«FIRSTNAME» «LASTNAME»
«ADDRESS»
«CITY», «STATE» «ZipCode»

December 17, 2012

Dear «FIRSTNAME» «LASTNAME»:

As you were recently informed, Educators Health Alliance Board of Directors has authorized and retained Xerox HR Solutions (Xerox) to conduct a dependent eligibility verification project. Like many companies today, we view this as an important component of an overall strategy aimed at controlling the rising cost of health care.

Why are we verifying the eligibility of your dependents? We are committed to providing high-quality health care benefits at a cost that is sustainable for you and for Educators Health Alliance benefit plans insured by Blue Cross Blue Shield Nebraska. In order to maintain that commitment, we need to confirm our benefit plans' eligibility guidelines are being followed so we do not pay claims for ineligible participants. We realize mistakes and misunderstandings can happen. For example, employees may forget to report a change such as a divorce resulting in costly claim overpayments.

What do you need to do? Complete the enclosed form(s) and return them by mail **OR** complete them online.

If you respond by MAIL	If you respond ONLINE
• Complete the form(s) for your dependents • Sign the original form and return in the enclosed postage paid envelope • Keep a copy for your records **Your response must be postmarked by February 22, 2013**	• Visit the following site, making certain that you use **the url exactly as it's written:** http://www.acs-dev.com/eha • Log in to the web site using the following information: o Participant ID: «PARTICIPANTID» o Password: Month, Day, and Year of your birth date [MMDDYYYY]. Example: June 14, 1955 = 06141955. • Follow the prompts to create a new password and specify three security questions • Read and accept the terms and conditions outlined in the data protection policy • Follow the instructions to complete the forms and/or view the current verification status of your dependents To submit your documentation electronically, select *Browse,* then navigate to documents stored on your computer and choose the document to upload **OR** select *Will send to Service Center* and mail a copy of documents in the enclosed postage-paid envelope **Your response must be completed by 11:59 p.m. (PST) on February 22, 2013**

What happens after you respond?

Mail Response: Approximately two (2) weeks after your response is submitted, Xerox will send you a written notice confirming the outcome of each dependent's eligible status.

ONLINE Response: Approximately two (2) days after your response is submitted, Xerox will post the eligibility determination for each dependent to your Employer Health Alliance web site noted above.

- Dependents determined to be eligible will have no change in coverage.
- Dependents determined to be ineligible will have **coverage cancelled effective March 31, 2013.**

What happens if you do NOT respond? If you do not satisfy the requirements noted in the **"What do you need to do?"** section above, your dependent's **coverage will be cancelled, effective March 31, 2013.**

For your convenience and privacy, this project is being operated independently by Xerox, whose eligibility specialists are available for your immediate assistance via the Xerox Helpline. Please utilize their expertise by calling 1-855-874-8505, Monday through Friday from 8 a.m. to 8 p.m. or Saturday from 9 a.m. to 2 p.m. (EST).

We greatly appreciate your cooperation in this process.

Sincerely,

Xerox HR Solutions,
on behalf of Employer Health Alliance Board of Directors

Xerox HR Solutions
P.O. Box 980
Maumee, OH 43537

«ProjectPhaseName»

Frequently Asked Questions

Who qualifies as an eligible dependent?

- Your eligible spouse to whom you are legally married;
- You or your eligible spouse's unmarried child who is under age 26 including natural child, stepchild, a legally adopted child, a foster child, or a child for whom you or your eligible spouse are the legal guardian;
- You or your eligible spouse's unmarried child age 26 or older, who is physically or mentally disabled and incapable of self-support;
- A child who is recognized as an alternate recipient in a Qualified Medical Child Support Order (QMCSO).

What should I do if I realize I'm covering an ineligible dependent?

Complete the Verification form(s) online or by paper selecting the voluntary removal option. Submit form(s) back to Xerox HR Solutions (Xerox) postmarked no later than February 22, 2013. Xerox will notify you that your ineligible dependent will be removed from coverage, effective March 31, 2013.

