



BEWELLM FOR SMALL BUSINESS EMPLOYER GUIDE



Affordable health insurance options. Made easy!

October 2019

WELCOME TO BEWELLM FOR SMALL BUSINESS

BeWellnm for Small Business is New Mexico's State Health Insurance Exchange where employers with 2 to 50 or full-time equivalent employees can access qualified health insurance plans to provide quality, affordable health coverage for their employees.

With multiple health and dental insurance companies and plans to choose from, employers like you can offer increased flexibility and choice to your employees. BeWellnm is the only place where small businesses can qualify for the small business health care tax credit.

We provide you with clearly defined levels of coverage— Platinum, Gold, Silver, and Bronze—to simplify the process of selecting from dozens of available health plans. Effective October 1st 2019, you can choose not only one, but multiple levels of coverage. For example, you can set your budget on the silver level, but allow employees to move up to gold.

As an enrolled employer, we strive to provide you with the highest level of service to make it easy for you to offer health insurance. Our Business Engagement Team is available to ensure that both you and your employees find the coverage you need and at a budget you can afford.

We're here to help! beWellnm for Small Business is committed to supporting your small business, and we invite you and your employees to contact our Business Engagement Team at (833) 862-3935 option #3.

You may also visit the beWellnm for Small Business website at www.bewellnm.com/small-business-health-insurance for a number of additional resources that may be useful to you.

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RESPONSIBILITY AND PRIVACY

Your Health Plan Responsibilities

While beWellnm for Small Business handles most of the administrative work to make offering health coverage easy for you as a business owner, you will have some responsibilities that you should be familiar with as a health plan sponsor. To provide a quick summary, you are responsible for the following when offering company-sponsored health coverage through beWellnm's small business program:

1. Knowing Your Full-Time Equivalent (FTE) Employee Count and Applicable Large Employer Status
2. Meeting beWellnm's Eligibility Requirements
3. Determining Your Level of Health Coverage and Premium Contribution
4. Following Privacy Rules
5. Deciding on Employee and Dependent Eligibility
6. Setting a New Hire Election Period
7. Paying Your Monthly Invoice
8. Providing beWellnm with Notices of Eligibility Changes
9. Notifying Employees of Open Enrollment
10. Identifying COBRA regulations and Notifying Terminated Employees of COBRA.
11. Additional 6 months continuation of benefits for employers with less than 20 employees.
12. Providing Employees with Health Plan Documents & Resources

In these pages, you will find information on each one of your responsibilities along with details that can help you manage a health insurance program for your employees. These include things like understanding privacy rules, knowing which of your employees are eligible for coverage, what to do if you need to make a change to your health coverage, or when and how to pay your premiums. Feel free to reference the table of contents found at the beginning of this guide for quick access to key topics or the last few pages of this guide for helpful resources and important phone numbers should you need further assistance.

Privacy Guidelines

When applying for health insurance, small businesses and their employees are required to reveal confidential information. Protecting this information is of utmost importance to beWellnm for Small Business. Any information collected on a beWellnm for Small Business employer or employee application, other than the name, address, birth date, and plan selection(s), will not be shared with you or a selected health insurance plan unless strictly necessary for the purposes of determining eligibility and enrollment. As a health plan sponsor, it's important for you to remember to be cautious when disclosing sensitive and personal information. Always adhere to applicable privacy rules to ensure the health information of your employees remains confidential and protected.

Employer Eligibility Guidelines

To be eligible for beWellnm for Small Business, you must have a minimum of 2 employees and no more than 50 full-time equivalent employees. Additional requirements are:

- Employer's principal business address must be in New Mexico or offer coverage to each eligible employee serving that employee's primary worksite
- At least one employee must receive a W-2; employee cannot be an owner or spouse of an owner
- Employer must offer beWellnm coverage to all eligible full-time employees
- Effective October 1, 2019 the employee participation requirement will change from the current 50% requirement to a 0% employee participation rate.
- Currently the employer must agree to contribute at least 40% percent of the lowest cost employee-only plan in your select level of coverage for your eligible employees' premiums. Effective October 1, 2019 the contribution rate will give employers the option to cover any amount of the premium including \$0 or any percent.

Counting Full-Time Equivalent (FTE) Employees

Only small businesses with 50 or fewer full-time equivalent (FTE) employees are eligible to enroll in beWellnm for Small Business. Calculating your total FTE employee count is your responsibility as an employer.

An FTE calculation includes all full-time and part-time employees who worked during the prior calendar year (or who are reasonably expected to work in the current calendar year if you did not exist as a company in the prior year). The calculation should also include employees employed by related entities meeting controlled group status under federal tax laws. To assist you in estimating your FTE employee count, we encourage you to visit the [IRS.gov/Affordable-Care-Act](https://www.irs.gov/Affordable-Care-Act) website and review the IRS-related Affordable Care Act resources available for employers on this topic.

Although the total FTE count determines your business' eligibility to participate in beWellnm for Small Business, it's important to note that not every employee may be eligible for coverage (See [Employee Eligibility & Verification](#)).

Did You Know?

