

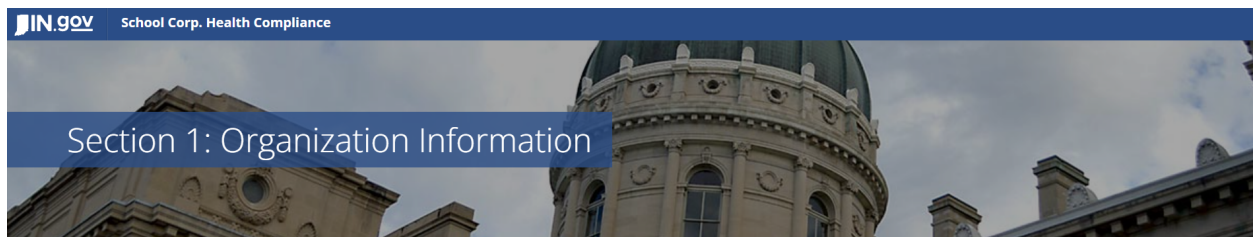
## 1260 HEA Reporting System Outline

The following outlines the process of the new 1260 HEA Reporting System. This system will no longer require log in information to complete this report, instead it will go off your school's corporation name and ID number. If you realize you made any mistakes upon completing this form, please notify us by emailing [benefitingschools@spd.in.gov](mailto:benefitingschools@spd.in.gov) and then submit an additional report through the system. This system does not save your work to come back to, so please ensure you have everything ready prior to beginning the report.

**System link:** <https://appengine.egov.com/apps/in/spd/school-corp-health-compliance>

Page 1:

Fill out all the required information listed on page 1 and press continue



School Corporation ID: \*

School Corporation Name: \*

Address \*

City \*

County \*

Zip \*

Contact Name \*

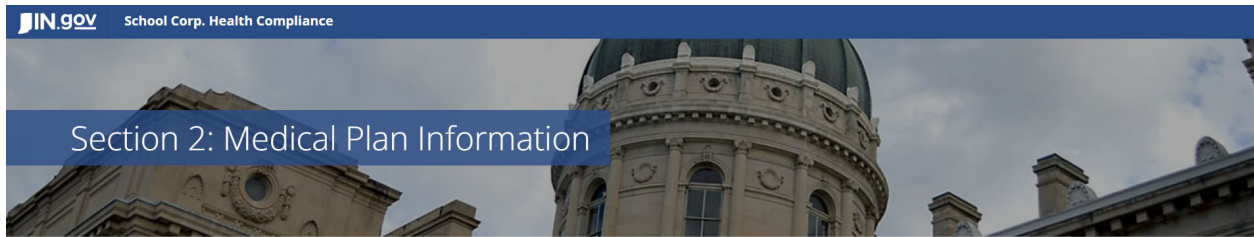
Contact Email Address \*

Contact Phone Number \*

CONTINUE >

Page 2:

This will be the page in which you will be filling out regarding the schools medical plans. All fields marked with the red asterisk are required. Once the information is submitted for each plan, you must select the add item button at the bottom. This will need to be done after each plan. If you do not do this, the information will not save. The bottom box will keep track of the information submitted and will also calculate the total employer cost. Once all plans are added, you will press continue to move onto the next section.



Medical Plans

Name of Medical Plan \*

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Type of Medical Plan \*

Please select an option

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Plan Year Start \*

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Plan Year End \*

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Insurance Type \*

Please select an option

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Employee Only Coverage - No. of Enrollees

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Employee Only Coverage - Annual Employer Contribution

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Employee + 1 - No. of Enrollees

---

Employee + 1 - Annual Employer Contribution

---

Employee + Spouse - No. of Employees

---

Employee + Spouse - Annual Employer Contribution

---

Employee + Spouse + 1 - No. of Enrollees

---

Employee + Spouse + 1 - Annual Employer Contribution

---

Family - No. of Enrollees

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Family - Annual Employer Cost