What are my coverage options if my dependent is determined to be ineligible?

If your dependent's coverage is cancelled as a result of this verification process, COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) continuation coverage will not be available, *unless your covered dependent's eligibility status has changed within the past 60 days due to a qualifying event.* Qualifying events include: divorce, child reaching limiting age for coverage, etc. In this case, you can temporarily continue coverage after it would otherwise end.

Also, please be aware that other coverage options are available for dependents that are no longer eligible. To view other coverage options you may contact Blue Cross Blue Shield Nebraska at 1-877-444-2583 or visit their web site at https://www.nebraskablue.com/shop-plans/individual-and-family.

Can I add or remove a dependent who is currently eligible for coverage under Educators Health Alliance benefit plans administered by Blue Cross Blue Shield Nebraska?

No. The purpose of this project is to remove only **ineligible** dependents. Adding or removing dependents from coverage is allowed only during the annual enrollment period, or within 31 days of certain "life events" which change your status.

How can I obtain lost documents required to prove my dependent's eligible status?

You may contact the government office in the county or state in which the event took place (i.e., birth, marriage, etc.). Most offices will mail a replacement document within five business days for a nominal fee. For a more immediate response, you may visit the county or state office to obtain the document the same day. **Please make sure you know what information you will need to present in order to obtain the document prior to visiting the county or state office.** You may also obtain documents online by visiting www.vitalchek.com. This web site is used by every U.S. state to process vital record requests and also has links to sites where you can request vital records from foreign countries or for American citizens born abroad. The average turnaround time for requests is three days, and requested documents are marked with the clerk of courts seal.

Will I be penalized if my spouse and/or dependent child(ren) is ineligible?

We know that it is rarely intentional to cover an ineligible dependent, so **we will not penalize you, or seek disciplinary action or repayment of claims** if you remove an ineligible dependent during this project.

How will my personal information be used and who will have access to it?

Only Xerox will have access to your personal information, which will be used solely to verify the eligibility of your dependents. All transmitted information will be treated as private and confidential, under penalty of law. Administrative, physical, and technological safeguards have been put in place to ensure the confidentiality of your personal information.

Who should I contact if I have additional questions?

Contact the Xerox Helpline by calling 1-855-874-8505, Monday through Friday from 8 a.m. to 8 p.m., or Saturday from 9 a.m. to 2 p.m. (EST), for additional assistance.

Xerox HR Solutions
P.O. Box 980
Maumee, OH 43537

«LASTNAME», «FIRSTNAME» («PARTICIPANTID»)
«PROJECTPHASENAME», «LOCATION»

NEBRASKA

Educators Health Alliance

Spouse Verification Form

Instructions: Please complete **ALL STEPS** of this Verification Form for your spouse. For the purposes of this form, the person identified in **STEP 1** below will be referred to as your "dependent." If you need assistance with this form, please call Xerox HR Solutions at 1-855-874-8505.