If your full-time equivalent or FTE employee count should increase beyond 50 throughout your plan year, you will continue to remain eligible for beWellnm for Small Business provided other eligibility standards are met. Should you elect to terminate your health coverage with beWellnm but want to re-apply at a later time you may no longer be eligible to participate if your FTE employee count has exceeded 50 employees.

EMPLOYER ELIGIBILITY GUIDELINES

Knowing Your Small and/or Applicable Large Employer Status

Applicable Large Employers

The Affordable Care Act, a federal law that changed the health care landscape for the United States in 2010, requires that employers of a certain size (50 or more full-time equivalent employees) offer health benefits coverage. These employers are known as “Applicable Large Employers” (ALEs).

The mandate requires that employers with 50 or more full-time equivalent employees offer health coverage that is both “affordable” and that meets a “minimum value” to their employees. The law also requires ALEs to offer coverage to employees for their dependent children below the age of 26. ALEs that do not offer health coverage could face a penalty from the IRS referred to as the Shared Responsibility Payment. This penalty is triggered when an employee who is not offered coverage by an ALE purchases health insurance on a state or federal health exchange and receives a federal subsidy to help pay for that coverage.

Employers that have less than 50 employees are considered a small business by the ACA, and while encouraged to offer health coverage are not required to do so by law. Nevertheless, employers that offer health coverage, regardless of whether they are small or large, may find that it helps them to attract top talent and improve productivity at their place of business. Providing employees with health coverage has also been demonstrated to increase morale and help with a company’s retention, making the business an attractive option for employees.

Offering coverage through beWellnm for Small Business can help you avoid the Shared Responsibility Payment and provide your employees with access to quality, affordable ACA-compliant health plans. For more information on the Employer Mandate, visit www.bewellnm.com/shop/SHOP-FAQs.

Small Business Group Size in New Mexico

In New Mexico the group size definition of a small business to include any business with at least two but no more than 50 full-time equivalent employees. Historically, small group size in the health insurance industry was determined for employers that had up to 50 full-time employees.

Employer Contribution Requirement

Employers that are eligible to participate in beWellnm for Small Business can contribute 0% to 100% of the cost towards the lowest premium available for employee-only coverage. This means that you can pay any amount and will have the option of contributing a dollar amount instead of a percentage toward the employee-only premium for the reference plan that you choose. This reference plan can be on any level of coverage and you will have the option of choosing your contribution rate. Your employees' premium contribution and out-of-pocket costs will depend on your reference plan and total contribution, your selected level(s) of coverage and the plan(s) your employee selects. Effective October 1, 2019 the contribution rate will give employers the option to cover any amount of the premium including \$0. Employers will also have the option to contribute a dollar amount to their employee's premium instead of a %. To qualify for the small business tax credit, you will need to contribute no less than 50% of the employee-only premium.

Employee Participation Rate Requirement

When offering coverage through beWellnm for Small Business, at least 50% of your eligible employees must enroll with beWellnm. Valid waivers are not counted when calculating participation. Effective October 1, 2019 the participation rate will change to 0%.

Valid waivers may include:

- Employer Sponsored Coverage
- Coverage through a union
- Military coverage
- Medicaid
- Medicare
- Other federal or state health coverage programs other than coverage through a Qualified Health Plan (QHP) sold in the Individual Exchange

Employer Eligibility & Verification

BeWellnm for Small Business will verify your eligibility as a business owner prior to allowing you to offer health insurance coverage to your employees. If you are determined eligible, beWellnm will notify you in writing confirming that you can participate. If there are any errors in your eligibility, beWellnm will provide you written notice of the discrepancy. From the date of notice, you will have 30 days to resolve any eligibility issues. If you choose not to take action within that 30-day period, beWellnm will provide an eligibility denial notice in writing to you.

Employee Eligibility & Verification

Employees are eligible to participate in beWellnm for Small Business if they receive an offer of coverage from you as an eligible employer and are permanently employed full-time. Employees that are considered “full-time” work an average of 30 hours per week over the course of a month. Eligible employees may be added during the plan year if they experience a qualifying life event or during your annual open enrollment period. Effective dates for coverage are always the first of the month.

Did You Know?

Part-time employees may be considered eligible at your discretion. In order to be counted in your participation rate calculation, part-time employees must work between 20 and 29 hours per week and be actively engaged in your business. In other words, these employees cannot be independent contractors (receive a Form 1099), temporary employees or work less than 20 hours a week for your company.

Employees who are **not** eligible for coverage include those employees who work less than 20 hours per week, receive a Form 1099 or are seasonal, temporary, or subject to collective bargaining arrangements through a union.

BeWellnm for Small Business verifies that your employee is eligible when you submit your application for coverage and will collect only the minimum information necessary to verify their eligibility and enrollment. When your employees' eligibility is determined, we will provide them written notice along with information on their right to appeal their eligibility determination.

If there are inconsistencies between your company and employee applications, beWellnm will provide written notice to you. You will have 30 days from the date of the notice to resolve the inconsistency. If no response is received within the 30-day period, beWellnm will provide a written notice of denial to enroll in the program.

Your employee may voluntarily elect to waive coverage. The employee must complete and sign the declination section on the employee application. An employee that waives their coverage is not eligible to enroll in your health plan until your next open enrollment period or unless eligible for a special enrollment period through a qualifying event.

