately be detected by FBMC, the Benefit Coordinator, or the employee. If FBMC detects the error, the Benefit Coordinator will be contacted by FBMC; if the employee or Benefit Coordinator detects the error, the Benefit Coordinator contacts a member of FBMC's Account Management team for assistance in resolution.

If you have an administrative error that needs taken care of, please contact MtFlexBenefits@fbmc.com.

Errors may be caused by clerical or systemic errors in recording elections; data exchange issues; rate errors; delays in affecting a change resulting in too much or too little salary reductions. Confirmed misinformation provided during enrollment by FBMC, Employer, or Enrollment Company is also treated as an administrative error.

Determining that a true error occurred is the result of meeting a clear and convincing error standard; standards must be applied objectively and consistently. This is customarily a joint research effort and discussion between FBMC and the Benefit Coordinator.

When it is determined by the Benefit Coordinator or FBMC that a bona fide error occurred, the election must be undone to the start of the plan year, it may not be made prospectively. The rationale is that the election was bad from the beginning. As the timing of discovery may cause a significant cash impact on an Employee, payroll corrections may be spread across several payroll cycles. However, adjustments must be concluded by the last payroll of the plan year to assure accurate year-end reporting.

Errors and adjustments must be documented thoroughly and the rationale explained. In the event of an audit, the IRS will be looking to see if the employer attempted an end run around the irrevocability rule to benefit its employee(s).

Approved Employee Appeals

An Appeal is a written request for variance to established rules submitted to FBMC by an employee. Sometimes a Benefit Coordinator will intercede on the part of an employee but all Appeals must be in writing by the employee and include sufficient documentation and rationale to support the employee's position on why a variance should be granted. If an Appeal is approved by FBMC, instructions and documentation will be provided by FBMC to the Benefit Coordinator. As with Administrative Errors, the

IRS will be looking to see if the employer attempted an end run around the irrevocability rule to benefit its employee(s). More detailed information is provided in Section V.

HIPAA Special Enrollment Rights

Rights under HIPPA are mandatory and apply to group health plans that are not deemed "excepted" benefits. This means that HIPAA's rights do not apply to the Mountaineer Dental or Vision plans, or to the Medical Flexible Spending Account as these benefits are excepted benefits. However HIPAA's Special Enrollment Rights do apply to the major medical plan and should be processed according to standard agency procedure.

Change in Employee Status

Consistent with Proposed Treasury Regulations §1.125-2(a)(1), the plan permits certain family status change events to enrollment elections. Employees may change a benefit election upon the occurrence of what the IRS refers to as a valid Change in Status (CIS) event. The change that is requested must be on account of, and correspond with, an event that affects their own, their spouse's or their dependent's gaining or losing coverage eligibility. Assuming that these general consistency requirements are satisfied,a change may be made.

The Mountaineer Flexible Benefit plan document requires that a request for a change in status be submitted to the Benefit Coordinator for processing within the month of and two months following the qualifying event. No change will be reviewed or approved after this three month period.

Q/A 6. What is the CIS Process? What is the Benefit Coordinator's Role?

The employee must complete and submit to his/her Benefit Coordinator an FBMC enrollment form, indicating "Change in Status" in the upper right corner within the required notification window. The FBMC Service Center is trained to help employees determine if a recent life or benefit change results in a valid CIS event.

The Benefit Coordinator reviews the form and assures all supporting documentation is provided. The form and documentation is sent to FBMC via FAX 850.514.5803 ATTN: CIS. FBMC must receive no later than the new month of and two months following the qualifying event.

Within 10 business days of receipt, FBMC's CIS Specialist reviews the form, the documentation attached and either approves or denies the change based on the validity of the triggering event and the consistency of the event to the requested change. IRS regulations are strictly followed. If there is any doubt about the appropriate action, the Specialist seeks assistance from FBMC's Compliance Team; the IRS is contacted as may be necessary.

An approved CIS is immediately processed by FBMC and made effective the first of the following month (excluding birth/adoption or court order which follow other defined dates). A copy of the approved form is faxed by FBMC to the Benefit Coordinator along with payroll adjustment instructions. FBMC attaches the CIS form to the employee's original enrollment form to document the transaction.

