

# GROUP ADMINISTRATOR GUIDE



A nonprofit independent licensee of the Blue Cross Blue Shield Association





## WELCOME TO THE GROUP ADMINISTRATOR GUIDE.

Welcome to our newest edition of the Group Administrator Guide. As always, it is our commitment to serve you, our valued clients, in the best possible way.

We hope this Guide is a tool that you will use quite frequently, to assist you in answering questions on our processes.

Wishing you a healthy and happy year!

*Jennifer A. Arnold*

Jennifer A. Arnold  
Manager Process & Training

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## ► HOW TO CONTACT US

Reason for Call	Who to Call
Commercial Large Group Benefits, Setup, Updates, Cancellations, Billing, Member Enrollment or Member Cancellations	Call your Account Service Consultant
Commercial Small Group Benefits, Setup, Updates, Cancellations, Billing, Member Enrollment or Member Cancellations	Call your Account Service Consultant
Technical Issues	Call our Web Help Desk at <b>1-800-278-1247</b> <b>select prompt number 2</b> Monday - Thursday 8 a.m. to 4:30 p.m. Friday 9 a.m. to 4:30 p.m.
Member Claims, Benefits or Authorizations for Medical, Dental or Pharmacy Plans	Members should call the <b>number on their Member ID Cards</b>

### BEFORE YOU CALL:

Due to Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, there are restrictions regarding the disclosure of health information to a third party without a Release of Information form on file with us. Account Service Consultant and Small Group Inquiry line phone numbers are for group administrators only. Each time a Group Administrator contacts their Account Service Consultant or the Small Group Inquiry Line, we require the following:

- Group Number (if not available, group address is required)
- Group Name
- Contact Name

**Our mailing address:** Excellus BlueCross BlueShield  
PO BOX 21146  
Eagan, MN 55121

**Our Billing/Payment Address:**  
Please refer to the address on your invoice.

**Our email address :**  
[ExcellusBCBS.com](http://ExcellusBCBS.com) - follow instructions on the website for secure email process.

## ► CUSTOMER CARE

Questions specific to an individual employee's claims or benefits should be directed to our Customer Care department using the telephone number listed on the employee's identification card.

### **Hours of Operation:**

Monday -Thursday 8 a.m. - 8 p.m., Friday 9 a.m. - 6 p.m. EST

## HELP US HELP YOUR ELIGIBLE EMPLOYEES

We are always happy to speak with eligible employees and look forward to assisting them and answering their questions. For their convenience, please remind your eligible employees of the online options available to them.

When your eligible employees do call Customer Care, please remind them to:

- Call the number listed on their identification card. Please note only some customer care numbers are open till 8 p.m. EST Monday through Thursday, and 6 p.m. on Friday.
- Have their identification card with them
- Have any bills or correspondence they are questioning with them
- Make sure they and everyone covered under their policy has completed an [AUTHORIZATION TO SHARE MY PROTECTED HEALTH INFORMATION FORM](#)

To comply with the federal Health Insurance Portability and Accountability Act (HIPAA) regulations, health plans must obtain a member's permission to share that member's protected health information with any other person. There are limited exceptions to this rule. Until a child reaches age 18, parents may access most of their child's health information without first obtaining the child's permission. However, regardless of the child's age, parents generally do not have access to diagnosis, treatment or payment information for sexually transmitted diseases, abortion, and drug and alcohol use, unless the child specifically authorizes the release of such information.

The necessary forms can be completed online – or we can fax or mail copies to you.

**When your eligible employees submit information/correspondence to Customer Care, please remind them of the following:**

- Complete all pertinent forms – do not leave anything blank
- Ensure that their member ID number is on the correspondence
- Include a contact phone number we can use to reach them if needed

### **Important information about the eligible employee's address:**

Many communications are sent directly to your eligible employee population, some of which include:

- New member packets
- Identification cards
- Monthly health summaries
- Certificates of coverage

Please make sure that we are always provided with the eligible employee's most current, correct and full address to ensure receipt of this important information.

To update or change their address, eligible employees can contact Customer Care by calling the number on their identification card, or you can contact the your account manager.

We also accept paper requests from groups and brokers to change a eligible employee's address.

Please complete one of our approved applications and mail it to us at  
P.O. Box 21146, Eagan MN 55121.

## FIRST-CALL RESOLUTION

First-call resolution is our goal. We are committed to resolving your inquiry during your initial call. We have established a number of initiatives and have empowered our Customer Care Advocates to do more than ever before. We will make calls on the eligible employee's behalf when necessary, set realistic expectations and follow-up in a timely manner. We are working hard to lessen the amount of work you have to do in order to resolve your issues.

Feedback can be provided through our phone surveys. We appreciate any and all comments.

## SETTING UP A MEMBER ACCOUNT ONLINE

It's easy for your eligible employees and eligible dependents on their policy to set up an account online... all they need is their ID number.

When eligible employees visit our website – [ExcellusBCBS.com](http://ExcellusBCBS.com) – they can select “Register & Create Account” and follow instructions to get set up.

There are a variety of options and services available for members online – listed below are some of them:

### View Benefits & Claims

- ▶ View benefits, copays and deductibles
- ▶ Review claim history
- ▶ Check the status of referrals and authorizations
- ▶ Obtain a copy of the monthly health summary

### Print Forms

- ▶ Claim forms
- ▶ HealthyRewards reimbursement forms (if applicable)
- ▶ Advance care planning
- ▶ Managing your privacy
- ▶ Membership and enrollment forms

### Make Changes

- ▶ Change and find a primary care physician
- ▶ Change address
- ▶ Find a doctor using our online directory
- ▶ Request (and print) a new ID card
- ▶ Get information on health care reform
- ▶ Find ways to save money on prescriptions
- ▶ Learn more about member Blue 365 discounts, including LASIK vision correction, glasses, massage therapy
- ▶ Contact Customer Care – via email or through a live chat

For members age 18 years and older who wish to have Protected Health Information (PHI) disclosed to someone other than themselves (including disclosure to parents), we recommend that they complete an authorization form for the disclosure of PHI. The completed form will allow us to disclose information to the person(s) named on the authorization and will eliminate delays in answering their questions should they need to contact us. On the member home page, the member can select Print Forms in the footer and then select Manage Your Privacy to access the form(s).

## DID YOU KNOW?

If you set up online accounts for your employees, be aware that you may be putting yourself at risk for unauthorized access to employees' protected health information, such as claims information.

We recommend that you avoid setting up online accounts on behalf of your employees. If employees need assistance setting up their online accounts, please instruct them to call our Web Help Desk at 1-800-278-1247. Select prompt number 1.

Our Web Help Desk hours are: Monday - Thursday 8 a.m. to 4:30 p.m Friday 9 a.m. to 4:30 p.m.


## ▶ MONTHLY HEALTH SUMMARY Q&A

### When will members receive a Monthly Health Summary?

The Monthly Health Summary will be sent to the eligible employee's mailing address when one or more members on the contract have claim activity during the previous month.

### Will protected health diagnosis information be on the Monthly Health Summaries?

Claims for protected diagnoses will appear on the Monthly Health Summary as a generic service (e.g. "office visit") – details of protected diagnoses will not be displayed.

**Excellus**  165 Court St.  
Rochester, NY 14647

JOHN Q. SAMPLE  
124 MAIN ST.  
ANYTOWN, NY 12345

**STATEMENT PERIOD**  
October 1, 2013 - October 31, 2013

**THIS IS NOT A BILL**

**PROFILE**

**Subscriber** John Q. Sample  
**Subscriber ID** 200000001

**Members Covered**

John Q. Sample	Angelina Lynne Sample
Angelina Lynne Sample	Lucy Sample
Billy Bob Sample	Brandon Sample
Kenneth Sample	
Krystina Sample	
Amy Sample	

**My Health Statement**

This summary information is for claims processed for all members covered under the Subscriber ID indicated above.

**Benefits for In - Network Services**

Benefit Period	January 1, 2013 - October 31, 2013
Copayments and Coinsurance	
Office Visit - PCP	\$15.00
Office Visit - Specialist	\$25.00
Coinsurance	0%
Deductible	
Individual	Not Applicable
Family	Not Applicable
Out-of-Pocket Maximum	
Individual	Not Applicable
Family	Not Applicable

Refer to your benefits information for details on out-of-network benefits.

**Life Has Moments. Share Yours.**

Submit your photo or video:

- For a chance to be on TV
- To be entered into a monthly drawing to win your choice of a mountain bike, kayak, treadmill or gift card

Visit [LifeHasAPlan.com](http://LifeHasAPlan.com) for more details and to see what others are sharing.

**Sign Up. Stay Informed.**

Get email updates on fitness and nutrition advice, health care reform, recipes, discounts and more.  
Sign up at [go.excelluscbcs.com/newsletter](http://go.excelluscbcs.com/newsletter)

**Mammograms Save Lives**

- A mammogram is an X-ray of the breast to find small tumors that you or your doctor are unable to feel
- Mammograms are important because the earlier breast cancer is found, the more successfully it can be treated
- Recommendations differ; talk to your doctor about when you should have a mammogram
- It's important to share any family medical history of cancer with your doctor.

Learn more about mammograms, breast cancer and 6,000+ other health topics at [ExcellusBCBS.com/Health](http://ExcellusBCBS.com/Health)

**Have You Had Your Flu Shot?**

It is recommended that everyone 6 months of age and older get a flu shot every year. Certain people are at higher risk for complications from the flu. They include:

- People 65 years of age and older
- Children under 5 years of age
- Pregnant women
- People with chronic medical conditions

If you haven't had your flu shot yet, talk to your doctor.

Write: Excellus BlueCross BlueShield, P.O. Box 27080, Rochester, NY 14602

Customer Service 1 (800) 898 1275

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**A claim was paid but according to the code in the comments the benefit is exhausted. An eligible employee contacts us and insists they have not used that particular benefit this year and the claim is indicating that it is paid. So, why is the code in the comments section?**

The code shows that the benefit is now exhausted with the newest claim or current claim that has processed and paid.

**A member is in a High Deductible Health Plan (HDHP) and wants to know why his/her prescription drug claims don't show on the Monthly Health Summary.**

Even though prescription drug claims do not appear on the medical Monthly Health Summary at this time, they are being calculated into the members' deductible and out-of-pocket maximum information that is shown on the cover page.

Members who have prescription drug coverage that has a deductible and/or coinsurance benefit design will receive a monthly My Rx Statement in addition to the Monthly Health Summary.

**What column should a member be looking at and comparing to the bill they receive from their provider's office in order to make sure they are being billed the correct amount?**

There is a section on the Monthly Health Summary titled Member Responsibility. This section consists of deductible, coinsurance, copay and non-covered expenses. The provider can bill the amounts listed in these columns. If members have any questions or concerns regarding how a claim processed, or believe the Member Responsibility is not correct, they can contact our Customer Care department at the phone number listed on the back of their ID card.

## ► MEMBERSHIP ENROLLMENT OPTIONS

We offer a variety of enrollment options, including Web, electronic and paper. Select the option that meets your business needs.

### ELECTRONIC ENROLLMENT

Electronic enrollment is a method of electronically submitting enrollment files and exchanging data that is compliant with the Health Insurance Portability and Accountability Act.

If you are currently submitting paper enrollment forms, and are interested, please contact us at [Electronic.Enrollment@Excellus.com](mailto:Electronic.Enrollment@Excellus.com) for more information on this option.

### BENEFITS OF ELECTRONIC ENROLLMENT

- ▶ Enjoy faster service
- ▶ Enrollment is submitted via a secure server
- ▶ Enrollment is submitted on one file rather than multiple paper applications or web transactions
- ▶ Decrease in manual interventions for additions, terminations or changes to current enrollment

### PLEASE NOTE

Valid Social Security numbers must be sent for eligible employees. A missing or invalid Social Security number will stop the transaction. It is also strongly recommended that valid Social Security numbers are sent for eligible dependents. We are required to ask for enrolled eligible employee and dependent Social Security numbers in order to meet our reporting obligations under the Affordable Care Act. If a valid Social Security number cannot be sent for an eligible dependent, then it must be omitted. This omission will not stop the enrollment process, however, a Social Security number solicitation letter will be sent to the employee. Do not send invalid Social Security numbers as they will impact eligibility.