Dependent Eligibility & Verification

Did You Know?

Spouses, as well as registered and non-registered domestic partners, are not considered “eligible dependents” and should seek their own coverage either through their employer, beWellnm's Individual Marketplace or a private health insurance company. You may elect to offer dependent coverage that includes spouses or domestic partnerships but it is not required when electing to offer dependent coverage.

Should you elect to offer dependent coverage, enrollees and their dependents must enroll in the same health and/or dental plan. Dependents that qualify and are eligible for health coverage through beWellnm for Small Business must be under the age of 26. Dependents include adopted children, foster children or those under legal guardianship. Disabled adult children (regardless of age) are also considered eligible dependents. Only dependents under the age of 19 are eligible for the pediatric dental and pediatric vision coverage. Please refer to your selective Evidence of Coverage (EOC) for more information. If the selected health plan does not include embedded Pediatric Dental, the employee has the option to select a supplemental children's dental plan. Dependents that lose eligibility for pediatric dental coverage subsequent to turning nineteen (19) years of age and wish to continue dental coverage under a standalone dental plan may select a standalone dental plan within 30 days of losing coverage. Eligible dependents may be added during the plan year if they experience a qualifying life event or during your annual open-enrollment period.

Did You Know?

Employers can elect to offer employee only-coverage. In the event that you choose to offer employee-only coverage, know that you may be subject to Shared Responsibility Payments if you are an ALE and your employees' dependent children seek coverage through a state or federal health exchange. However, if you should elect not to offer dependent coverage and are not required to because of your business size, your employees may be able to purchase coverage for their dependents through beWellnm's Individual Marketplace. Dependents may even be eligible to receive financial assistance for a health plan should they need it.

In verifying eligibility for your employee's dependents, we will provide written notice if there are inconsistencies between your company and employee applications. You'll have 30 days from the date of the notice to resolve the inconsistency. If no action is taken within that 30-day period, beWellnm will provide written notice to your employee about their dependent's denial of eligibility to enroll in the program.

ELIGIBILITY APPEAL PROCESS

If you or your employees receive a denial of eligibility or do not receive timely notification of eligibility from beWellnm for Small Business, you have the right to appeal the decision. Appeals must occur within 90 days from the date of the denial notice. Once an appeal is submitted, beWellnm will provide a response to the appeal in writing. Appeals will be decided independently and the appeal board will review all evidence submitted by the appellant. If you as a business owner or your employees are determined to be eligible for health coverage as a result of the appeal process, the eligibility decision is backdated and effective starting the date of the incorrect determination.

For questions regarding the appeals process, contact the beWellnm for Small Business Engagement Center at (833) 862-3935 or send an e-mail to Business@bewellnm.com

REPORTING CHANGES TO BEWELLM

Reporting a Change to Your Business

A number of events can occur throughout the year that can impact your business. You may change your ownership structure, your business name or primary contact, your address or your federal and state tax ID. These are important changes, and it is your responsibility to notify beWellnm for Small Business promptly. A change in tax ID will require a new application.

If your principal business address should change, know that it may affect premium rates and/or plan options for both you and your employees (see [Your Health Plan Premiums](#) on pg. 13). However, beWellnm for Small Business will not make retroactive rate changes for employers that fail to inform us of address changes. Premium and rate changes will only be effective at your plan year renewal.

Please notify us of a business change by electronic correspondence at business@bewellnm.com or at 1-833-862-3935 option #3

Please allow one to two billing cycles for your business change to be updated in our system and on your monthly invoice.

Reporting a Change in Employee/Dependent Eligibility

As a health plan sponsor, you are required to report any changes in your employees' eligibility to beWellnm for Small Business. Changes that should be reported include an employee's:

- Change of address
- Change in work hours or work relationship
- Loss or gain to other health coverage
- Change in dependent status
- Termination of employment
- Death

All changes should be submitted using the beWellnm for Small Business Portal for your employer account at business.bewellnm.com. All changes are to be within a 60-day window from the date of change; therefore, any retro terms or add; exceeding a 60 days window will require approval from beWellnm. Please submit request to [business @bewellnm.com](mailto:business@bewellnm.com)

Please allow one to two billing cycles for your employee or dependent change to be updated in our system and on your monthly invoice.

Making Changes to Your Health Coverage

Once enrolled in beWellnm for Small Business, you or your employees can only make changes to health coverage during your annual election and 10 day open-enrollment period. Employers can make Plan changes 45 days prior to renewal usually the 15th through 30th of the preceding month. For example, for a renewal date of August 1st, the employer will make changes June 15th through 30th. The employee will then have a 10-day open enrollment period from July 1st through July 10th. If the employee does not make any changes, they will be passively renewed with a plan similar to the previous year.

Modifications that can be made during this time include changes to your:

- Selected level of coverage (Bronze, Silver, Gold, Platinum)
- Reference Plan
- Contribution percentage
- New hire waiting periods
- Number hours of work necessary for coverage
- Update number of FTEs
- Dependent coverage
- Infertility coverage

If the employer's reference plan is no longer available at renewal and the employer does not select a new reference plan during the employer's annual election period, a default plan will be auto selected on behalf of the employer. The auto-selected reference plan shall be the lowest cost plan in employer's current selected tier and the employer's contribution will remain the same as previously elected.