A denied CIS is formally documented in letter form, outlining the reason for the denial and any other pertinent information. The denial letter is mailed to the employee's home address, with a copy provided to the Benefits Coordinator.

Important Note: Submitting a CIS to PEIA does not update Mountaineer Flexible Benefits unless the CIS is also submitted to FBMC following the procedure above. It is a common appeal situation for an employee to add or drop a dependent or change coverage from single to family on his/her medical plan and assume incorrectly that the change is also effective with Mountaineer Benefit coverages. The processes are completely separate and updating one does not update the other.

The table that follows is provided as a general reference guide for Benefit Coordinators; it identifies the status event as well as the type of change permitted.

Change In Status (CIS) Events Table Type of Change	Applicable Benefit Elections	Non-Applicable Benefit Elections (No Change Permitted)	Consistency Conditions	Alerts/Cautions
1. change in employee's legal marital status, including marriage, divorce, death of spouse, annulment, or state-granted legal separation that impacts eligibility for coverage	Applies to elections for all §125 qualified benefits; however, certain consistency requirements may preclude change of certain benefits.	The pre-tax change must also be permitted under the underlying benefit plan or policy, or no change is permitted. Note: pay cut is not a change in status unless it affects eligibility. Termination and rehire within 30 days, or unpaid leave of less than 30 days is not an election change event (EE must be reinstated in same benefits)	Election changes permitted only if facts and circumstances show 1) one of the six qualified events has occurred and 2) the change satisfies consistency rules. General consistency rule provides that the change must be on account of and correspond with the CIS event. Relaxed consistency rules apply for Group Term Life, Disability, & ADD and permit changes to coverage under any CIS event whether or not eligibility is gained or lost.	1. If eligibility is not impacted, no change is permitted. Marriage also triggers HIPAA Special Enrollment right
2. change in number of tax dependents under Code §152; and Code §21(b)(1) (specific to DCAP coverage) who are eligible for and may "benefit from" coverage under the plan (where benefit from refers to spouse/dependent benefitting from EE's participation in MFSA or DCAP).				2. Gaining dependent also triggers HIPAA Special Enrollment right
3. any event that changes employment status of employee, spouse or tax dependents that affects eligibility under café plan or underlying benefit. Note: a plan may establish automatic loss and termination of coverage without the need for change in status paperwork (i.e. drop of spouse from health plan upon divorce).				3. Examples that may affect eligibility include: new hire/termination, strike or lockout, return from unpaid leave, change in worksite, change in coverage at second job, FT to PT, exempt to non-exempt, classified to non-classified, change in bargaining unit.
4. change in coverage eligibility: spouse or tax dependent satisfies (or ceases to satisfy) dependent eligibility requirements due to age, gain/loss of student status, or marriage under café plan or an underlying benefit.				4. Since PPACA, it is not unusual to lose coverage under dental or vision but not under major medical. Only the benefit in question may be changed; only the individual in question may be dropped.
5. change in residence of employee, spouse or tax dependent causing person to no longer be eligible for health coverage.				5. Coverage may be dropped/changed if change in residence affects eligibility for managed care option. No change in MFSA permitted.
6. commencement/termination of adoption proceedings				6. Applies only to health coverages not excepted under HIPAA; tag along for other eligible dependents permitted. Coverage for adoptee may be made retroactive to date of adoption or placement for adoption.

Health Savings Account

An employee must be enrolled in a high deductible health plan in order to participate. During the plan year, changes may be made on a once per month basis. Any change requires the completion of a new enrollment form which employee submits to his/her Benefit Coordinator. The form is marked CIS by the Benefit Coordinator (no accompanying life/benefit change documentation is required) and submitted to FBMC. Even though submitted as a change in status (CIS), the change does not require approval by FBMC. See also Q/A 6.

Cost and Coverage Changes

The plan permits mid-year changes to medical benefits (does not apply to Medical FSA) if there is a significant change in cost, or increase/reduction in type of medical coverage. The need for procedures to address this type of change will be discussed at the group level and instructions provided to Benefit Coordinators.

This also includes the ability to make a change to the Dependent Care FSA with a change in custodial care provider. This type of change may be affected by completing a new enrollment form which employee submits to his/her Benefit Coordinator. The form is marked CIS by the Benefit Coordinator and submitted to FBMC.