# WEB ENROLLMENT

Web enrollment is available to all employer groups. This type of enrollment has two options:

**1) Full Access Option:** this option allows you to enter all employee applications and make updates to a member's coverage on our website.

- ▶ **Please note:** For cancelling members with ID numbers that are nine characters long, with an alpha character in the middle, use the first day of the month as the cancel date.

**Another feature is that your** employees may submit their own updates and enrollment requests. If you choose this option, we will notify you whenever you have an employee enrollment and change request pending for approval or denial.

**2) View Only Access:** this option allows you to view a real-time member roster and print/order ID cards.

Benefits of web enrollment

- ▶ Enjoy faster service
- ▶ Receive immediate confirmation that request is received
- ▶ View real-time member roster 24/7 (sort by subgroup, name, age, date of birth, active/terminated status)
- ▶ Convert roster to a Microsoft Excel spreadsheet to make reconciliation of invoices easier
- ▶ View and update a member's policy (change member address and/or phone)
- ▶ Print/order ID cards

## Social Security Inclusion

- ▶ We are required to ask for a Social Security number in order to meet our reporting obligations under the Affordable Care Act. Also, it is strongly recommended that valid Social Security numbers are sent for all dependents.

**To add or activate a new group number, or remove an old group number from your web account, an existing user can:**

- ▶ Log on our website [ExcellusBCBS.com](http://ExcellusBCBS.com), and follow the link for Employer, and go to the Quick Links section under the "Enroll and Update" tab

To learn more about this convenient method of enrollment, simply go to our website at [ExcellusBCBS.com](http://ExcellusBCBS.com), follow the link for "Employer" and select "Register," then complete the Group Web Access Request Form. Upon approval, we will send you an email with a username and password. Once you receive this, you may complete the registration process online.

If you are a Broker interested in web enrollment, please contact [BrokerContractsExcellus@Excellus.com](mailto:BrokerContractsExcellus@Excellus.com).

# PAPER ENROLLMENT

Paper enrollment is our traditional method of enrolling new members and making changes to a member’s coverage. Our goal is to work with you to ensure that all required fields on the application are complete and accurate. This will reduce the number of applications returned to you for additional information/clarification and will speed up the process to enroll members.

Below are a few reminders to assist in the enrollment process:

✓	Always use blue or black ink on the applications.
✓	If highlighting, only use yellow.
✓	Write legibly.
✓	Complete all areas of the application.
✓	Always provide an employee’s hire date.
✓	Include all signatures.
✓	Check appropriate coverage boxes.
✓	<p>We are required to ask for a valid Social Security number in order to meet our reporting obligations under the Affordable Care Act.</p> <p>Also, it is strongly recommended that valid Social Security numbers are sent for all dependents.</p> <p><b>Please note:</b> Missing or invalid Social Security numbers will result in a Social Security number solicitation letter being sent to the employee. Missing or invalid Social Security numbers will not stop enrollment.</p>
✓	Ensure a complete and legible subscriber address is included.
✓	Applications that have missing or illegible information may not be processed. If this is the case, we will notify the group with a letter.
✓	Activity must be submitted as it occurs to ensure timely enrollment or cancellation. Please do not send activity with your premium payment.
✓	Mail the completed application to: Excellus BlueCross BlueShield, P.O. Box 21146 Eagan MN 55121, or visit our website to scan a secure request to us.
✓	<p>Regarding cancellation dates:</p> <ul style="list-style-type: none"> <li>▶ For cancelling members with ID numbers that begin with a “2” and do not contain an alpha character, use the last day of the month as the cancel date.</li> <li>▶ For cancelling members with ID numbers that are nine characters long, with an alpha character in the middle, use the first day of the month.</li> </ul>
✓	Use only acceptable enrollment forms, which are available to print from the website at: <a href="http://ExcellusBCBS.com/Employer">ExcellusBCBS.com/Employer</a> . Click on Print Forms at the bottom of the employer/benefit administrator’s home page. If you submit an alternate group enrollment form, the form may not be processed.

# ENROLLMENT AND BILLING SUPPORT FORM

## Why use this form?

The purpose of this web based form is to streamline all of your Membership and Billing inquiries and requests. By submitting your inquiries and requests via this form, they are securely transmitted directly to the request management system that is utilized to assign and process requests within our Membership and Billing department. Requests submitted via this online tool can be easily tracked, assigned and managed through completion. The process is simple; this document outlines how to use the form and what to expect once you submit an inquiry to Membership and Billing.

- ▶ **Please note:** You must have an active web account to use this feature.

## Accessing the form

Employer Home Page	Broker Home Page
<ul style="list-style-type: none"><li>• From the Employer home page of our website, click on the 'Contact Us' box on the right</li><li>• Select the "By Email" tab</li><li>• Click on the link in "Check Out Our Process for "Enrollment &amp; Billing Support"</li></ul>	<ul style="list-style-type: none"><li>• From the Broker home page of our website, click on the 'Contact Us' link in the bottom right hand side under 'Let Us Help'</li><li>• Select the 'Email' tab</li><li>• Click on the link in "Check Out Our Process for "Enrollment &amp; Billing Support"</li></ul>

## Using the Form

The fields of the form are self-explanatory. To ensure your inquiry is routed appropriately, please review the below descriptions for the '**Reason for Inquiry**' field:

- ▶ **Billing** – Use to request copies of invoices.
- ▶ **E-File** – Only groups that have been pre-approved for our e-file enrollment may use this option.
- ▶ **ID Card Request/Research** – Use to submit a request for a new set of ID cards or when requesting a mass reissue of ID cards for an entire group.
- ▶ **Reconciliation** – Use to request a research posting of funds or to request a history of payment activity.
- ▶ **Eligible employees** – Use for member activity, new enrollments (single or multiple enrollments), member additions to existing contracts, membership changes, terminations, general questions and research. All appropriate paperwork must accompany the request and required fields must be completed.

## Tracking System and Notifications

You will be notified when your inquiry is received, assigned and completed.

- ▶ **Inquiry Received:** As soon as your inquiry is submitted, you will receive a pop up message indicating that your inquiry was received. This is a system generated generic message; there are no timeframes or specific information noted.
- ▶ **Tracking Number:** When your inquiry has been assigned internally, you will receive an automated email from the system which will include a tracking number. The tracking number can be referred to with any questions related to the inquiry. This tracking number will take up to one business day to be received.
  - ▶ The email you receive with your tracking number contains specific information about the inquiry.

- ▶ Based on the type of inquiry, the automated email sent to you could contain the group name, group number, broker name, subscriber name, subscriber ID#, and the membership inquiry number.
- ▶ **Complete:** This email will advise that the inquiry was completed. The tracking number and resolution to the inquiry will be provided in this email. If for some reason the request was not completed, please reach out to your Account Service Consultant. The tracking number will need to be provided.
- ▶ **Closed – No Action Taken:** If your inquiry does not contain the necessary information to complete, it will be closed without any action taken. A detailed description of the reason for closing out the inquiry will be provided in this email. A subsequent request will need to be filled out with the necessary information if this is asked for in the closure notification. If questions about it exist, utilize the tracking number when contacting your dedicated support.

**Additional Information Regarding Future Enhancements:**

Please note that the following enhancement is in process; we are unsure of the exact timeframe that this will be in production at this time.

- ▶ Examples of each reason will be displayed to be sure you selected the right reason for your inquiry. This will help to ensure the inquiry is routed to the appropriate area for resolution.

# CANCELLATION REQUESTS

## Easy Options For Cancellations

Visit our website at [Employer.ExcellusBCBS.com](http://Employer.ExcellusBCBS.com) and go to the “Contact Us” section. Follow our secure email instructions to send your cancellation request electronically. (Note: if using the secure email option, please keep a copy of this request for your records.)

Visit the “Enroll and Update” tab to view “Online Enrollment & Account Maintenance” options.

## For paper cancel submissions:

Visit [Employer.ExcellusBCBS.com](http://Employer.ExcellusBCBS.com) and select the “print forms” option. Select from one of the approved application request forms, and complete the following sections of the form for a subscriber cancellation:

- ▶ Subscriber information
- ▶ Group/Employer information
- ▶ Subscriber/Employee status
- ▶ Cancellation information

For termination of a dependent, please complete the following sections of the approved application form:

- ▶ Subscriber information
- ▶ Group/Employer information
- ▶ Subscriber/Employee status
- ▶ Cancellation information (check the dependent information portion of this section)
- ▶ Dependent information (list the dependent that is cancelling off the policy)

The Group Representative signature must accompany this form.

**Please note:** In order to streamline the process and eliminate numerous paper forms, we no longer accept any forms that were formerly used for individual or multiple subscriber/member cancellation requests.

Once the form is completed, it can be mailed to Excellus BlueCross BlueShield, P.O. Box 21146 Eagan MN 55121.

## Regarding cancellation dates:

For cancelling members with ID numbers that begin with a “2” and do not contain an alpha character, use the last day of the month as the cancel date.

For cancelling members with ID numbers that are nine characters long, with an alpha character in the middle, use the first day of the month.

## ▶ BILLING AND PAYMENT INFORMATION

### BILLING INFORMATION

- ▶ Your next billing statement will automatically generate at the same time each period. Delays in billing can be expected at renewal.
- ▶ All enrollments processed before the bill run date will appear on the current month's invoice. If activity is processed after the bill run date, it will appear on the next month's invoice. Paying as billed will reduce member disruption.
- ▶ It is important that you reconcile the billing statements each month to ensure that all members being billed are still active and enrolled in the correct tier/enrollment type. This will ensure that our records are up to date, allow timely claim payments and prevent denials of activity requests due to our retroactivity guidelines. If preferred, an enrollment listing can be downloaded from our website at [Employer.ExcellusBCBS.com](http://Employer.ExcellusBCBS.com).

- ▶ Upon receipt of your invoice each month, please check the activity changes listed on the invoice. If you find a discrepancy, please contact your Account Service Consultant. As most activity is subject to a 30 day retroactive period, taking the proactive step of checking your invoice will help avoid retroactive requests.

## PAYMENT INFORMATION

- ▶ Premium is due by the due date on your bill
- ▶ Pay as billed by paying the "Total Premium Due" on your billing statement
- ▶ Submit your payment with the remittance stub to the address listed on the reverse side of the stub or pay your bill on-line. Allow seven business days from the mailing date for payment to be credited to your account
- ▶ Payments should include all applicable group numbers
- ▶ Premium payment backup is needed at the time the payment is submitted but should not be mailed to our bank lock box. Please send separately using one of the following options:
  - ▶ Secure email via [ExcellusBCBS.com](mailto:ExcellusBCBS.com)
  - ▶ Mail to: Excellus BlueCross BlueShield, P.O. Box 21146 Eagan MN 55121
  - ▶ If you are paying for more than one group number, provide a breakdown of how much you are paying for each group number. This will ensure that your account is properly credited
- ▶ Do not send any activity or correspondence with your payment to our bank lock box. Please follow instructions listed above to forward payment backup

## ▶ FLEXIBILITY AND SIMPLICITY WITH ONLINE BILL PAY

### VIEW & PAY INVOICES ONLINE

Introducing Online Bill Pay – a tool that gives HR administrators the flexibility to do all of the following on the Web:

- ▶ View invoices & payment activity
- ▶ Email notification of new invoices
- ▶ Create customized reports
- ▶ Pay invoices online with checking or savings accounts

### GET STARTED TODAY!

To sign up for Online Bill Pay:

- ▶ Visit [Visit Employer.ExcellusBCBS.com](http://VisitEmployer.ExcellusBCBS.com) and select **Billing**
- ▶ Complete and submit an Online Bill Pay Access Request Form

**If you have any questions, please contact your account consultant.**

# DELINQUENCY

- Delinquency is based on date billed, due date and payment dates
- If payment is not posted to the group's account by the 10th of the month, a delinquent notice is automatically generated and mailed
- If after 35 days the bill is not paid, a cancellation notice is generated and mailed to the group advising that payment is needed within 10 days, or the group will be cancelled
- If payment has not been received on the 45th day, coverage will be cancelled

## Example:

A group is billed for its June premium on May 15. The group bill has a due date of June 1.