During your annual Open Enrollment, employees can make plan changes within your selected level(s) of coverage, and add dental coverage and/or dependents.

If at renewal an employee's plan is discontinued, the employee's plan may be passively renewed to the lowest cost plan within the same carrier and same metal tier. If the same carrier is not available with beWellnm, the employee's plan may be passively renewed to the lowest cost plan with a different carrier within same metal tier.

Employees can make changes to health coverage throughout your plan year should they experience a qualifying event, such as becoming a newly hired employee or a new parent. For more information on what changes can be made during these time periods, see [Qualifying Life Events – Special Enrollment](#).

PREMIUM BILLING AND PAYMENTS

BeWellnm's financial management system is the system of record for transactions related to billing and payment for coverage for Employer Groups (Group) purchased through the Exchange. This section will detail the policies, procedures and rules governing the following:

- Premium billing
- Premium payments
- Adjustments due to retroactive eligibility changes or other reasons
- Grace period
- Non-payment of premium

Premium Billing

Initial bills are generated during Special Enrollment Periods (SEP). When a plan selection has been made and employees have enrolled, the initial bill is available on the Group's online account.

Ongoing premium bills are generated on the 5th of each month in advance of the coverage month. Payment is due on or before the 1st day of the month of coverage. Example, the bill for May coverage is generated on April 5th and due on May 1st. The billed amount is based on the coverage selected by each enrolled employee. Any transactions (adds/terms/changes) created from the last billing cycle are included in the subsequent month's bill as adjustments. The bill will include all carriers which the employees are enrolled.

The Group can access and pay their monthly bill on the beWellnm portal. If a Group has selected the recurring payment option, the statement will reflect the net billed amount that will be deducted from their account.

Premium Payments

Initial Payment

Groups must pay the first month's premium in full before coverage will take effect. Failure to send in the initial payment in full by the due date may result in cancellation of the policy, a delay in the policy effective date or require re-submission of enrollment documents.

Ongoing Payments

Groups must continue paying their premium for each month they are enrolled. Payments are due on the 1st day of the coverage month. Payment must be received by this date to ensure there is no disruption to coverage. Although employees can choose from multiple carriers, Groups pay with a single payment for all enrolled employees. Premium payments are made directly to beWellnm.

A Group who make changes to their account after their bill has been generated, and before they submit their payment, should log into their online account to review the amount due. For Groups with a recurring payment, any changes made during this period will be included in the amount deducted from their account. Changes that may impact a change in premium include: updates to plan selection or family composition.

Groups that do not pay their full balance by the payment due date are at risk of experiencing an interruption in coverage. It is the Group's responsibility to make sure they are paid in full by the payment due date

Payment Types

Recurring payments – Groups that elect recurring payments authorize beWellnm to automatically collect their monthly premium from their bank account or credit card each month. The recurring payment process is run on the 18th of the month prior to the effective month of coverage (i.e. April 18th for May coverage). Recurring payments can only be set up after a Group has paid their first invoice in full. If the bank information is not updated prior to the recurring payment process, a one-time payment will be required by the 1st of the coverage month to avoid disruption of coverage. BeWellnm will carry forward the recurring payment from one policy year to the next. A Group is required to attest online and agree to the terms and conditions when selecting recurring payments.

One-time payments – Groups can make one-time payments by accessing their account in the beWellnm portal. A confirmation number will be issued after completing an online payment. Groups should retain the confirmation number for their records. The banking information entered for one-time payments is not retained in the system and will need to be reentered when making subsequent one-time payments.

Grace Period and Termination for Non-payment of Premium

If premium payment has not been received by beWellnm on or before the first day of the coverage month, a 30-day grace period is triggered and initiates the process for termination of the Group for non-payment of premium. A delinquent notice will be emailed to the Group contact on file. The notification will inform the Group that payment has not been received and the group policy will be terminated if payment is not received within the grace period. At the same time, a separate delinquent notice will be sent to each covered enrollee under the group plan.

If payment is not received within the grace period, the Group will be terminated. A termination notice will be sent to the Group and Broker, if applicable, notifying them of the termination. A termination notice is also sent to all covered enrollees under the group plan.

The acceptance of any partial payment shall in no way constitute a waiver of rights to terminate a Group for non-payment. The termination will take effect on the last day of the month in which full payment was received by beWellnm.

Reinstatement - If a Group is terminated due to non-payment, but within 30 days following the termination Group requests reinstatement, pays all premiums owed including any prior premiums owed for coverage during the grace period, and pays the premium for the next month's coverage, beWellnm may reinstate the Group in its previous coverage. A Group may be reinstated after termination for non-payment only once per calendar year.

For your convenience, beWellnm for Small Business has posted these important documents to our website and can be found at:

Plans

bewellnm.com/small-business-health-insurance.com

Application

business.bewellnm.com

ENROLLING YOUR EMPLOYEES

Annual Election and Open Enrollment Period

Open Enrollment is the time of year when your small business is eligible to change its offer of health coverage to employees. BeWellnm for Small Business will send you a notice of your plan renewal and annual election period 60 days prior to the completion of your plan year. During this time, you can explore plan options and make necessary reference plan and/or contribution changes to your health coverage (See [Making Changes to Your Health Coverage](#)). The election period for you to make changes to your offer of coverage is at least 15 days in length, election period.