STEP 1: Qualification of Marital or Domestic Partnership Status (Please provide a response for **EACH** item listed below. Responses left blank will be considered "Incomplete.")		**«SPOUSEFIRSTNAME» «SPOUSEBIRTHDATE»**
Item 1	Please confirm the gender of your dependent (Check one)	☐ Male ☐ Female
Item2	My current relationship with the person noted above is: ☐ Legally Married ☐ Legally Separated ☐ Common Law Married ☐ Legally Divorced ☐ Domestic Partner ☐ Other (Please explain on back of this form)	
Item 3	Is your dependent on active duty in the armed forces of any state, country or international authority?	☐ Yes ☐ No
STEP 2: Proof of Marital Status (Please select **ONE** of the following Options and attach the REQUIRED documentation. Please provide **COPIES ONLY.**)		
Option 1	Employee's 2011 federal tax return Acceptable tax documentation includes Forms 1040, 1040A and 1040EZ. Include BOTH page 1 and page 2 of the tax return. Page 2 must include signatures or an e-file confirmation number. "Mark out" all financial information and the first five digits of all Social Security numbers.	☐
Option 2 (Be certain to include **ONE** document from Part 1 **AND** **ONE** document from Part 2)	**Part 1:** Select **ONE** of the following: • Copy of Marriage Certificate • Civil Union Certificate • Affidavit of Common Law Marriage	«SP_MC» ☐
	Part 2: Select **ONE** of the following forms of proof of joint ownership: • Copy of a mortgage statement • Copy of a bank statement or utility bill • Copy of a current rental or lease agreement (must include signature page) **Documents must be dated on or after September 1, 2012 and show current mailing address, employee's name and spouse's name.** *DO NOT send an envelope as proof of joint ownership.*	☐ ☐ ☐
Option 3	If married on or after September 1, 2012, marriage certificate only	☐
Option 4	If legally separated or divorced, please provide the portions of the court documents confirming the names of both parties; date of the separation or divorce and judge's stamp or signature.	«SP_LDCD»
Option 5	None of the Above (Please attach documents and explanation to this form.)	☐
Option 6	I have reviewed the eligibility guidelines and the person noted above is no longer eligible for coverage. By selecting this option, I acknowledge and I understand his or her coverage will be terminated, effective March 31, 2013.	☐

STEP 3: Required Dependent Information *Please indicate how you will provide or validate your dependent's Social Security number.*	
Called the Xerox Service Center to report (Phone: 1-855-471-4834)	☐
Submitted SSN on web portal	☐
Social Security Number provided: _____-_____-_____	☐

STEP 4: Signature *(This form will only be processed if the **EMPLOYEE's** signature is present below.)*

I certify the information I have provided is true and correct and that I am responsible for updating this information in the event it changes. I understand the information will be reviewed and a determination will be made regarding my dependent's eligibility for coverage. I acknowledge that falsifying this information or failing to update this information can lead to cancellation of my dependent's coverage and disciplinary action up to and including termination of employment. Submission of this form does not guarantee eligibility for benefits.

_____ _____

Employee Signature (Required) **Date**

POSTMARK DEADLINE: February 22, 2013

Please DO NOT send originals – they will not be returned. Please keep a COPY of this document for your records.

Xerox HR Solutions
P.O. Box 980
Maumee, OH 43537

«LASTNAME», «FIRSTNAME» («PARTICIPANTID»)
«PROJECTPHASENAME», «LOCATION»

NEBRASKA

EHA Educators Health Alliance

Dependent Child(ren) Verification Form

Instructions: Please complete this form for all child(ren) dependents. If you need assistance, please call Xerox HR Solutions at 1-855-874-8505.

STEP 1: For ALL Dependents		**«CHILDFIRST1» «CHILDDOB1»**	**«CHILDFIRST2» «CHILDDOB2»**	**«CHILDFIRST3» «CHILDDOB3»**
Select only **ONE** form of documentation per dependent and check the applicable box. Attach documentation to this form.				
Biological Child	Copy of Birth certificate showing employee as parent	«CH_BCB1»	«CH_BCB2»	«CH_BCB3»
Adopted Child	Court approved adoption order or placement order; or, modified birth certificate	«CH_ACO1»	«CH_ACO2»	«CH_ACO3»
Stepchild (biological child of spouse)	Copy of Birth certificate showing spouse as parent	«CH_BCS1»	«CH_BCS2»	«CH_BCS3»
Foster Child; Permanent Legal Guardianship; Custody	Court Documents (see below)	«CH_FCCD1»	«CH_FCCD2»	«CH_FCCD3»
None of the above	Please attach explanation to this form	☐	☐	☐
Voluntary Removal	I have reviewed the eligibility guidelines and the person noted above is no longer eligible for coverage. By selecting this option, I acknowledge and understand their coverage will be terminated, effective March 31, 2013.	☐	☐	☐