- If not paid, the delinquent notice will generate and mail on or around June 10.
- If no payment is posted, the cancellation notice will generate and mail on or about July 5.
- If no payment is received 10 days from the cancellation notice, the group cancellation will be processed from July 15 through July 20.

**For questions:** Call the Corporate Accounts Receivable at 1-877-208-4163.

Please view the attached statement to help familiarize yourself with your billing statement.

# SAMPLE BILL STATEMENT

**Header Information:**

- (CORPORATE LOGO)
- Your Group's Identification Number
- Group ID - Subgroup ID: 00000000-0000
- Date Billed: MM/DD/YYYY
- Billing period: From - To
- Date Payment Due: MM/DD/YYYY
- Invoice #

**Contact Information:**

Your group's name and address  
**CONTACT NAME**  
 GRP NAME  
 ADDRESS 1  
 ADDRESS 1  
 CITY, ST ZIP

**Table:**

Previous Billing		Current Billing	
Previous Total Due	\$4,268,233.23	Current Invoice	\$1,942,261.40
Payments	\$1,325,727.67	Retroactive Adjustments	(\$8,802.60)
Outstanding Balance	\$2,942,505.56	Total Premium Due	\$4,875,964.36

**Footer and Payment Information:**

DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT

Do not send any correspondence with your payment.

Please include all remittance stubs when submitting payment

Group ID	Subgroup ID	Payment Due	Total Amount Due	Billing Period
00000000	0000	00/00/0000	\$0.00	00/00/0000 - 00/00/0000

Make Check Payable To:

Health Plan Name  
 P.O. Box #  
 City, State, Zip code

AMOUNT ENCLOSED \$

IMPORTANT: Never send correspondence with your stub

## ► ELIGIBILITY

### GROUP ELIGIBILITY

New York state law has limitations regarding which types of employer groups qualify for group health insurance coverage. These requirements vary by type of entity (e.g., employer). In addition, we have certain underwriting guidelines, as permitted by law, that govern whether a group may be accepted for coverage or may maintain coverage. The most common of these guidelines are shown below:

- The group must have a worksite in our service area
- The group must meet the definition of an insurable group, or have an exception from the NYS Department of Financial Services
- A small group must be community rated. A large group may be experience rated. Definitions of these terms are below
- The group must have at least one common-law employee enrolled in the health insurance coverage. The sole owner of a business, regardless of business structure (e.g., C-corporation) is not a common-law employee.

#### Group Size

A small group is one in which:

- The group has one to 100 full-time equivalent employees
- If the sole owner of a business or the spouse of a sole owner is enrolled, at least one other common-law employee must be enrolled

A large group is one which has 101 or more full-time equivalent employees.

See the Annual Group Information Form for assistance in calculating full-time equivalent employees.

For further information, see the following website: FAQs for small group expansion to 1-100 employees: [https://www.dfs.ny.gov/consumers/small\\_businesses/small\\_group\\_expansion\\_faqs](https://www.dfs.ny.gov/consumers/small_businesses/small_group_expansion_faqs)

#### Community Rating

The premium for all persons covered by a policy are the same, based on the experience of the entire pool of risks, without regard to age, sex, health status, occupation or any other demographic factors. The rates may vary by geographic location, product type (e.g., PPO), product features (e.g., copayments) and network (e.g., open).

#### Experience Rating

The premium for the policy selected by the group is determined partially or in full by the group's claims experience and/or demographics, depending on the group's size.

If you have further questions regarding our underwriting guidelines or these terms, please contact your Broker or Account Manager.

### SUBSCRIBER ELIGIBILITY

The subscriber is the person to whom we issue the policy. In order to enroll in our insurance programs, subscribers must meet the criteria outlined in this section. Except as otherwise specified, we rely on you for verification of subscriber eligibility. We may request information to support enrollment of a subscriber at any time, so please maintain these records as long as the individual remains enrolled in our coverage, regardless of how many years he or she remains enrolled. Once the individual terminates coverage, you must retain these records for 10 years. Please note this 10-year requirement applies for paper, web and electronically-submitted requests.



Eligible subscribers must be citizens of the United States, permanent residents or non-immigrants whose authorization status permits employment. Products that require a gatekeeper in the form of a primary care physician (e.g., HMO, POS) or certain products with limited networks require that the subscriber live, work or reside in the service area of our plan. A few gatekeeper products allow the subscriber to live in a contiguous country.

If you have questions about the type of product purchased by your group, please contact your Account Manager or Broker.

## ACTIVE EMPLOYEES

### FULL-TIME EMPLOYEES

If the group is an applicable large employer (see definition below), a full-time employee must work on average 30 hours per week.

If the group is not an applicable large employer, it may establish the number of hours required to classify its employees as full-time, anywhere between 30-40 hours. For example, the group may establish the threshold at 35 hours.

Generally, an applicable large employer under the Affordable Care Act is any company that has an average of at least 50 full-time employees or full-time employee equivalents.

### PART-TIME EMPLOYEES

Part-time employees for a small group or a sole proprietor must work 20 hours or more per week in order to qualify for health coverage. Large employers may include employees who work 17.5 hours or more per week.

### RETIRED EMPLOYEES

Retirees are eligible for coverage if your group includes retiree coverage as a formal employee benefit as part of a written program. The retiree must fulfill the age and years of service requirements of the written retiree program.

The retiree, and all eligible dependents, must enroll in our products prior to the retirement date. The retiree and dependents must also maintain coverage continuously throughout retirement to remain eligible. If a spouse or dependent requires enrollment in a different product than the employee (e.g., employee is over 65 and spouse is under 65), the spouse and/or dependents must complete the appropriate application(s) for coverage to enroll in coverage.

### CONTINUANTS

Individuals entitled to coverage through COBRA, NYS Continuation or the Young Adult Option are entitled to enroll as the subscriber if the individual received all appropriate notices, the election and first premium payments were timely and we receive the application on time.

For further information, see the Continuance section, later in this guide.

## INELIGIBLE SUBSCRIBERS

The following individuals are not eligible for enrollment in your health insurance programs:

- ▶ Employees working fewer than the required hours listed in the eligible employees section
- ▶ An employee in the employer's probationary period
- ▶ Individuals paid for periodic services, such as consultants
- ▶ Contract employees
- ▶ Temporary employees
- ▶ Volunteers
- ▶ Any individual who is not a bona fide employee or former employee

Check with your Account Manager or legal counsel regarding 1099 or seasonal employees.

## WHAT HAPPENS WHEN A SUBSCRIBER LOSES ELIGIBILITY?

You must process a cancellation transaction immediately when a subscriber becomes ineligible, or we may not be able to honor your cancellation transaction for the requested date. You must notify us within 30 days from the date the subscriber loses eligibility. Please see the Retroactive Policy section for further information.

Those who become ineligible as a subscriber include:

- ▶ An employee whose employment is terminated
- ▶ A COBRA or NYS continuant that does not pay premium on time
- ▶ A retiree who dies

## ELIGIBLE DEPENDENTS

The dependent must have an existing relationship with the subscriber, and must meet criteria as defined below, and as contained in the subscriber certificate or plan document. Except as otherwise required by law (e.g., COBRA, NYS Continuation), coverage of dependents is based on the employee or member being the primary person covered under the policy.

Similar to the eligible subscribers section, eligible dependents must meet certain criteria in order to obtain and maintain coverage. In the past, we may have requested certain information to verify eligibility. In today's world of electronic and web enrollment, we generally rely on you to verify dependent eligibility and do not request these documents. We may request information to support enrollment of any dependent at any time, so please maintain these records for as long as the individual remains enrolled in our coverage, regardless of how many years he or she remains enrolled. Once the individual terminates coverage, you must retain these records for 10 years. We have included helpful information regarding the types of acceptable documentation normally expected immediately following the definition of each type of eligible dependent.

Eligible dependents must be citizens of the United States, permanent residents or non-immigrants whose authorization status permits an extended stay in the United States. The dependent must have an existing relationship with the subscriber, and must meet criteria as defined below, and as contained in the subscriber certificate. Excellus BCBS HMO coverage requires the dependents to live or reside in the service area, unless enrolled in the Away From Home Care<sup>®</sup> program for families living apart.

If you have questions about the type of product purchased by your group, please contact your Account Manager or Broker. If you have questions regarding the eligibility of a dependent, please contact Enrollment Processing.

**For further information, see the following websites:**

**Dependent to 26:** [healthcare.gov/law/features/choices/young-adult-coverage/index.html](https://www.healthcare.gov/law/features/choices/young-adult-coverage/index.html)

**Dependent to 30:** [dfs.ny.gov/consumer/faqs/faqs\\_S6030\\_Age29\\_young.htm](https://dfs.ny.gov/consumer/faqs/faqs_S6030_Age29_young.htm)

## SPOUSE

A spouse is eligible whenever the couple is legally married in a state or country that recognizes the type of marriage. The definition of spouse includes opposite sex and same-sex spouses, as well as common-law spouses.

As the group administrator, you must permit enrollment for all spouses who qualify and properly apply for coverage.

Following the Supreme Court's decision on June 26, 2015, same sex marriage is legal in all states in the United States. For that reason, we have removed the table contained in previous editions that provided information regarding which states permitted same sex marriage. If the same sex marriage occurred in another country, e.g., Canada, please seek advice from your legal advisors regarding whether the marriage is valid.

Common law marriage is a legal form of marriage in certain states and the District of Columbia. For questions on common law marriage and eligibility, please seek counsel with your own legal advisors.

For information regarding domestic partners, please see the information under Other Adult Dependents of the Subscriber on subsequent pages.

## ELIGIBLE CHILD DEPENDENTS OF THE SUBSCRIBER

A dependent child must meet criteria related to the relationship with the subscriber, as well as age and, in some cases financial dependency. Please review the following sections for more detail.

### Age

Effective with renewals on or after October 1, 2010, the standard dependent age limitation for medical contracts is to the age of 26. New York State insurance law mandates that a group either add a rider to cover dependents through age 29 or offer a special type of continuation called the Young Adult Option (YAO).

For further information regarding the Young Adult Option, please see the Continuation of Coverage section, later in this manual.

If your group's present policy only covers dependents to age 26 and you are interested in coverage for dependents to age 30, contact your broker or Account Manager for a proposal. This change is available only at renewal.

Please note that these rules affect medical plans only. Freestanding dental and vision plans are not affected and may have different types of eligible dependents and age requirements than the health plan and include eligibility provisions (e.g., the dependent must be a full-time college student) to obtain the higher age limitations.

For further information, see the following website:

*Dependent to 30:*

[https://www.dfs.ny.gov/consumers/health\\_insurance/faqs\\_Age29\\_make\\_option](https://www.dfs.ny.gov/consumers/health_insurance/faqs_Age29_make_option)

The following comparison provides eligibility information regarding the age thresholds under these important laws:

General Provision	ACA	NYS Dependent to 30
Age limit	Under age 26	Under age 30
Children subject to the provision	Children (natural and adopted), legal guardian, stepchildren	Any covered dependent child
Children not subject to the provision	Children dependents not listed above	N/A
Financial dependency	Not required for affected children Is required for all other children	Not required
Residency with the parent, stepparent, adoptive or proposed adoptive parent	Not required	Not required
Residency within NYS or the insurer's service area	Not required	Required
Marital status	May be married	Unmarried
Student status	Not required	Not required
Child is eligible for, or covered by their employers plan	Eligible	Not eligible
Child is covered by Medicaid	Eligible	Not eligible

## FINANCIAL DEPENDENCY

Unless specifically included in the exemption for dependency under ACA or New York state dependent to 30, as shown in the table above, the dependent (e.g., children of a domestic partner) must be financially dependent upon the subscriber for support.