Once you have made your health coverage changes, if any, you can start an open-enrollment period for your employees to make their health plan selections for the upcoming plan year. The open-enrollment period for your employees must be at least 10 calendar days in length. During Open Enrollment, employees can review their plan options, discuss buying decisions with their family and make plan changes for your upcoming plan year. They may also add and terminate eligible dependents.

Open Enrollment Notifications

At the start of your annual open-enrollment period, beWellnm for Small Business will provide you with instructions for renewing your health or dental plan, plus making plan changes.

Once you receive a renewal notice from beWellnm, it is your responsibility to notify your employees and any Federal COBRA (see [COBRA Health Plan Administration](#) on pg. 22) participants of:

- Their right to change their health and dental coverage during Open Enrollment
- The start and end dates of your open-enrollment period
- Your contribution amount toward their employee premium

You are responsible for notifying your eligible employees of the availability of health and dental plans offered through beWellnm for Small Business. It is important that you provide to your employees notice of Open Enrollment. In addition, it is important to emphasize that unless an employee experiences a qualifying event, employees will not be able to make changes to their coverage after your annual open-enrollment period.

Did You Know?

A valid waiver would include health coverage through another employer, a union, the military, Medicaid, Medicare or other federal or state health coverage programs other than coverage through a Qualified Health Plan (QHP) sold in the Individual Exchange.

You are also responsible as a health plan sponsor for providing certain health plan documents to your enrolled employees. This includes making Summary of Benefits and Coverage (SBC's), and health plan change summary documents available for your employees to use and reference. If an eligible employee declines or "waives" coverage, the employee must indicate they are declining coverage and state any other sources of coverage by completing and signing the Declination Acknowledgment on the Change Request Form for Employees.

It is important that beWellnm receive your health coverage changes no later than the 10th of the month prior to your plan year renewal date to ensure your employees receive new ID cards by the start of your plan year. Changes received after that date may result in processing delays. Employees wishing to change carriers must do so prior to the renewal month.

New Hire Enrollment

Employees added during the plan year are guaranteed coverage until the end of your plan year. A new hire is eligible for coverage the first day of the month after completion of your company's waiting period. You choose the waiting period that is right for your business, but the total waiting period cannot exceed 90 calendar days¹. A newly eligible employee shall have a 30-day period to enroll in a qualified health plan beginning on the first day the employee becomes eligible.

After initial enrollment, plan changes submitted thru the 15th day of the first coverage month will be effective retroactively to the 1st of the current month unless otherwise requested. BeWellnm will process plan changes submitted after the 15th day of the first coverage month for the 1st of the *following* month.

Waiting Periods must be in compliance with 42 U.S.C. Section 300gg-7 and applicable state law.

Deciding on a Waiting Period

The new hire waiting period for coverage cannot exceed 90 calendar days from the first day of your new hire's employment counting as day one. Since coverage begins on the first day of the month, you will want to choose a waiting period that is in compliance with the maximum 90-day time frame:

For example, the following two scenarios would be in compliance:

- First of the month following 60 days from the date of hire;
- First of the month following the date of hire

When your employee is eligible to enroll in your beWellnm for Small Business health plan, you will then send them an invitation from the beWellnm Small Business Portal. This will allow your new hire to begin the open-enrollment process. New employees will then be able to make their plan selection prior to coverage taking effect the following month.

It is our aim to connect your employees with health insurance as quickly and easily as possible. Application processing times include employer and employee eligibility verification. Submitting applications that are incomplete or have inconsistencies may delay processing times. beWellnm will notify your employee of these inconsistencies and notification of an eligibility determination (See [Employee Eligibility & Verification](#) on pg. 9).

Qualifying Life Events – Special Open Enrollment Window

Employees and their dependents can enroll outside of open enrollment if they experience a qualifying life event. Qualifying life events allow employees, spouses and/or their dependent(s) to be eligible for health care benefits outside the annual open-enrollment period. If an employee waives coverage during Open Enrollment, they must either wait for the next annual open-enrollment period or have a qualifying event in order to be enroll in your group health coverage.

A list of qualifying events that would start a special enrollment period can be found in the following table. For more information on qualifying events, please visit www.bewellnm.com/special-enrollment-life-changes.

Native Americans are able to make a change in coverage at any time. The effective date of the coverage will apply 1st of the following month. They are not help to a qualifying life event and or Special Open Enrollment Window.