Open Enrollment under Another Employer's Plan

Changes are permitted that correspond with changed benefit elections of an employee's spouse during open enrollment under another employer's plan. Any change requires the completion of a new enrollment form which employee submits to his/her Benefit Coordinator. The form is marked CIS by the Benefit Coordinator along with any accompanying documentation required and submitted to FBMC.

Judgment/Decree/Order

Only changes are permitted that correspond specifically with the terms of the written document. Any change requires the completion of a new enrollment form which employee submits to his/her Benefit Coordinator. The form is marked CIS by the Benefit Coordinator along with a copy of the order and submitted to FBMC.

Post-tax Product Changes

Post-tax products are not restricted by Section 125 irrevocability rules. Thus if an employer's plan permits, changes may be made mid-year in coordination with the applicable coverage provider. In addition changes must be made mid-year if the applicant fails underwriting requirements or if there is discovery of fraud of international misrepresentation of fact by the insurer.

The Mountaineer Flexible Benefit post-tax products are addressed as follows:

Life Events

Note: this product is no longer offered to new employees, but there are participants from prior enrollments.

All changes or inquiries must be directed to Trustmark, the underwriter of this insurance coverage. In the event an employee is terminated, the employee has the option of contacting Trustmark to establish a direct billing process.

Trustmark Customer Service: 800.918.8877.

Group Legal Plan

Although the legal plan is a post-tax product, it follows the same rules as pre-tax products; no changes are permitted mid-year without a corresponding change in status event.

Leave of Absence

An employee who goes on unpaid leave of absence during any plan year may continue his/her Mountaineer Flexible Benefits plan coverages by paying the premiums directly to FBMC, on an after-tax basis.

All benefits, including the two Flexible Spending Accounts, may be continued by the employee while on leave. An employee on unpaid non-FMLA leave may choose to continue his/her benefits by paying directly since any coverages not continued may not be reinstated until the next plan year.

** FMLA special election and enrollment rules dictate that eligible benefits be reinstated upon return from leave regardless if continued while on approved FMLA.*

Q/A 7. How does an employee pay directly for coverages? What is the role of the Benefit Administrator?

When completing the necessary agency forms for leave, an employee should at that time make arrangements with his/her Benefit Coordinator to continue Mountaineer Flexible Benefit coverages. The Benefits Coordinator advises the employee of the total premium due based on the coverages the employee wishes to continue.

Personal payments, payable to WV-Mountaineer Flexible Benefits, are to be sent by the employees to the Benefit Coordinator to oversee the employees' payments while on leave. The Benefit Coordinator complete a Mountaineer Flexible Benefits Personal Pay Summary Form and submits the check to:

FBMC Benefits Management, Inc.
ATTN: Accounting-WV
P.O. Box 1878
Tallahassee, FL 32302

Note: the Personal Pay Summary Form is available on the PEIA website under forms and downloads, Mountaineer Flexible Benefits.

Non-Discrimination Testing

The IRS permits any mid-plan year changes that are needed to meet non-discrimination testing requirements. This testing is performed annually to assure the plan does not discriminate in favor of highly compensated individuals. Changes, if any, would be coordinated between FBMC and PEIA; Benefit Coordinators are then notified.

Employee Death, Termination or Retirement

When an employee who participates in Mountaineer Flexible Benefits separates from service, all pre-tax benefits cease on the last day of the month in which the employee is terminated. The Plan prohibits a participant from making subsequent payments to the Plan unless he/she exercises applicable rights under COBRA.

Q/A 8. How is FBMC notified of an employee's separation from service?

The Benefit Coordinator follows the standard Payroll Reconciliation process described previously:

County Boards of Education and participating non-state agencies notify FBMC via the billing process;

State agencies, and campuses notify via the payroll deduction/eligibility file.

Important Notes:

When an employee separates, it is extremely important to specify if the employee is terminating employment or retiring from service. This key information may trigger COBRA rights which must be addressed timely in accordance with federal law.

In the event of an employee's death, reduction in hours, or Medicare eligibility the Benefit Coordination must notify FBMC within 30 days of the qualifying event.

IV Benefit Continuation

Overview

Federal law (COBRA) requires that group health plans give employees and their families the opportunity to continue health care coverage at group rates for a defined period of time when there is a *qualifying event* that would otherwise result in a loss of coverage through an employer's plan. COBRA's provisions apply to certain former employees, retirees, spouses and dependent children.