### Documentation

When financial dependency is a requirement of coverage, we recommend the group maintain the following documentation, as applicable, in the member file:

- ▶ A sworn and notarized statement certifying that the subscriber and/or covered spouse is responsible for the medical expenses of the child, or a sworn and notarized statement certifying that the subscriber is responsible for at least 50 percent of the support of the child
- ▶ A copy of the last tax statement indicating that the child was the subscriber's dependent
- ▶ Other evidence (e.g., divorce decree) indicating the subscriber has responsibility for the child's medical expenses or new responsibility for at least 50 percent of the support of the child

## CHILD OF THE SUBSCRIBER

The natural children of the subscriber are eligible for coverage, if the children meet the relationship and other requirements, such as age, as described in this section.

Children are eligible from the moment of birth, if the subscriber adds the child within 30 days of the birth. Please advise employees not to wait to enroll their newborns. The parent does not need to wait for a newborn's Social Security number to add the newborn to coverage.

In the event a child is eligible for coverage due to a Qualified Medical Child Support Order (QMCSO), the child is eligible as of the date the court order is final, provided that the order meets the definition of “qualified.” Your group is responsible to certify that the QMCSO is qualified by using the Qualified Medical Child Support Order Certification Form, which is on our website. This form and a copy of the court order must accompany a paper application in all cases.

Please note, we will accept an application without a subscriber signature in the case where a QMCSO is issued and the subscriber is not cooperative in adding the child.

If a covered dependent child of the subscriber gives birth, the newborn grandchild is not eligible unless the subscriber adopts the child or obtains legal guardianship. See requirements for adopted child or legal guardianship in the appropriate sections below.

### **Documentation**

We recommend the group maintain the following documentation in the member file:

- ▶ A birth certificate
- ▶ A sworn and notarized statement that the subscriber is the natural parent of the child
- ▶ A QMCSO Certification Form and a copy of the court order, when applicable

## **STEPCHILD**

The stepchildren of the subscriber are eligible for coverage as of the date the subscriber marries the child’s parent. Coverage is effective on the date of the marriage, as long as the subscriber applies for coverage within 30 days of the marriage.

In the event a stepchild is eligible for coverage due to a QMCSO, the child is eligible as of the date the court order is final, if the order meets the definition of “qualified.” A QMCSO Certification Form and a copy of the court order is necessary, when applicable.

### **Documentation**

We recommend the group maintain the following documentation in the member file:

- ▶ A sworn and notarized statement that the subscriber’s spouse is the parent of the child
- ▶ Copy of the child’s birth certificate and a copy of the marriage license to establish the relationship to the subscriber as a stepparent
- ▶ The QMCSO Certification Form and a copy of the court order, when applicable

## **PROPOSED ADOPTIVE CHILD**

A child, who the subscriber has consented to adopt and for whom the subscriber has entered into an agreement to support, is eligible for coverage, even though the adoption is not final. Proposed adoptive children are either newborns or older children. The requirements for each are as follows:

### **Newborn Proposed Adoptive Child**

Newborn proposed adoptive children are eligible for coverage from the moment of birth, if the subscriber:

- ▶ Takes physical custody of the child upon discharge from the hospital or birthing center
- ▶ Files a petition under section 115-c of the New York Domestic Relations Law within 30 days of the birth

If the circumstances do not meet both of these conditions, the child is eligible on the date the subscriber meets the requirements to add the child as a non-newborn proposed adoptive child or the adoption is final.

### **Non-Newborn Proposed Adoptive Child**

These children are eligible during the waiting period prior to finalization of adoption, if the subscriber has entered into an agreement to support the child.

### **Foreign Proposed Adoptive Children**

If the parent requests coverage for a foreign adoption that has not reached the final stage or the child is not physically in the United States at the time the application for coverage is submitted, please contact your Account Service Consultant for guidance, prior to acceptance of the application or enrollment of the proposed adoptive child.

#### **Documentation:**

Documentation requirements for a newborn proposed adoptive child include both of the following:

- ▶ A copy of the 115-c petition
- ▶ Proof that the subscriber has physical custody of the child upon discharge from the hospital or birthing center

Documentation requirement for a non-newborn proposed adoptive child, include both of the following:

- ▶ A statement from the adoption agency or, in the case of a private adoption, other appropriate documentation indicating that the subscriber is the proposed adoptive parent and the approximate or target date of adoption
- ▶ Proof that demonstrates the proposed adoptive child is dependent upon the subscriber during the waiting period prior to the adoption becoming final

Documentation requirements for a foreign proposed adoption include documentation similar to the above, and a copy of both the original and translated documents.

## **ADOPTED CHILD**

When an adoption is final, the child is eligible for coverage under the same terms and conditions as a natural child.

### **Foreign Adoptions**

If a parent requests coverage for a child adopted from a foreign country and the child is not physically in the United States at the time the application for coverage is submitted, please contact your Account Service Consultant, before you accept the enrollment application for the adopted child. If the adoption is not final, the child must meet the criteria for a proposed adoptive child. See the previous section regarding the requirements for coverage of a proposed adoptive child

#### **Documentation:**

Documentation requirements for a newborn proposed adoptive child include both of the following:

- ▶ A copy of the 115-c petition
- ▶ If the adoption occurs in a foreign country, obtain a copy of both the original and translated documents.

## **LEGAL GUARDIANSHIP**

A child for whom the subscriber is the legal guardian. Please note that custody alone is not sufficient. A court must specifically confer legal guardianship. The child is eligible for coverage on the date of the court order.

Documentation requirements include of the following:

- ▶ A copy of the court order that conveys legal guardianship of the child to the subscriber or spouse. Custody agreements or orders do not convey legal guardianship

## FULL - TIME STUDENT

For products not subject to federal or New York state age limit requirements (e.g., stand alone dental/vision), the age limits and eligibility requirements may vary and may include a full-time student status requirement. Please review the subscriber certificate or applicable plan documents for details.

If the product includes a full-time student status as a requirement of eligibility, a full-time student must enroll in 12 or more credit hours per semester at an accredited institution of higher learning. Students are not required to attend college during the summer months, but must enroll for the fall semester in the spring, with the intent to return to college in the fall.

We require the group to maintain the following documentation in the member file:

- ▶ Same as established for any other type of dependent based on the relationship between the subscriber and the dependent; plus
- ▶ Proof that the dependent is attending school on a full-time basis; and
- ▶ Subscriber completion and submission of a student certification form to us on an annual basis

## OTHER ADULT DEPENDENTS OF THE SUBSCRIBER

### Domestic Partner

We cover domestic partners in most, but not all, of our benefit programs. Please review the language in the subscriber certificate to determine whether the coverage your group has purchased includes coverage for domestic partners. Our standard domestic partner language includes coverage for both same and opposite-sex partners. Your group may not limit coverage to just one of the two categories, if the language in the certificate includes both types of partnership.

A Domestic Partnership must meet the criteria specified in the subscriber certificate for relationship and financial interdependency.

To qualify as domestic partners, members must demonstrate that they have been living together in a committed relationship for a minimum of six months and are:

- ▶ Not married to any other party
- ▶ A couple of the same sex or opposite sex
- ▶ 18 years of age or older
- ▶ Not related by blood or otherwise barred from marriage to each other

If the domestic partner meets the criteria as specified in the subscriber certificate, his or her children are also eligible for enrollment in your group's coverage.

Your group must maintain the following documentation in your records:

- ▶ Affidavit attesting to the domestic partnership
- ▶ Certificate of Domestic Partnership or Declaration of Domestic Partnership
- ▶ Materials supporting cohabitation and financial interdependency, per the affidavit

## Adult Child Incapable of Self - Sustaining Employment

A child who is incapable of self-sustaining employment may be eligible to remain on a parent's policy beyond the age (e.g., 26) where coverage would otherwise terminate. The parent's coverage must be a type of coverage that includes dependent coverage. The parent must apply for coverage and provide proof of incapacity within 31 days of the time the child ages off the policy.

The child must meet all of the following conditions:

- ▶ The condition occurred before the dependent reached the maximum age under the certificate
- ▶ The child was covered under the parent's policy at the time he or she would have otherwise reached the maximum age under the certificate
- ▶ The condition continues to exist
- ▶ The child is unmarried
- ▶ The child is dependent upon the subscriber for support

Our Medical Director reviews all applications for coverage of a disabled dependent. The Medical Director will determine whether the condition is permanent or temporary. If the condition is temporary, we will periodically request the recertification of the dependent's eligibility, through the submission of a new Disabled Dependent Form. If the child loses eligibility, (e.g., marries), the child may not re-enter coverage under the parent's policy at any future point.

Documentation must accompany the application, and include:

- ▶ A completed Disabled Dependent Form
- ▶ Proof of financial dependency

Dependent Form :

To obtain a Disabled Dependent Form, please go to our website at [Excellusbcbs.com](http://Excellusbcbs.com)

- ▶ broker or employer tab
- ▶ print forms (on bottom of page)
- ▶ Disabled Dependent Forms

You may also contact your Account manager to obtain the form.

## INELIGIBLE DEPENDENTS

Unless specifically included above as eligible, the dependent is not eligible for coverage. Examples of ineligible dependents include:

- ▶ Former spouses from the date that the marriage is annulled or ends in divorce
- ▶ Children who are older than the age limit or who do not meet the definition of an eligible dependent specified in the subscriber certificate, e.g., a child who:
  - ▶ turns 30 when enrolled in a product where the group has purchased the dependent to 30 rider
  - ▶ turns 26 when enrolled in a product where the group has not purchased the dependent to 30 rider
  - ▶ is 26 to 30 years old and marries, moves out of state, becomes eligible for or enrolls in his or her employer's coverage or is no longer dependent upon the subscriber for support
  - ▶ is no longer a student for products such as freestanding dental that may include such limitations
- ▶ Adults who merely live together and do not qualify as domestic partners (when coverage includes domestic partners)
- ▶ Grandchildren, unless the grandparent adopts or becomes the legal guardian of the grandchild
- ▶ Foster children placed in the care of foster parents



- ▶ Parents, grandparents, aunts, uncles, brothers, sisters, nieces, nephews and other relatives
- ▶ Foreign exchange students who live with the host family

## WHAT HAPPENS WHEN A DEPENDENT LOSES ELIGIBILITY?

You must process a cancellation transaction immediately when you learn that a dependent is ineligible, or we may not be able to honor your cancellation transaction for the requested date. You should ensure that your employees understand that they need to notify you within a few days, but never more than 30 days, after the date the child loses eligibility.

Those who become ineligible under a subscriber's contract include:

- ▶ Divorced spouse
- ▶ A member who no longer meets the eligibility requirements in the Eligibility Section of this guide
- ▶ Deceased dependent

Please see the Retroactive Policy section for further information.

## ▶ ENROLLMENT AND MAINTENANCE PROCEDURES

We have compiled the information in this section to assist you with enrollment procedures. Our goal is to help you enroll your members quickly and accurately.

We cannot emphasize strongly enough that you must review and reconcile your bill each month to ensure that our membership records for your group are accurate. If you find any discrepancies, please contact the Enrollment Processing Inquiry Unit immediately.

If you are an administrator for an employer group, you are entitled to establish certain policies for your group, by class of employee, at what point a new employee or rehire may apply for coverage and/or which products are available to each class of employee. The following are important decisions you must make and communicate to us, so we can properly create and maintain your group on our system.

### CLASS OF EMPLOYEE

Although the employer has a choice in classifying employees, there are limitations based upon NYS insurance law and regulations. To comply with these limitations, we are providing you with the following list of characteristics to take into consideration when determining employee classifications:

- ▶ Geographic location of employment (e.g., New York, Ohio, Pennsylvania).  
This does not pertain to the employee's address or minor differences in geographic location, such as by ZIP code
- ▶ Earnings (e.g., commissioned, non-commissioned)
- ▶ Method of compensation (e.g., hourly, salary)
- ▶ Hours (e.g., full-time, part-time)
- ▶ Occupational duties (e.g., management, non-management)
- ▶ Family status of the employee (e.g., single, family)

An employer may not establish employee classifications that do not conform to federal or state labor laws, are discriminatory, patently unfair or that create adverse selection.