LIFE EVENT	TIME FRAME FOR APPLICATION	WHO CAN ENROLL?
Termination of Employment (ex-employee now eligible for a special enrollment as a dependent under a spouse's plan)	30 days from the last day of coverage	Employee (in this case, the employee is the still-employed spouse), spouse (who was terminated) and child dependents
Divorce, Legal Separation, or Loss of Dependent Status (dependent spouse or child loses coverage under subscriber's plan)	30 days from the last day of coverage	Employee plus dependents
Enrollee Loses a Dependent (spouse or child through death, divorce or legal separation)	30 days from the last day of coverage	Employee plus dependents
Death of the employee's spouse/registered or unregistered domestic partner (dependents lose coverage under deceased subscriber's plan)	30 days from the last day of coverage	Employee plus dependents
Reduction in Hours that led to ineligibility for benefits (makes the employee who lost eligibility, eligible for a special enrollment as a dependent under a spouse's plan)	30 days from the last day of coverage	Employee (in this case, the employee is the employed spouse), spouse (who lost eligibility) and child dependents
Qualified Health Plan Decertification	30 days from the last day of coverage	Employee plus all enrolled dependents
Loss of Pregnancy-related Coverage	30 days from the last day of coverage	Employee plus dependents
Loss of Medicaid Coverage	60 days from the last day of coverage	If employee loses, employee plus dependents. If dependent loses, dependent only.
Gains a Dependent (child, marriage, domestic partnership, court ordered mandate)	30 days from the event (marriage, domestic partnership decree, birth, adoption, foster care placement, QMSCO)	Employee plus all dependents (adult and child)

COBRA Exhaustion (as opposed to termination for non-payment)	30 days from the last day of coverage	If employee exhausts, employee plus all dependents. If dependent exhausts, dependent only.
Erroneous Enrollment in a Qualified Health Plan	30 days from the last day of coverage in the wrong plan	Enrollee(s) who experience the error
Qualified Health Plan Misconduct	30 days from the last day of coverage in the QHP at issue	Employee plus all dependents
New Access to a Qualified Health Plan due to a permanent move, assuming that prior to the move, the enrollee had one or more days of MEC in the 60 days prior to the move, unless the enrollee was living outside of the US or was living in a US territory	30 days from the date the new access began	Employee plus all dependents
Loss of Access to a Qualified Health Plan because of a permanent move (moving out of an HMO service area)	30 days from the last day of coverage in the lost QHP	Employee plus all dependents
Released from Incarceration	30 days from the date of release	Employee plus all dependents
Returning from Active Duty	30 days from the date of return	Employee plus all dependents
An American Indian (allowed to change plans once per month, every month)	30 days advance notice for every month they want to make a change	Employee plus all dependents
Other Exceptional Circumstances on a case-by-case basis	30 days from the date of the event or last day of coverage, depending upon the circumstances. Consult with a beWellnm representative.	Determined on case-by-case basis

TERMINATING COVERAGE

Terminating Your Small Business Coverage

To terminate health coverage for your company, you must provide written notice via electronic communication to business@bewellnm.com prior to the end of the month in which coverage should end. Notifications can be received up to the last day of the prior month for terminations to take effect the following month. Employees enrolled in health plan will also receive notification from beWellnm of discontinuation of health coverage within 15 days from the employer's written notice to beWellnm for Small Business. Such notification will provide information about other potential sources of coverage, including access to individual market coverage through the Exchange.

Terminating Coverage for an Employee or Dependent

To terminate coverage for an employee that has left employment or is ineligible, please make changes on the Small Business employer portal. If an employee would like to terminate their own coverage and/or the coverage of a dependent, the employee can terminate their coverage on the beWellnm Small Business Portal at business.bewellnm.com

The coverage termination effective date for an employee and his/her dependents is based on the reason as

TERMINATION REASON	TERMINATION EFFECTIVE DATE
Death	The date of death.
Termination of Employment	The last day of the month in which eligibility changed.
Ineligible	The last day of the month in which eligibility changed.
Employee Request	The last day of the month in which an employee requests termination or a date in a subsequent month specified by the employee as long as the date is the last day of the month.

An earlier effective date of termination may be determined on a case-by-case basis by beWellnm and the QHP. However, the effective date of termination may be no other date other than the last day of the month.

Please allow 10 calendar days for the processing of Employer Termination. BeWellnm for Small Business will email the terminated employee or dependent a notice of termination. The former employee may be eligible for COBRA continuation coverage.

COBRA allows certain former employees and other participants such as retirees, spouses, former spouses, and dependent children the right to continuation of health coverage of your company's health plan rates. COBRA coverage, however, is only available when health coverage is lost due to a COBRA qualifying event.

Six Month Continuation Coverage ADMINISTRATION

Six-month continuation coverage is also known as state continuation generally applies to companies with less than 20 full-time employees and FTEs for 50% of their working days in the previous calendar year. Companies not subject to federal COBRA are usually subject to the state continuation regulations of the state where the company's plans are based.

If a former employee elects to continue the group health insurance, the coverage given will be the same coverage that is currently available to active employees and their families as well as the same benefits, choices, and services such as:

- The rights to open enrollment to choose among available coverage options;
- The rights to add qualified beneficiary dependents;
- The rights to remove dependents voluntarily; and
- The rights to remove dependents when they are no longer eligible for coverage.

The six-month state continuation provides coverage for individuals under employer group health plans that have 20 or less employees. Six-month continuation is administered by the employer as a health plan sponsor or by a Third-Party Administrator (TPA) that you hire to perform this service for you. For more information on six month continuation coverage, please contact your TPA or visit <https://www.dol.gov/general/topic/health-plans/cobra>.