In addition, the State of West Virginia allows eligible retiring employees and surviving spouses to continue certain group benefits upon retirement from state service.

This section describes the benefit continuation procedures associated with COBRA and Retirement.

COBRA Services

FBMC makes COBRA services available through its subcontractor PayFlex. PayFlex provides an end-to-end outsourcing solution that conform to all federal and industry regulatory requirements, including HIPAA compliance.

Standard Services include:

- Qualifying Event Notices
- COBRA elections and terminations
- Premium collection and distribution
- Eligibility updates to carriers
- Disability extensions
- Conversion Rights Notices
- Notices of Unavailability
- Medicare Notices
- Notice delivery via First Class mail (including Proof of Mailing for Initial Rights Notices and Qualifying Event Notices)
- Severance package management
- Member IVR and Call Center Customer Service
- Website member service for current account status, payments and mailed documents
- Member communication options via email with eNotify™ and website alert notifications
- Plan sponsor website for reports, documents and member information
- Comprehensive plan sponsor reporting package with On-Demand feature
- Plan sponsor management support
- Updates on legislative changes pertaining to COBRA administration

Not all Mountaineer Flexible Benefit coverages are eligible for continuation; COBRA applies only to vision, dental and hearing plans, and the Medical FSA. Who qualifies for coverage under COBRA's Qualifying Events differs for employees, spouses and dependents. And the duration of COBRA benefits differs based upon the qualifying event. The chart below summarizes the events and periods of coverage.

Qualifying Events	*Who Qualifies For COBRA?*	For How Many Months?
Termination	Employee, Spouse, Dependent Child	**18***
Reduced Hours	Employee, Spouse, Dependent Child	**18***
Employee entitled to Medicare	Spouse, Dependent Child	**36**
Divorce/legal separation	Spouse, Dependent Child	**36**
Death of covered employee	Spouse, Dependent Child	**36**
Loss of "dependent child" status	Dependent child	**36**

** Note: In the case of individuals who qualify for Social Security disability benefits, special rules apply to extend coverage an additional 11 months.*

Q/A 9. What is the process to continue benefits through COBRA? What is the Benefit Coordinator's role?

The following procedures are consistent with the requirements specified by law. All timelines are dictated within the COBRA statute.

Step one. When the employee or Benefit Coordinator notifies FBMC of a qualifying event, PayFlex forwards by regular mail a COBRA Notification of Rights letter and an application form to the employee.*

**The Benefit Coordinator follows the standard agency Payroll Reconciliation process described previously to advise FBMC that an employee has terminated.*

Step two. The employee has sixty days to complete and return the application form to PayFlex.

Step three. Upon receipt of the application, PayFlex will send an initial bill to the employee that will be effective from the date coverage is lost. Premiums from the interim period are included on the bill and must be paid to keep the coverage in force under COBRA. The employee is given the option to make payments monthly, quarterly, semi-annually, or annually.

Benefits will remain in effect throughout the coverage period as long as premiums are paid. PayFlex notifies each COBRA participant thirty days prior to the time that COBRA benefits are discontinued. If rate changes occur during the annual open enrollment period, employees who are continuing benefits under COBRA will be notified of the rate increase or decrease. Unless the employee chooses to drop the benefit(s), the change will become effective with the start of the new plan year and the employee's COBRA bill will be adjusted accordingly.

Retirement Services

On behalf of PEIA, FBMC makes certain retirement services available to eligible individuals, oversees the payment collection process, and forwards premium collected to coverage providers.

Eligible individual includes: a retiring employee, a former employee, surviving spouse of a former employee of the State of West Virginia, County Board of Education or any non-state agency who receives income under the WV Consolidated Public Retirement Board or is a participant in a TIAA-CREF retirement plan.

Eligible benefits include: Mountaineer Flexible Benefit dental, vision, hearing and legal plans. Flexible spending accounts (FSAs) and health savings accounts (HSAs) are not offered to retirees.

Once selected, benefit coverages of retirees remain in effect for the entire plan year, except under limited circumstances, including: marriage, divorce, birth, or death, or an event that impacts coverage eligibility. Any coverages cancelled mid-year cannot be reinstated until the next open enrollment period.