Common employee classifications include:

- ▶ Active/retiree
- ▶ Hourly/salary
- ▶ Management/non-management
- ▶ Union/non-union

Please note that our systems include COBRA and Young Adult Options (Dependent to 30) as standard employee classifications. Although these individuals were not generally the subscriber when enrolled as a non-continuant, we must include these employee classifications in order to enroll these individuals as the subscriber once enrolled in continuation.

Your group may request a change to its employee classifications throughout the year, provided you submit the request in writing at least 30 days in advance. These changes apply prospectively. To request a change to your group's employee classifications, please contact your group's Account Manager or Broker.

## PROBATIONARY PERIOD

A probationary period is the period of time an employee must wait after the hire date before enrollment in the employer's group coverage. This is also referred to as the employer waiting period. An employer may establish probationary periods that vary for its employee classifications, but may have only one probationary period for each employee classification.

For example, an employer may establish a probationary period of 30 days from date of hire for salaried staff and the first of the month following the date of hire for hourly staff. Other common probationary periods are:

- ▶ Date of hire
- ▶ 60 or 90 days from the date of hire
- ▶ The first of the month 30 or 60 days from the date of hire

Employees must meet the probationary period before enrollment, even if the employee experiences an event that would otherwise entitle the employee to a special enrollment opportunity.

An employer's probationary period for health products, may not exceed 90 days from the date the employee became eligible for coverage.

### Change An Existing Probationary Period

Your group may request a change in probationary period for a class of employee once per year, provided you submit the request, in writing, at least 30 days in advance. The changed probationary period applies to any employee hired after the effective date of the change. To request a probationary period change, please contact your group's Account Manager or Broker.

### Rehired Employee

Your group may establish a policy that the probationary period does not apply to rehired employees. A rehired employee is one who has a break in employment of at least one day, but not more than six months.

Our default policy is that rehired employees must meet the probationary period. If your group wants to waive the probationary period for rehires, it must establish this policy by notifying us at least 30 days in advance of the effective date. The changed rehire policy applies to employees rehired after the effective date of the change. To change the rehire policy, please contact your group's Account Manager.

### **Key Employees:**

A fully insured group may request to waive the established waiting period for an employee who is a key employee. We define a key employee as one who is in:

- ▶ An advanced level of management; or
- ▶ A highly skilled professional or technical position; and
- ▶ A position that is extremely difficult to recruit for and fill; and
- ▶ The inability to fill that position could cause the organization to fail or go out of business

Typically, this definition applies to CEOs, CFOs, medical doctors (particularly in rural settings) and certain IT positions.

If your company wishes to request a waiver of the probationary period, send a letter on company letterhead explaining the full details of the situation, including the impact if the position remains unfilled, along with any other supporting documentation that may be appropriate and relevant. This waiver is on a case-by-case basis. If we grant a waiver for one employee, it does not guarantee that we will grant any future waivers.

## **▶ SUBSCRIBER LEVEL ACTIVITY**

### **HOW DO I ENROLL, CHANGE OR TERMINATE EMPLOYEES OR DEPENDENTS?**

#### **Submission of Application, Web-transaction, or Electronic file submission.**

You must submit the request directly to the Enrollment Processing department in accordance with our retroactivity policy, as shown later in this guide. This is true, regardless of whether the application is on paper, submitted through the Web or in an electronic format.

Please submit applications when received, up to 90 days in advance, to ensure the best possible service and to comply with the retroactivity policy below. Do not hold the applications until the end of the month.

You should not wait to terminate an employee or dependent while the individual is in the election period for COBRA, NYS Continuation or the Young Adult Option. If the individual elects continuation of coverage, the individual is entitled to reinstatement of coverage, within the guidelines that pertain to those options.

All transactions require a completed application, electronic file submission or transaction through the Web. It is important for the person completing the application or submitting the transaction to acknowledge the fraud statement.

Requests should be submitted within 30 days of an event. If you do not submit requests on time we will deny the request and the subscriber or dependent must reapply at the next open enrollment period or special enrollment.

#### **Important Information on the Application**

While every field is important, the following sections of the application require special attention to ensure timely processing of the application and accurate claims processing.

#### **Other Coverage**

Although pre-existing condition provisions cannot be included in medical products since your 2014 renewal, it is possible that other types of products (e.g., stand alone dental/vision) will contain pre-existing condition provisions.

If the benefits for your group are subject to pre-existing condition provisions, it is critical that this section is complete and accurate. If there is a gap in creditable coverage of 63 or more days, the subscriber and/or dependent(s) may be subject to waiting periods.

If the individual checked the box indicating prior coverage, please ensure that all fields in this section of the group enrollment form are complete.

You are responsible to obtain the Certificate of Coverage (COC) issued by the prior carrier or other proof of creditable coverage from the member. You must maintain this information as part of the subscriber or dependent's records, as specified in the eligibility section. We may request the information from you at any time.

If the group enrollment form indicates that other coverage existed, but the section is incomplete, we will send a "portability" letter to the member, requesting the information above.

Proper information regarding other coverage that remains in effect is crucial to the proper administration of coordination of benefits. This important insurer function helps us ensure a claim is not overpaid and keep our premiums as low as possible. See the Coordination of Benefits section, later in this manual.

### **Cancellation Reason Codes**

It is important to select the proper code when you submit a cancellation. Please refrain from using the same or a few codes for every transaction. These codes trigger certain activity in our systems, including whether or not an individual is:

- ▶ Offered a conversion policy upon termination
- ▶ Entitled to a special enrollment period

### **Primary Care Physician (PCP) Enrollment Requirements**

The primary care physician information is a requirement for enrollment in HMO products. Please note, we will return enrollment requests for HMO products that do not have PCP information completed.

### **Primary Care Physician Change Request**

Due to requirements in the Health Insurance Portability Accountability Act (HIPAA), group administrators, brokers and Account Managers may not update the PCP information on the member's behalf. Members must contact Customer Care, or visit our website to make PCP changes.

## **ADD A SUBSCRIBER OR DEPENDENT(S)**

Examples of when your group may add a subscriber or dependent are:

- ▶ Employee has fulfilled the probationary period and elected coverage
- ▶ Spouse or dependent is newly eligible

If you do not submit an addition in accordance with the retroactivity policy, we will deny your request and the subscriber or dependent must reapply at the next open enrollment period or special enrollment opportunity.

### **Exceptions to the 30-day retroactivity period:**

- ▶ Add a subscriber to COBRA continuation of coverage. The COBRA law provides for an extensive notice and election period. We will honor a request to reinstate a member to coverage as a COBRA continuant for a period of up to 179 days for a subscriber related event and 239 days for a dependent related event. We encourage you to wait until the continuant pays his or her first premium before you reinstate the coverage or you may be liable for the premium. Please note that you must still submit the original transaction to terminate the individual within the standard 30 days. The reinstatement to coverage as a COBRA continuant is the only portion that is an exception.

See the COBRA Timeline Table in the Continuation of Coverage Section

- ▶ Add a subscriber to NYS continuation of coverage. The notice and election period for NYS continuation is much shorter than COBRA. We will honor a request to reinstate a member to this coverage for a period of up to 95 days for a subscriber event and 125 days for a dependent event.

**Please Note:** The subscriber/dependent must pay the premium at the time he or she elects NYS Continuation

See the NYS Continuation Timeline in the Continuation of Coverage section

- ▶ Add a former dependent under the Young Adult Option (YAO). The election period for initial enrollment allows for retroactive enrollment. We will honor a request to enroll a Young Adult if we receive the request within 60 days of the termination date.

**Please Note:** The subscriber/dependent must pay the premium at the time he or she elects the Young Adult Option.

## CHANGE A SUBSCRIBER OR DEPENDENT(S)

### Benefit Changes

Benefit changes are generally restricted to the open enrollment period. An exception to this rule is if your group has different products for members when Medicare is primary. If your group has these products and you provide timely notice, we permit product changes at the point when Medicare changes status from secondary to primary or the reverse. We also allow product changes during certain Special Enrollment Periods, such as when there is a newly eligible dependent.

### Demographic Changes

We refer to the following and other similar changes to the member's information, as demographic changes:

- ▶ Last name or corrections to the spelling of names
- ▶ Address
- ▶ Phone number

You may submit demographic changes at any time. The change is effective the date we enter the information into our system. For a name change, please submit the request in writing or via our website. We suggest you request and maintain a marriage certificate, divorce decree or other records to support a name change.

## CANCEL A SUBSCRIBER OR DEPENDENT(S)

The ACA placed restrictions on cancellation transactions that it defined as rescissions. Please be certain you read the information under Rescissions in the Retroactive Policy section carefully, as you may be required to provide advance notice of termination to your employees or dependents, and it may restrict your ability to terminate coverage as of the requested date.

A subscriber may voluntarily terminate coverage entirely or remove a dependent at any time during the year. The subscriber does not have to wait until open enrollment. Voluntary terminations must be submitted 30 days in advance. Once terminated, the subscriber must wait until open enrollment or a special enrollment opportunity to rejoin group coverage or add the dependent to his or her coverage.

### **Cancellation Effective Dates:**

- ▶ To cancel a member whose ID number begins with a "2" and does not contain an alpha character, use the last day of the month of the event date as the cancellation date
- ▶ To cancel a member whose ID number is eight digits long with an alpha character in the middle, use the first day of the next month after the event date, as the cancellation date

## **▶ ENROLLMENT OPPORTUNITIES**

There are three times when employees or dependents may enroll. The first is at the point of initial eligibility (e.g., new hire, birth). The second opportunity is when an event occurs (e.g., divorce, loss of coverage) that qualifies the employee or dependent for a special enrollment period. The third opportunity is at the annual open enrollment period. The following sections explain these three periods.

### **INITIAL ENROLLMENT**

If an employee does not enroll himself/herself or dependents when initially eligible, he or she will not have a second opportunity until open enrollment or a special enrollment event.

#### **New Hire**

A new employee is eligible to enroll at the end of the probationary period established for his/her class of employee.

#### **Rehire**

In accordance with the rehire policy selected by your group, the rehire is eligible either from the date of hire or at the end of the probationary period. See the Probationary Period section for further information.

#### **Newly Eligible Dependent**

The following events qualify a dependent for addition to the subscriber's coverage:

- ▶ Marriage (the spouse and any qualified stepchildren)
- ▶ Birth (the newborn)
- ▶ Adoption of a child, spouse and employee or a qualified proposed adoptive child (the adoptive or proposed adoptive child)
- ▶ A Qualified Medical Child Support Order (QMCSO) is issued

If the employee has certain newly eligible qualified dependents and the employee has not enrolled in coverage, the employee and his or her spouse may qualify to enter coverage along with the new dependents and spouse, due to a special enrollment event. See below.

### **SPECIAL ENROLLMENT PERIOD**

Certain events qualify employees and/or dependents for enrollment opportunities during the plan year, rather than at open enrollment. These events typically are major life events that affect coverage decisions. However, these events do not supersede the probationary period. An employee is not entitled to enroll until the end of his/her applicable probationary period.

If the employee does not currently have coverage because the employee previously waived coverage and experiences certain special enrollment events, the employee may be qualified to enroll in coverage outside open enrollment and add some or all qualified dependents, depending on the event and the type of dependent.

If a member submits an application on a timely basis, it is your obligation to accept and forward applications for enrollment, whenever one or more of the following events occur.

### Involuntary Loss of Coverage

Loss of coverage under another employer’s or spouse’s plan due to:

- ▶ Change in working hours
- ▶ Termination of employment
- ▶ Other employer terminates coverage or ceases to contribute to the cost of coverage
- ▶ Divorce
- ▶ COBRA or other continuation maximum period is reached

### New Dependent

A new dependent due to:

- ▶ Marriage
- ▶ Birth
- ▶ Adoption or qualified proposed adoption
- ▶ Legal guardianship

### Former Dependent Regains Eligibility for Coverage

- ▶ **Dependent to 30 – For example:** a dependent who is 27 years old moves back into New York state
- ▶ **Dependent to 26 – For example:** a 21-year-old dependent returns to college and regains eligibility for a freestanding dental product with 19/23 coverage for dependents

### Medicare Status Changes

- ▶ Medicare eligibility or Medicare primary/secondary status change, which necessitates a change of product
- ▶ When a subscriber becomes Medicare eligible and the group offers a Medicare policy, dependents of his/her family may remain eligible on the group policy. That family member will be allowed to become the subscriber on their own policy within the group, if the dependent was active on the subscriber’s plan at the time of Medicare eligibility.
  - ▶ The dependent will be allowed this coverage for the remainder of time that the subscriber carries their Medicare primary plan with the group, or they age off the coverage before then.
  - ▶ If you have further questions on this, please contact your Account Manager.