Court Documents: Qualified Medical Child Support Order (QMCSO); Divorce Decree or National Medical Support Notice (NMSN) or Legal Guardianship. Documentation must include:

- Name of the employee, spouse as responsible party
- Name(s) of minor child(ren)
- Health care coverage requirements (QMSCO and NMSN only)
- Judge's signature, support order number, and seal

STEP 2: ***Please indicate how you will provide or validate your dependent's Social Security number for age 1 and older.***		**«CHILDFIRST1»**	**«CHILDFIRST2»**	**«CHILDFIRST3»**
Item 1	Called the ACS Service Center to report (Phone: 1-855-874-8505)	☐	☐	☐
	Submitted SSN on web portal	☐	☐	☐
	Social Security Number provided for each dependent	___-__-____	___-__-____	___-__-____

STEP 3: For Dependents age 19 to 25 ONLY	**«CHILDFIRST1»**	**«CHILDFIRST2»**	**«CHILDFIRST3»**
Is your dependent on active duty in the armed forces of any state, country or international authority?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

STEP 4: For Dependents age 26 and older ONLY			
Please place an "X" in the box beneath the dependents' name **IF** they are currently permanently and totally disabled.	☐	☐	☐

STEP 5: Signature *(This form will only be processed if the **EMPLOYEE's** signature is present below.)*

I certify the information I have provided is true and correct and that I am responsible for updating this information in the event it changes. I understand the information will be reviewed and a determination will be made regarding my dependent's eligibility for coverage. I acknowledge that falsifying this information or failing to update this information can lead to cancellation of my dependent's coverage and disciplinary action up to and including termination of employment. Submission of this form does not guarantee eligibility for benefits.

_____ _____

Employee Signature (Required) **Date**

POSTMARK DEADLINE: February 22, 2013

Please DO NOT send originals – they will not be returned. Please keep a COPY of this document for your records.

Xerox HR Solutions
P.O. Box 980
Maumee, OH 43537

ACTION REQUIRED
FINAL NOTICE

«FIRSTNAME» «LASTNAME»
«ADDRESS»
«CITY», «STATE» «ZipCode»

January 30, 2013

IMPORTANT

FAILURE TO RESPOND COMPLETELY will result in the cancellation of your dependent's coverage, effective March 31, 2013.

Dear «FIRSTNAME» «LASTNAME»:

On December 17, 2012, a packet was sent to your home address requesting eligibility information for your dependent(s) covered under Employer Health Alliance benefit plans insured by BlueCross Blue Shield Nebraska. Our records indicate we have either not received a response from you or the response you submitted was incomplete. Therefore, **you MUST satisfy the following requirements in order to continue coverage for your enrolled dependents.**

What do you need to do? Complete the enclosed form(s) and return them by mail **OR** complete them online.

If you respond by MAIL	If you respond ONLINE
• Complete the form(s) for your spouse/domestic partner and/or dependent child(ren) • Sign and return the original form in the enclosed postage-paid envelope • Keep a copy for your records **Your response must be postmarked by February 22, 2013**	• Visit the following site, making certain that you use **the url exactly as it's written:** http://www.acs-dev.com/eha • Log in to the web site using the following information: o Participant ID: «PARTICIPANTID» o Password: Month, Day, and Year of your birth date [MMDDYYYY]. Example: June 14, 1955 = 06141955. • Follow the prompts to create a new password and specify three security questions • Read and accept the terms and conditions outlined in the data protection policy • Follow the instructions to complete the forms and/or view the current verification status of your dependents • To submit your documentation electronically, select *Browse,* then navigate to documents stored on your computer and choose the document to upload **OR** select *Will send to Service Center* and mail a copy of documents in the enclosed postage-paid envelope **Your response must be completed by 11:59 p.m. (PST) on February 22, 2013**

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Sincerely,

Xerox HR Solutions,
on behalf of Employer Health Alliance Board of Directors

«ProjectPhaseName»

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