On an annual basis, retirees have the ability to change benefit elections or continue unchanged. This open enrollment coincides with the open enrollment for active employees.

Q/A 10. What is the process to continue benefits post Retirement? What is the Benefit Coordinator's role?

Step one – Employee selects retirement date. The Benefit Coordinator's role is to discuss with eligible retirees or beneficiaries the retiree benefits available and assist as may be needed with FBMC contact information and completion of enrollment forms.

Step two - Benefits DO NOT automatically continue from active employment into retirement; employees must contact FBMC during the 90-day period prior to his/her anticipated retirement date and request a Retiree Enrollment packet.

Step three – Employee selects coverages to continue and actively enrolls by completing a Mountaineer Flexible Benefits Retiree Enrollment Form; method of payment is determined on the form and may be made by: 1) retirement check; 2) monthly bill, or 3) bank account ACH. Payments for premiums must be made in advance.. For example:

CPRB Retirees:

FBMC coordinates payments with the state retirement system. Premiums are deducted from the retiree's CPRB retirement check, unless premium costs are greater than the total amount of the check in which case payments can be made directly by the use of a monthly billing statement. Until deductions are set up payment by personal check or money order is required. A billing statement will be sent for each retirees use until deductions begin from his/her retirement check.

If paying by direct bill or ACH, full premium payments must be paid by the due date indicated on each monthly billing statement.

TIAA-CREF Retirees:

Payment by personal check or money order must be sent with the monthly billing statement supplied and must be paid by the due date specified. Payments may also be set up by ACH.

Step four - Employee submits the white copy of the enrollment form no later than 60 days of retiring to FBMC's Retiree Direct Bill Department. Coverage is effective the first day of the month following retirement (benefits are billed accordingly).

Step five – Retiree makes payment to continue coverage. If payments are not set up via ACH or the state retirement system, payment must be mailed by the deadline date to FBMC as follows:

Retiree Direct Bill Department Direct Bill P.O. Box 10789 Tallahassee, FL 32302-2789

For questions, retirees or Benefit Coordinators may contact FBMC Customer Service at 1-844-55WVA4U (844-559-8248) 7 a.m. – 7 p.m. ET, Monday – Friday.

V Employee Appeals

An appeal is a formal written request for reconsideration of the manner in which a transaction was handled. Generally an appeal must be filed within 30 days of the date the transaction in question occurred.

An appeal is typically triggered when an employee is dissatisfied and challenges established procedure. For example:

- Enrollment appeals often occur because the enrolment deadline is missed and the enrollment form is rejected.
- A mid-year status change appeal might be triggered by a rejected form that missed the plan's 60 day window, or a request that is inconsistent with the qualifying event.
- A claims appeal is typically due to a reimbursement claim or insurance claim being denied in full or in part because information is missing or the claim is ineligible.

Each appeal is reviewed by FBMC on its own merits taking into account 1) the extenuating circumstances as relayed by the employee, 2) any/all corroborating information submitted by the employee to support his/her position, and 3) application of specific plan rules and governing regulations.

Appeals are reviewed and determination made within 30 days of receipt of the written request. FBMC provides a formal written response to the participant that includes the rationale for approval or for denial. FBMC Benefits Administration will notify the Benefit Coordinator if an appeal is approved that results in a change to an enrollment election or to a Change in Status.

Because of the highly regulated nature of Section 125 Cafeteria Plans and the obligation to maintain the plan in strict compliance to avoid jeopardizing the plans tax free status, most appeals cannot be approved.

The following chart identifies by type of appeal where the appeal should be submitted.

Type of Appeal	Address to Submit
Enrollment Appeals	FBMC Benefits Management ATTN: Enrollment Appeal PO Box 1878 Tallahassee, FL 32302-1878
CIS Appeals	FBMC Benefits Management ATTN: Enrollment Appeal PO Box 1878 Tallahassee, FL 32302-1878
FSA Appeals	PayFlex Claims Group ATTN: FSA Claim Appeal FAX: 855.703.5305; OR Employee may upload written request and accompanying documentation to the PayFlex employee portal
Insurance Claim Appeal	Employee should follow the instructions provided on the claim denial by the insurance provider