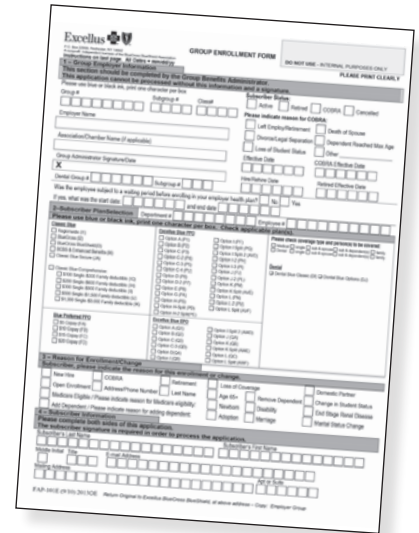
### Network Limitations

- ▶ The subscriber moves out of the service area of a limited network health plan (e.g., HMO), and your group offers other coverage without a limited network

### Eligibility for Government-Sponsored Program or Premium Assistance

- ▶ Loss of eligibility for a government-sponsored program, such as Medicaid
- ▶ The employee or children become eligible for premium assistance through Medicaid or Child Health Plus in an eligible state, such as New York state or Pennsylvania

If you have questions regarding whether an event qualifies the employee for a special enrollment period, please contact your Account Service Consultant for assistance.



### Events that do not create a Special Enrollment:

- ▶ Voluntary loss of coverage
- ▶ Early termination of COBRA due to nonpayment
- ▶ The spouse's employer raised employee contribution, but did not cease contributions

## ANNUAL OPEN ENROLLMENT PERIOD INFORMATION

Once per year, an employer must offer employees the opportunity to participate in open enrollment.

Open enrollment does not supersede the probationary period. An employee is not entitled to enroll until the end of his/her applicable probationary period.

### Employee Options at Open Enrollment

Open enrollment is the time when employees may:

- ▶ Change benefits if the employer offers more than one product to the employee's class of employee (e.g., union employees)
- ▶ Enroll in coverage, if the eligible employee declined enrollment when initially eligible or subsequently disenrolled
- ▶ Add eligible dependents who:
  - ▶ did not enroll at initial eligibility or a subsequent special enrollment opportunity
  - ▶ were previously disenrolled from coverage or who lost eligibility and have subsequently regained eligibility
- ▶ Voluntarily disenroll existing dependents

## ▶ GROUP LEVEL ACTIVITY

Group level activity is a change that affects all or a defined portion (e.g., a particular employee classification) of the group, rather than activity that affects a particular subscriber or dependent.

We have designed this section to help you understand and follow the requirements which allow us to administer your overall group benefits in the most accurate and efficient manner possible.

In general, your group may add a new benefit or change benefits only at your group's renewal date. You may terminate an existing benefit at any time.

You should advise us of any group level activity at least 30 days in advance, to ensure that we can process the change well in advance of the effective date for the following reasons:

- ▶ Ensure that new identification cards and benefit certificates are in the member's hands before the changes go into effect
- ▶ Provides time for the member and providers, if applicable, to follow product protocols, such as preauthorization, to avoid penalties
- ▶ Allows the member to take full advantage of any rewards programs built into the product
- ▶ Enhances member satisfaction

If you need a quote for alternate benefits, please contact your Account Manager or Broker. We suggest you request a quote at least 60 days in advance of your renewal date, to allow time to review the quotes and



make a decision. If you are adding a new benefit and employees will have to review the selections and make choices, you may want to request a quote 90 days in advance of your renewal date.

Please submit new benefit, change to benefit, and termination of benefits requests to the Sales department.

## GROUP ACTIVITY TRANSACTIONS

### Adding a new benefit

This transaction is to add an entirely new product offering (e.g., a second health plan option to your existing package of benefits, such as a high deductible health plan). You must provide:

- ▶ A signed rate sheet for the new plan offering.
- ▶ A memo or similar document to indicate that you are adding a new plan and not replacing an existing offering. Include whether you have web access.
- ▶ New applications (either paper or electronically) for all members who are not presently enrolled with us and who:
  - ▶ Elect the new benefit(s), or
  - ▶ Change to the new offering

If you perform subscriber maintenance via our website, you must wait until we add the new benefit to your group before submitting subscriber requests.

### Change an existing benefit

This transaction is to change everyone enrolled in existing Product A to a new Product B (e.g., from a PPO with a \$20 copay to a PPO with a \$25 copay). You must provide:

- ▶ A signed rate sheet for the new plan offering
- ▶ A memo or similar document that indicates you are replacing your current plan with the selected option and instructions
  - ▶ Requesting us to transfer of all membership from Product A to Product B, or
  - ▶ That you will perform the maintenance electronically

### Terminate an existing benefit

This transaction is to terminate all coverage for one or more groups or subgroups. For example, your group no longer provides coverage for retirees or has closed a location.

Please provide us with a memo or similar document that includes:

- ▶ The specific package you wish to terminate
- ▶ The effective date of termination
- ▶ Instructions regarding the treatment of terminated members. For example, transfer members from Product C to Product D

### Terminate the group or subgroup

This transaction is to terminate all coverage for one or more groups or subgroups. For example, your group no longer provides coverage for retirees or has closed a location.

Please provide us with a memo or similar document that includes:

- ▶ The specific group and/or subgroup you wish to terminate
- ▶ The effective date of termination
- ▶ Instructions regarding the treatment of terminated members. For example, please advise us:

- ▶ To terminate the member(s) from the subgroup without transfer, or
- ▶ Transfer the member to another subgroup that your group offers. Provide the destination subgroup and benefit plan for these members, or indicate that you will initiate the transaction electronically.

## ▶ MEDICARE

Medicare is a federal health benefits program available to people based on age (65 or over), disability or condition (e.g., end-stage renal disease).

### There are different types of Medicare fee-for-service coverage

1. **Part A** - Covers institutional services, such as hospital or skilled nursing facility when followed by an inpatient hospital stay, subject to Part A deductibles and copayments.
2. **Part B** - Covers professional medical services, outpatient hospital services, ambulance services, durable medical equipment, medical supplies, services of other qualified health care professionals such as physical therapists. These services are subject to Part B deductibles and coinsurance.
3. **Part C** - Medicare Advantage Plans. An integrated plan that covers all of the services covered by Medicare A and B, but subject to different cost sharing than Medicare. These plans may also cover services not covered by Medicare A or B. See page 37 for more information on Part C Medicare coverage.
4. **Part D** - Prescription drug coverage.

The Centers for Medicare and Medicaid Services (CMS) administers Parts A and B. Parts C and D are administered by private insurance companies under the supervision of CMS.

### Medicare Secondary Payer (MSP) Rules and Regulations

Medicare has rules that specify when it is the primary or secondary payer of benefits. You, as the group administrator, are responsible for understanding how these MSP rules and regulations apply to your group and to report your group's size accurately.

#### Working aged rules

These rules apply to employees who are over 65, eligible for either Medicare Part A or B, actively working during the specified time frame and who receive a health benefit as a condition of employment.

- ▶ If the company has 19 or fewer employees, Medicare is primary and we are secondary
- ▶ If the company has 20 or more employees Medicare is secondary and we are primary

#### Retiree Rules

Medicare is the primary payer for retired employees who are over 65, regardless of the group's size.

#### Disability rules

These rules apply to employees who are under age 65 and eligible for Medicare due to disability.

- ▶ If the company has fewer than 100 employees, Medicare is primary regardless of whether the employee is in active employee status or not. We are the secondary payer
- ▶ If company has 100 or more employees during the specified time frame and subscriber is actively working, Medicare is the secondary payer and we are primary
- ▶ If a subscriber is not in active employee status, regardless of company size, Medicare is primary to subscriber's plan for Medicare eligible members

## End-stage renal disease (ESRD)

These rules apply to all participants enrolled in the group's coverage, if

- ▶ The employee is in active status (regardless of age) or the employee is disabled and under 65
- ▶ The member is diagnosed with permanent kidney failure, based on a diagnosis consistent with ESRD, such as chronic renal failure

If the member has dialysis:

- ▶ A 30-month coordination period applies where the group's health insurer is the primary payer before Medicare.
- ▶ After 30 months, Medicare is primary and the group's health plan is secondary

If the member receives a transplant:

- ▶ At the end of the coordination period, Medicare becomes primary
- ▶ If a member receives a successful kidney transplant, Medicare eligibility ends 36 months after the successful kidney transplant
- ▶ The Medicare office sends the member a letter once Medicare ends. The member must provide this letter to us, so that we may process claims accordingly

We correspond directly with members who are eligible for Medicare due to ESRD to obtain the effective dates for Medicare Part A and B and to ensure we are processing claims in accordance with Medicare Secondary Payment rules.

This is a simplified explanation, and there are many exceptions to the above rules and regulations. Special rules apply to owners of companies, association-type groups, clergy/religious order members, part-time employees, domestic partners and same-sex spouses.

Please visit [Medicare.gov](https://www.Medicare.gov) for additional Medicare information.

## ▶ MEDICARE ADVANTAGE GROUP COVERAGE

### Our mailing address

Medicare Division  
P.O. Box 546  
Buffalo, New York 14201

### Customer Care – Contact Information

Questions specific to an individual member's claims or benefits should be directed to our Medicare Customer Care Advocates at 1-877-883-9577.

### Enrollment – Contact Information

Questions regarding the enrollment status or eligibility of a Medicare member can be directed to our Medicare Enrollment Department at 1-877-240-1320.

## ELIGIBILITY

Members must meet the following eligibility requirements to enroll in a Medicare Advantage (MA) or Medicare Advantage-Prescription Drug (MA-PD) Plan:

- ▶ Be entitled to Medicare Part A.
- ▶ Be enrolled in Medicare Part B.
- ▶ Permanent resident of the plan service area.
- ▶ Comply with the CMS guidelines regarding end-stage renal disease.

All enrollments in MA and MA-PD Plans are processed as single contracts. Any dependents of eligible members must qualify for Medicare individually in order to be eligible to enroll in a MA or MA-PD Plan. For those members with a spouse or dependent who is not Medicare eligible, the spouse or dependent may enroll in a non-Medicare plan if offered, commonly referred to as “commercial” coverage. Commercial enrollments are handled separately and may have different eligibility guidelines.

## PLAN SERVICE AREA

The approved plan service area for MA and MA-PD Plans is listed below.

**Medicare Blue Choice (HMO)** – Broome, Cayuga, Chemung, Chenango, Clinton, Cortland, Delaware, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Oneida, Onondaga, Ontario, Oswego, Otsego, Schuyler, Seneca, St. Lawrence, Steuben, Tioga, Tompkins, Yates and Wayne counties are covered in New York state.

Employer Group must be headquartered in Rochester, NY in order for retirees to enroll into one of the Medicare Blue Choice (HMO) plans.

**Medicare Blue PPO** - Broome, Cayuga, Chemung, Chenango, Clinton, Cortland, Delaware, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Oneida, Onondaga, Ontario, Oswego, Otsego, Schuyler, Seneca, St. Lawrence, Steuben, Tioga, Tompkins, Yates and Wayne counties are covered in New York state.

Employer Group members can live anywhere in the United States and Puerto Rico in order to enroll with Medicare Blue PPO Plans. The Employer Group must be headquartered in one of our 31 counties listed above.

## ENROLLMENT

Excellus BCBS must receive a signed paper application form from each member who is enrolling in a MA and MA-PD Plan.