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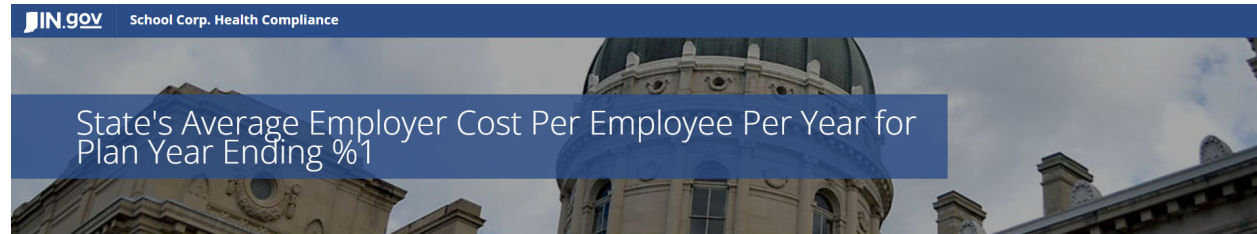
ADD ITEM

| Plan Name | Type of Plan | Start | End | Ins. Type | EOC - No. of Enrollees | EOC - Annual Employer Contribution | EOC- Total Annual Cost | E+1 - No. of Enrollees | E+1 - Annual Employer Contribution | E+1 - Total Annual Cost | E+S No. of Employees | E+S Annual Employer Contribution | E+S Total Annual Cost |
|-----------|--------------|-------|-----|-----------|------------------------|------------------------------------|------------------------|------------------------|------------------------------------|-------------------------|----------------------|----------------------------------|-----------------------|
|-----------|--------------|-------|-----|-----------|------------------------|------------------------------------|------------------------|------------------------|------------------------------------|-------------------------|----------------------|----------------------------------|-----------------------|

< PREVIOUS    CONTINUE >

Page 3 and 4:

Within page 3 and 4, you will find additional questions regarding your school's plan. All information that is listed with an asterisk is required. If any of these do not apply to you, please list 0 to be moved forward to the next portion. Any questions that are grayed out, are automatically calculated by the system, and therefore cannot be edited. Once the first page is completed, you will press continue and answer the additional question on the follow page. After everything is answered you will then press the submit button to complete the report.



1. Total number of health insurance eligible employees, including board members and legal counsel (do not include dependents or retirees): \*

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1a. How many of your health insurance eligible employees are teachers? \*

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2. Are all individuals insured under the school corporations employee health coverage eligible for the same plans: \*

Please select an option

2a. If your answer is "No", please explain how your practice comports with IC 20-26-17-5(4)(A).

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3. How many employees receive compensations for electing not to enroll in the group health insurance program: \*

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4. What is the annual dollar amount paid to employees to elect not to enroll in the group health insurance program: \*

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5. Additional compensation, if any, provided to member(s) to offset the cost of health care coverage: \*

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5a. Please provide an explanation of any arrangements.

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5b. Is your pharmacy benefit carved in with the medical carrier, or carved out to a stand-alone pharmacy benefit manager? \*

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5c. Is the pricing negotiated under a group purchasing arrangement (collective, consortium, trust)? \*

Please select an option

5d. What percentage of your cost is attributed to pharmacy? \*

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6. Does your school corporation offer / sponsor an on-site clinic? \*

Please select an option

6a. If so, is it funded outside of the health plan?

Please select an option

6b. If funded outside of the health plan, what is the annual dollar amount spent on the on-site clinic:

---

7. Total number of employees, including board members and legal counsel, enrolled in your health plans: \*

0

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8. Total employer contribution to all health plans ( sum of "Total Employer Plan Cost" from Section 2 for all health plans offered by your school corporation):

\$0.00

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9. Total annual employer contributions for all participants to a Health Savings Account (HSA), Health Reimbursement Account (HRA), Medical Flexible Spending Account (FSA), or Active VEBA: \*

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10. Total Broker or Benefit Consultant fees paid if they are not included in the premium: \*

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< PREVIOUS

CONTINUE >



## State's Average Employer Cost Per Employee Per Year for Plan Year Ending %1 (cont.)

11. Sum of lines 5, 8, 9, & 10:

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12. School's Average Employer Cost Per Employee Per Year (line 11/line 7):

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13. State's Average Employer Cost Per Employee Per Year for Plan Year Ending 12/31/2021:

\$13,369.24

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14. State's Average Employer Cost Per Employee Per Year for Plan Year Ending %1: \*

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< PREVIOUS

SUBMIT