Note: Employer will NOT receive a different invoice for six-month continuation participants, nor a separate payment for these individuals. They are included in the same billing and premium payment process as active employees.

COBRA HEALTH PLAN ADMINISTRATION

COBRA Health Plan Administration

The Consolidated Omnibus Budget Reconciliation Act (**COBRA**) offers employees and their dependents who lose their health benefits the opportunity to continue their coverage under the employer's health benefit plan for limited periods of time under certain qualifying events such as voluntary or involuntary job loss for any reason other than gross misconduct, reduction in the hours worked, death, divorce, and other qualifying life events.

If a former employee elects to continue the group health insurance, the coverage given will be the same coverage that is currently available to active employees and their families as well as the same benefits, choices, and services such as:

- The rights to open enrollment to choose among available coverage options;
- The rights to add qualified beneficiary dependents;
- The rights to remove dependents voluntarily; and
- The rights to remove dependents when they are no longer eligible for coverage.

There are two types of COBRA offered. The type of COBRA that your company qualifies for is determined by the size of your company. Federal COBRA benefits are administered by the employer group.

Federal COBRA provides continuation of coverage for individuals under employer group health plans that have 20 or more employees. Federal COBRA is administered by the employer as a health plan sponsor or by a Third-Party Administrator (TPA) that you hire to perform this service for you. For more information on Federal COBRA coverage, please contact your TPA or visit <https://www.dol.gov/general/topic/health-plans/cobra>.

Note: Employer will NOT receive a different invoice for Federal COBRA participants, nor a separate payment for these individuals. They are included in the same billing and premium payment process as active employees.

COBRA TYPE	WHO QUALIFIES?	WHO ADMINISTERS?
Federal COBRA	Employers with 20 or more employees	Employer or an employer hired Third Party Administrator (TPA)

COBRA Qualified Beneficiaries

A qualified beneficiary is an individual who was covered by a group health plan on **the day a qualifying event occurred that caused him or her to lose coverage**. Only certain individuals can become qualified beneficiaries due to a qualifying event, and the type of qualifying event determines who can become a qualified beneficiary when it happens. A qualified beneficiary must be a covered employee, the employee's spouse or former spouse, or the employee's dependent child. In certain cases, involving the bankruptcy of the employer sponsoring the plan, a retired employee, the retired employee's spouse or former spouse, and the retired employee's dependent children may be qualified beneficiaries. In addition, any child born to or placed for adoption with a covered employee during a period of continuation coverage is automatically considered a qualified beneficiary. An employer's agents, independent contractors, and directors who participate in the group health plan may also be qualified beneficiaries.

COBRA Qualifying Events

COBRA qualifying events cause an individual, whether an employee, spouse or dependent, to lose health coverage. The type of qualifying event determines the qualified beneficiaries and the amount of time that health coverage must be offered under COBRA. The following table below shows the specific qualifying events, the qualified beneficiaries who are entitled to continuation of coverage, and the maximum period of continuation of coverage that must be offered based on the type of qualifying event.

QUALIFYING EVENT	QUALIFIED BENEFICIARIES	FEDERAL COBRA LENGTH OF COVERAGE
Voluntary or involuntary termination of employment (for reasons other than gross misconduct) or reduction of employment hours	Employee Spouse Dependent Child	18 months
Employee becomes entitled in Medicare	Spouse Dependent Child	36 months
Divorce or legal separation	Spouse Dependent Child	36 months
Death of employee	Spouse Dependent Child	36 months
Loss of "dependent child" status	Dependent Child	36 months

*In certain circumstances, qualified beneficiaries entitled to the 18 months of continuation of coverage may become entitled to disability extension for an additional 11 months (for a total of 29 months) or an extension of 18 months (for a total of 36 months). The Social Security Administration (SSA) determines the qualified beneficiary before the 60th day of continuation of coverage which the qualifying event occurs.

**The continuation of coverage may vary due to when the employee becomes entitled to Medicare prior to or after the end of the covered employee's employment or reduction of hours of employment.

Events That Do Not Qualify for COBRA

Certain events may cause loss of coverage but do not qualify for COBRA continuation. These non-qualifying events include when an employee:

- Waives coverage
- Fails to elect within the 60-day timeframe to elect COBRA continuation coverage
- Voluntary removes their dependent's coverage
- Is terminated due to gross misconduct

Your Federal COBRA Notification Responsibilities

Under Federal COBRA, employers must provide qualified beneficiaries and their families certain notices explaining their COBRA rights, how to elect COBRA, and when it can be terminated in a timely manner when they experience a loss of health coverage.

COBRA Election Notices

For employers that qualify for Federal COBRA (20 or more employees), you or your hired TPA must send your former employee their Federal COBRA Notification & Rights with a Federal COBRA Election Form within 14 days of their health coverage termination. The purpose of this notification is to inform your employee of their COBRA qualifying status and the rules and regulations of the COBRA Continuation Coverage.

For more information on federal COBRA coverage, please visit dol.gov/general/topic/health-plans/cobra.

Employee Termination Notices

Employers that qualify for Federal COBRA are responsible for notifying a current COBRA participant directly when their COBRA health coverage has terminated.