### Group Enrollment Applications

- ▶ It is important that the correct Employer Group enrollment forms are used. If a member completes an “Individual” enrollment form, he/she will be enrolled in an individual plan.
- ▶ Please review all enrollment forms for completeness to ensure proper processing.
- ▶ If we determine that the group enrollment form is incomplete, the form cannot be processed and will be sent back to the member.

### Alternative Enrollment Method

- ▶ In limited cases, plan sponsors may be eligible to submit a data file from the employer group for enrollments. Disenrollments, cancellations or terminations of coverage cannot be accepted through this mechanism.
- ▶ Any group that wishes to utilize the alternative enrollment method must receive prior approval from both Excellus BCBS and from CMS. Please contact your Account Consultant for further information regarding group requirements and responsibilities.

## EFFECTIVE DATE OF ENROLLMENT

All enrollment forms must be signed prior to the requested effective date and must also have the requested effective date listed on the enrollment form. In no event can the requested effective date be prior to the date the member signed the application.

## THE ENROLLMENT PROCESS

After an enrollment form is entered into the Excellus BCBS membership system, an electronic file is sent to CMS to verify eligibility for each member. If the enrollment is accepted, each member will be mailed a letter that acknowledges and confirms their enrollment and includes the effective date of coverage. If the enrollment is denied, the applicant will receive a denial letter; and he or she will be individually responsible for paying the cost of all medical or pharmacy services received while the enrollment application was pending.

If the enrollment form is incomplete or eligibility cannot be verified, a letter is mailed to the member requesting the additional information needed to complete the enrollment. The enrollment process will not continue until the additional information is received and Medicare eligibility is verified. If the needed information is not provided by the member within 21 calendar days or the end of the month, whichever is later, the application will be rejected as it is assumed the member is no longer interested in enrolling in the MA or MA-PD Plan.

### **Note- Member Contact**

With regard to Member eligibility for MA and MA-PD Plans, we may need to contact the member directly for additional information. It is important that we ensure that the member is making a fully informed decision in regard to his/her enrollment choices. While the plan sponsor may be able to provide particular information specific to a member's enrollment request, we may need to contact the member directly over-the-phone or by mail to verify information.

## DISENROLLMENT

### **Disenrollment Process - Entire Group**

If the plan sponsor wishes to terminate the group MA or MA-PD Plan, a written request must be received by us 45 days prior to the requested effective date.

We must notify a member at least 21 days prior to a plan sponsor termination that he/she has the option to enroll in a MA or MA-PD Plan as a direct pay individual. We will provide affected plan sponsor's members with this notice at least 21 days prior to the plan termination. If we receive written notice of plan termination less than 45 days before the requested termination date, we will extend the termination date of the group contract by one month in order to meet the CMS required time frames for this member notification. Retroactive disenrollments will not be processed and are not allowed due to notification requirements for the member per CMS guidance.

### **Disenrollment Process - Specific Individual**

The plan sponsor will establish its own criteria for member eligibility in its plan. If it is determined that a member no longer qualifies for the group status, the plan sponsor must submit appropriate documentation to request the involuntary disenrollment of the member. This documentation must clearly state the reason why the member is no longer eligible and provide a minimum of 30 day notification prior to disenrollment. If 30 days notification is not provided by the plan sponsor, we will extend the disenrollment date of the member by one additional month in order to meet the CMS required time frames for member notification. The plan sponsor should maintain records of the notification and the dates in the event of any CMS audit(s).

### **Disenrollment Process - Individual Initiated**

If a member requests to voluntarily disenroll from the employer-sponsored plan, he/she may submit his/her own written request to us to do so. CMS requires that these requests be processed regardless of the member's enrollment in an employer-sponsored plan. These types of requests are processed for the first of the following month after the written disenrollment request is received. In addition to this form of disenrollment, if a member enrolls in another MA or MA-PD Plan he/she will be automatically disenrolled from his/her current plan. In order to re-enroll, a new enrollment application will need to be submitted.

## Disenrollment Process - Medicare Supplement Plans

Disenrollment requests are processed for the first of the following month after the written disenrollment request is received or for a specific date as long as the effective date is written on the request and there has been no claims utilization.

Upon notification to the Plan, a group may disenroll a member from a Medicare Supplement plan for:

- ▶ loss of eligibility
- ▶ non-payment of premiums
- ▶ Death (The group must send the Plan written notification of a member's passing along with date of death)

A group may also disenroll a member if he or she is moving to a MA plan. Enrollment into a MA plan does not automatically terminate the Medicare Supplement plan. The termination date will be determined by the receipt date of the disenrollment request. The request should be received prior to the effective date of the MA plan in order to prevent the member from having overlapping coverage.

## DISENROLLMENT PROCESS – MEDICARE INITIATED

In certain cases, a member may be involuntarily disenrolled from an MA or MA-PD plan due to loss of eligibility for continued enrollment. We are notified of these eligibility changes electronically each week by CMS. The list below provides examples of when a member may be involuntarily disenrolled:

- ▶ Loss of entitlement to Medicare Part A
- ▶ Termination of enrollment in Medicare Part B
- ▶ Permanent move outside of the plan service area
- ▶ Enrollment in another MA and/or MA-PD Plan
- ▶ Death

When we complete an involuntary disenrollment for one of the above reasons, we will send written notification directly to the member or his/her estate.

## LOW INCOME SUBSIDY (LIS)

Medicare also provides extra help (a subsidy) with Part D prescription drug costs and premiums for eligible individuals whose income and resources are limited. This help takes the form of subsidies paid by the federal government to the Medicare Prescription Drug Plan in which the eligible individual enrolls. The subsidy provides assistance with the premium, deductible and copayments/coinsurance of the program.

Further information on the low income subsidy can be found on the Social Security Administration (SSA) Web site at [SSA.gov](http://SSA.gov).

### Low Income Subsidy Eligibility

- ▶ Individuals become LIS eligible either by being deemed eligible by CMS or through application to the SSA.
- ▶ Individuals are eligible when they receive Medicaid benefits either as a full dual eligible or a partial dual eligible or if they are a Supplemental Security Income (SSI) recipient. Individuals are often deemed retroactively and are always deemed through the end of the calendar year.
- ▶ Individuals that apply for LIS through SSA may gain, lose or have a change to their LIS status at any point during a calendar year.

### **Low Income Subsidy Enrollment Process**

We are notified of LIS status changes on a regular basis by CMS and by individual members. If it is determined that a member is eligible for this subsidy, the member's enrollment will be updated accordingly once our Medicare Enrollment Department receives notification.

### **Low Income Premium Subsidy Pass Through Requirement**

Plan sponsors are required to comply with the same requirements related to the low income premium subsidy amount that applies to Medicare Prescription Drug plan sponsors offering Part D plans to individual beneficiaries. Any low income premium subsidy amount paid on behalf of a member who is LIS eligible must first be used to reduce any portion of MA-PD Plan premiums paid by the member. Any remainder may then be used to reduce any portion of the plan sponsor's MA-PD premium contribution.

For plan sponsors with a community rated or prospective experience rated MA-PD Plan, we will reduce the monthly premium charged to the plan sponsor for the LIS beneficiary. It is the responsibility of the plan sponsor to reduce the LIS eligible member's contribution to premiums or refund the appropriate amounts directly to him/her within 45 days from the date we receive the subsidy payment from CMS.

For plan sponsors with a claims-based billing arrangement or self-funded arrangement, we will issue a refund check directly to the plan sponsor for the premium subsidy amounts received on behalf of the LIS eligible member. It is the responsibility of the plan sponsor to reduce the LIS eligible member's contribution to premiums or refund the appropriate amounts directly to the LIS eligible member within 45 days from the date we receive the subsidy payment from CMS.

## **CREDITABLE COVERAGE**

Plan sponsors who offer prescription drug coverage are required to notify Medicare eligible policyholders whether their prescription drug coverage is creditable coverage. Creditable coverage is coverage that is expected to pay on average as much as the standard Medicare prescription drug coverage. Please visit [CMS.gov/CreditableCoverage](https://www.cms.gov/CreditableCoverage) for more information.

### **Medicare Late Enrollment Penalty**

Individuals eligible for Medicare who do not join a Medicare Prescription Drug Plan (Part D) when they are first eligible, and who do not have prescription drug coverage that is at least as good as standard Medicare prescription drug coverage (creditable drug coverage) may pay a late enrollment penalty if they later join a Medicare Prescription Drug Plan. Individuals must pay the late enrollment penalty if they join a Medicare Prescription Drug Plan after having a period of 63 days or longer without Medicare prescription drug coverage or other creditable prescription drug coverage after they are first eligible to join. This period will start three months after they are eligible to join a Medicare Prescription Drug Plan. Individuals are eligible to join a Medicare Prescription Drug Plan once they are entitled to Medicare Part A and/or enrolled in Medicare Part B.

Individuals will have to pay a penalty for every month he/she was eligible to join a Medicare Prescription Drug Plan and was not enrolled in one. They will have to pay this penalty in addition to his/her monthly premium for as long as they are enrolled in a Medicare Prescription Drug Plan.

The late enrollment penalty amount is at least 1% of the Part D national average premium for each full uncovered month that an individual was eligible to join a Medicare Prescription Drug Plan and did not.

Upon application for enrollment in a MA-PD Plan, the Medicare Enrollment Department will consult CMS eligibility systems and our internal eligibility systems for the following information.

- ▶ The date the member was first eligible to enroll in a Medicare Prescription Drug Plan.
- ▶ The start and end dates of any period in which the member was previously enrolled in a Medicare Prescription Drug Plan.
- ▶ The start and end dates of any period in which the member was enrolled in a creditable drug plan for which a former employer or union was receiving the Retiree Drug Subsidy from CMS.
- ▶ The start and end dates of any period in which the member was enrolled in a creditable drug plan offered by the same plan sponsor through Excellus BCBS.

If we determine that the member had a period of 63 days or longer without Medicare prescription drug coverage or other creditable prescription drug coverage, we will calculate the number of full months that the member did not have coverage.

The late enrollment penalty will appear on the plan sponsor's monthly bill for any member that is subject to the late enrollment penalty. The plan sponsor has the discretion to pay the penalty amount on behalf of their members or to bill the member for the penalty amount. Regardless of which option is chosen, the plan sponsor is responsible for remitting the entire amount due to Excellus BCBS each month.

## BILLING AND PAYMENT INFORMATION

### Billing

- ▶ It is important that you reconcile your billing statement each month to ensure that all members being billed are still active and enrolled in the correct MA or MA-PD plan. This will ensure that our records are up-to-date, allow timely claim payments and prevent denials of activity requests due to CMS retroactivity guidelines.

### Payments

- ▶ Submit the payment with the payment remittance stub to the address shown on the reverse side of the remittance stub.
- ▶ Do not send any activity with your premium payment to our bank lock box. Activity such as new adds, cancellations or changes will not be processed with your payment.

## BENEFIT CHANGES

### Mandated Benefit Changes

- ▶ During the year, Congress may mandate Medicare to provide coverage for specific items. These changes generally are effective the first of the year; however, effective dates may vary. CMS requires that each member receive notification of these benefit enhancements, as well as any other plan benefit changes.
- ▶ We will notify members directly of any mandated Medicare benefit changes.

### Voluntary Group Benefit Changes

- ▶ Voluntary benefit changes may be requested on renewal and must be received by us no less than 30 calendar days prior to the requested effective date.
- ▶ In addition, group MA and MA-PD members must be provided with written notice of any change in benefits, contributions or service areas at least 30 days prior to the effective date of the change. Plan sponsors that voluntarily make changes to its plan offering are responsible for mailing this notice to their members. Records of the notification and the dates should be retained in the event of any CMS audit(s).



## Individual Notification Of Changes

### Annual Notice of Change (ANOC)/Evidence of Coverage (EOC)

- ▶ Each September, CMS requires MA and MA-PD organizations to provide written notification to each MA or MA-PD member detailing all the benefit changes or enhancements, as well as any service area changes that affect all members. This mailing is sent to individual and group members and includes the following documents:
- ▶ The annual mailing that will be sent to group members is based on the active benefit package as of August 1.