The termination notice should be sent to the employee's last known address following:

- Failure to submit their premium payment on time
- Your termination of employee health coverage
- Your COBRA participant starting coverage with another group plan
- Your COBRA participant starting coverage with Medicare
- Your COBRA participant's request for termination

Employee COBRA Notifications

Your former employee or eligible dependents must notify you or beWellnm for Small Business, whichever is applicable, of their COBRA election within 60 days of their qualifying event. Failure to provide notification will result in their loss of health coverage continuation rights.

COBRA Coverage Payment

Employer will NOT receive a different invoice for COBRA participants, nor a separate payment for these individuals. They are included in the same billing and premium payment process as active employees.

COBRA Termination

Employer and or third-party administrator is responsible for terminating COBRA coverage for employee.

SMALL BUSINESS TAX CREDITS

Small Business Tax Credits

The Patient Protection and Affordable Care Act (ACA) offers eligible small business owners' access to federal tax credits that make providing employee health insurance more affordable. Small businesses may qualify for a federal tax credit that reimburses up to 50 percent of their employee premium contribution if they purchase coverage through beWellnm for Small Business.

The tax credit amount depends on a number of factors including the number of full-time employees and the amount contributed towards health insurance premiums. Generally, small businesses that have fewer than 25 full-time equivalent employees and pay an average annual salary of less than \$50, 000 per year (adjusted annually for inflation) will be eligible for the tax credit. Employers with fewer than 10 full-time equivalent employees with wages averaging less than \$25,000 per year will be eligible for the maximum tax credit amount. The maximum available tax credit is 50 percent of insurance premium expenses and is available for a total of two consecutive years. Tax credits are also available for qualifying nonprofit or tax-exempt employers. Nonprofit or tax-exempt employers must meet the same eligibility criteria; however, their maximum tax credit amount will be somewhat lower.

To assist you in estimating the small business tax credit for your business, a tax credit calculator is available at www.bewellnm.com/shop/small-business-toolkit/Small-Business-Tax-Credit-Calculator. You can use this calculator to help determine if you qualify for the federal tax credit and to estimate your tax credit amount. BeWellnm also encourages you to visit IRS.gov and to contact your tax professional for additional information or assistance.

CONTACT BEWELLM FOR SMALL BUSINESS

Contact beWellnm

BeWellnm for Small Business is committed to supporting your small business health insurance program. BeWellnm for Small Business invites you and your employees to contact us or your Certified Insurance Agent with any questions or concerns. You may also visit the beWellnm for Small Business website at bewellnm.com/small-business-health-insurance for access to additional resources that may be useful to you.

These online resources include:

- Tax Credit Calculator
- Resources for Participating Employers, including –
 - Employer & Employee Change Request Forms
 - Appeal and Complaint Forms
 - Health & Dental Plan Resources
 - Contact Information
- Information about the Employer Mandate
- Latest News and Articles
- Locate a Certified Insurance Agent

If there are additional questions, or if you should need assistance with the application or enrollment process, please contact your Certified Insurance Agent or the beWellnm for Small Business' Service Center at (833) 862-3935 option #3 for assistance.

BEWELLM HEALTH & DENTAL INSURANCE COMPANIES

Health Insurance Companies

Presbyterian Insurance Company (PPO)

www.phs.org/employers/group-insurance-plans

(505) 923-5256

Presbyterian Health Plan (HMO)

www.phs.org/employers/group-insurance-plans

(505) 923-5256

True Health New Mexico

truehealthnewmexico.com

(855) 769-6642

Dental Insurance Companies

Best Life

www.bestlife.com

(855) 769-6642

ADDITIONAL RESOURCES

Human Services Department (HSD)

Visit <https://www.hsd.state.nm.us/> or by phone: **(888) 997-2583**.

The NM Human Services Department (HSD) manages a budget of approximately \$7 billion dollars* of state and federal funds and administers services to more than 800,000 low-income New Mexicans through programs such as:

Behavioral Health Services (mental illness, substance abuse and compulsive gambling), Child Support Establishment and Enforcement, Community Services Block Grant (CSBG), General Assistance for low-income individuals with disabilities, Low-Income Home Energy Assistance Program (LIHEAP), Meals for Homeless People, Medicaid and Children's Health Insurance Program (CHIP), Refugee Resettlement Program (RRS), School Commodity Foods Program, SNAP Education Program (SNAP-Ed), Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), The Emergency Food Assistance Program (TEFAP)

Office of Superintendent of Insurance (OSI)

Visit <https://www.osi.state.nm.us/> or by phone at **(855) 427-5674**.

This state agency handles complaints against HMOs and PPOs. Consumers can file a complaint with the OSI against their PPO carrier if coverage was denied based on lack of medical necessity or if a treatment is being considered experimental or investigatory in nature. This agency administers what is called an "Independent Medical Review" (IMR). If their situation qualifies, an independent physician will review the health insurance company's decision and has the power to overturn that decision. The IMR is a free service available to anyone in New Mexico enrolled in a managed care health plan. This agency has the power to file a "standard complaint" against a health insurance company about a coverage denial and can overturn the company's decision.