## MISCELLANEOUS

### Reinstatements

If a member unintentionally disenrolls from the employer group MA or MA-PD Plan due to enrollment in another similar plan they may be reinstated under certain circumstances.

Deliberate and intentional disenrollments made by the member are only eligible for reinstatement if the member directly contacts the other plan to cancel his/her enrollment prior to the effective date of a deliberate disenrollment. This request is the responsibility of the member and cannot be performed by the employer representative.

### Enrollment Cancellation

Cancellations may be necessary in cases of mistaken enrollment made by a member. A member may cancel his/her enrollment only by contacting us prior to the effective date of the enrollment. Cancellations properly made to the plan sponsor prior to the effective date of the enrollment request being cancelled are also acceptable. Plan sponsors must submit appropriate documentation showing that the member contacted the plan sponsor prior to the effective date of coverage in order to cancel the enrollment.

Requests to cancel an enrollment that are made after the effective date of coverage will be considered for disenrollment effective the first of the following month.

### Address Changes

When an address for a member has changed, it is the responsibility of the member to notify us by contacting Customer Care at the phone number listed on their Identification Card. If it is determined that the member resides outside of our plan service area as a result of the move, then the member will no longer be eligible to stay in one of our MA or MA-PD plans and must be disenrolled.

### Individuals' Demographic Changes

#### **Includes name changes, date of birth changes and Social Security number changes**

For updates to personal information due to typographical errors by us, notifications can be made to Customer Care for correction. However, other updates to personal information must be initiated by the member through the SSA. We will be notified of these changes electronically by CMS each month. Once the change is processed, the member's information will be updated and a new Excellus BCBS ID card will be issued if necessary.

## ▶ CONTINUATION OF COVERAGE

There are two types of continuation: COBRA and NYS Continuation. In addition, a NYS law allows dependents to be covered to age 30. If your group does not add the rider to extend the age limit on your policy through age 29, it must offer a special type of continuation, known as the Young Adult Option (YAO). For further information on all three programs, see below.

Your group is responsible for properly administering these programs. We provide some general information below and links to additional resources. We recommend that you consult with your advisors (e.g., legal counsel) if you have specific questions or unique situations, as these laws and regulations are quite complex.

**Please Note:** The employer group must be in active status in order to offer Continuation of Coverage.

### COBRA

COBRA (Consolidated Omnibus Budget Reconciliation Act) is a federal law. It applies to employers with 20 or more employees who provide group health plans. It applies regardless of whether the plan is insured or self-insured. It does not apply to groups who are not employers.

COBRA provides your employees, or their dependents, with the right to keep the group health insurance benefits they would otherwise lose, on the occurrence of specified events. The member preserves his or her rights, if the member makes the election and pays premium on a timely basis.

### ELIGIBILITY

#### Qualified Individual

- ▶ Enrolled in a product that is subject to COBRA the day before a qualifying event
- ▶ An employee, the spouse of an employee or the qualified dependent child

**Qualifying Events and Length of COBRA Employee and Qualified Dependents** – Up to 18 months of continued group coverage must be offered to the qualified employee and dependents for the following qualifying events:

- ▶ termination of employment
- ▶ reduction in hours

**Dependent** – A qualified dependent may elect COBRA independently of the employee when the qualifying event causes the dependent to lose coverage. Up to 36 months of continued group coverage must be offered for these qualifying events

- ▶ Death of the covered employee
- ▶ Medicare entitlement of employee
- ▶ Divorce/legal separation from the covered employee
- ▶ Loss of “dependent child” status under the plan (e.g., age-off)

### TERMINATION OF COVERAGE

COBRA continuation of coverage terminates at the earliest of the following:

- ▶ Reaching the maximum continuation period
- ▶ Non-payment of premium
- ▶ First entitlement to Medicare, if the first entitlement is after the COBRA election

For additional information on COBRA, please review the information at the following website:

<http://dol.gov/COBRA/>

## COBRA TIMELINE

Below is a chart to reference that will assist with avoiding retroactive request

	Employee Loses Eligibility for Employer's Health Plan	Dependent Loses Eligibility for Employer's Health Plan
<b>Employee must notify employer of event</b>	Not Applicable	Within 60 days of event that causes ineligibility
<b>Employer must notify employee of COBRA rights</b>	Within 44 days from the date of the qualifying event*	Within 44 days of the date employee notified the employer of the qualifying event
<b>Employee's election period</b>	Within 60 days from date employer notifies employee of COBRA rights	Within 60 days from date employer notifies employee of COBRA rights
<b>Employee pays 1st premium</b>	Within 45 days of COBRA election	Within 45 days of COBRA election
<b>Employer submits application to EHP</b>	Within 30 days of initial premium payment	Within 30 days of initial premium payment
<b>Max days elapsed</b>	179 days	239 days

\* If your group has a Plan Administrator, you must notify the Plan Administrator within 30 days. The Plan Administrator has 14 days to notify the employee.

If you are the Plan Administrator, you have the entire 44 days to provide notification.

There may be times when the COBRA enrollment process reaches the maximum period. It should however, be unusual. There are steps that you can take to keep the timeline to a shorter, more manageable period. Here is an example of a COBRA election for a terminated employee:

Activity	Time Elapsed
Employee is terminated and employer provides notice at exit interview	1 day
Employee elects coverage and pays first premium with election	5 days
Employer submits the application to insurer	11 days
<b>Total time elapsed</b>	<b>17 days</b>

## NEWYORK STATE CONTINUATION

New York state continuation applies to any insured health plan, regardless of the group's size and whether or not the group is an employer. It does not apply to self-insured plans unless the self-insured plan voluntarily subjects itself to these provisions. It does not apply to free-standing dental or vision plans.

New York state requires the availability of a total of 36 months of continuation for any individual who is entitled to continuation. The 36 months is in combination with any continuation already utilized under COBRA (where applicable), it is not in addition to COBRA. COBRA does not apply (e.g., loss of coverage for a non-employee). New York state insurance law expands the availability of continuation to dependents who are not otherwise included under COBRA (e.g., same-sex spouse). A domestic partner who loses eligibility due to termination of the domestic partnership is not eligible for NYS Continuation.

Unlike COBRA, the member must include the initial premium with the continuation election. The termination reasons for NYS continuation are similar to COBRA.

For additional information on New York state's continuation requirements, please review the information at the following website: [http://dfs.ny.gov/consumer/faqs/faqs\\_cobra.htm](http://dfs.ny.gov/consumer/faqs/faqs_cobra.htm)

## NYS CONTINUATION TIMELINE

Below is a chart to reference that will assist with avoiding retroactive request

	Employee or Member Loses Eligibility for Health Plan	Dependent Loses Eligibility for Health Plan
<b>Employee must notify Employer of event</b>	Not applicable	Within 60 days of event that causes ineligibility
<b>Employer must notify Employee of continuation rights</b>	5 business days, per NYS Labor Law, Section 195	W/in 44 days of the date employee notified the employer of the qualifying event
<b>Employee or Member's election period</b>	Within 60 days of date: 1. Employer notifies employee of continuation rights, or 2. The actual termination date, whichever is later	Within 60 days of date: 1. Employer notifies employee of continuation rights, or 2. The actual termination date, whichever is later
<b>Employee pays 1st premium</b>	Simultaneously with election	Simultaneously with election
<b>Employer submits application to EHP</b>	With in 30 days of election	With in 30 days of election
<b>Max days elapsed</b>	95 days	125 days

There may be times when the process reaches the maximum period. It should however, be unusual. There are steps that you can take to keep the timeline to a shorter, more manageable period. Here is a State Continuation election for a terminated employee:

Activity	Time Elapsed
Employment terminates due to a layoff. Employer provides notice two weeks prior to the employee's last day of employment	0 day
Employee elects coverage and pays first premium with election	30 days after last day of employment employer submits application to insurer
Employer submits application	11 days
Total time elapsed	41 days

## YOUNG ADULT OPTION (YAO)

This law was effective for all coverage renewed on or after September 1, 2009. This law applies to all insured medical coverage, including Healthy New York and self-insured coverage under a municipal cooperative health benefit plan, when the group does not add the rider to extend the age limit under the family policy to include dependents through age 29. It does not apply to other self-insured groups. The law does not apply to free-standing dental-only, vision-only or drug-only coverage.

The subscriber or member may continue coverage for a young adult from 26 to 30 years of age, under group coverage, if enrolled in a type of policy that includes coverage for dependents. The young adult may not enroll without the parent's current and continued enrollment as an employee, member of the group or due to a right to continuation under either COBRA or NYS continuation.

### Eligibility:

A young adult is eligible, if:

- ▶ Unmarried
- ▶ At least 26 years of age, but not yet 30
- ▶ Not insured by or eligible for, coverage through an employer
  - ▶ Lives, works or resides in our service area
  - ▶ Not eligible for Medicare

### Enrollment:

There are three times when a Young Adult may enroll:

- ▶ At the time the young adult initially ages off the policy
- ▶ When the young adult experiences a change in circumstance and regains eligibility as a young adult (e.g., a married young adult divorces)
- ▶ At each annual open enrollment period

Coverage is effective the date of the loss of coverage, if the young adult applies for coverage within 60 days of the initial loss of coverage due to aging off the parent's policy. Coverage is prospective, and starts no later than 30 days from the receipt date of the election and premium for any other time the Young Adult re-enrolls.

The premium rate for the young adult is 102% of the premium for a single adult who is enrolled in the same product as the parent.

### Termination of Coverage:

A young adult loses eligibility if:

- ▶ Coverage is voluntarily terminated by the young adult or parent
- ▶ The parent is no longer enrolled in the group
- ▶ The young adult: turns 30, becomes eligible for or enrolls in coverage through his or her employer, marries or moves outside our service area
- ▶ The policy is cancelled for nonpayment
- ▶ You cancel the group policy and do not replace it

A young adult who continues coverage under the YAO, is not eligible for either COBRA or NYS Continuation, when the young adult loses coverage under this option. The YAO is in lieu of COBRA or NYS Continuation, not in addition to those programs.

### Helpful Hints:

Please ensure that a subscriber or young adult signs the Young Adult Certification form prior to submission. Please submit forms no more than 60 days prior to the eligibility date of the Young Adult option. The premium is required when the subscriber or dependent elects the YAO, so do not activate coverage until the premium is paid.

If your employees have questions regarding a Young Adult Certification form, they can contact our Customer Care department by calling the phone number on their identification card.

## ► PRIOR COVERAGE INFORMATION NEEDS

### Prior Coverage Information Needed When Adding a Member

A Certificate of Coverage is not required upon a member's initial enrollment. However, the applicant must complete the other coverage information section on the group enrollment form with the following information:

- ▶ Previous coverage effective date
- ▶ Previous coverage termination date
- ▶ Previous coverage enrollment (family, individual, etc.)
- ▶ Name of previous insurance carrier
- ▶ Type of coverage (medical, dental, etc.)
- ▶ Identification number of policy
  - ▶ If enrolling via the Web, all of the above information must be provided. We are providing general information as you may receive questions from members covered under your policy.

## ► COORDINATION OF BENEFITS (COB)

### WHAT IS COORDINATION OF BENEFITS?

- ▶ Most health insurance contracts or certificates have a clause that allows the benefits of one policy to be coordinated with those of another. This clause, referred to as coordination of benefits, describes which policy is considered first, or "primary," for claims payment
- ▶ Please refer to your member certificate to review the COB clause
- ▶ A plan that does not contain a COB clause consistent with these rules is always primary

### NOTE:

- ▶ Be sure that subscribers complete the "Other Coverage" section of the group enrollment form
- ▶ These rules do not always apply when one policy is Medicare
- ▶ Please notify us if there is a change to an employee's other coverage information. We want to be certain our records are accurate so we process the claims correctly
- ▶ **Rules to determine which plan pays first**
  - ▶ If a person is covered under one medical plan as an employee and under another plan as a dependent, the plan under which he/she is an employee is primary
  - ▶ If a child is covered under both plans, the birthday rule is applied to determine which contract is primary. Under this rule, the plan of the parent whose birthday (month and day) falls earlier in the year is primary

- ▶ If both parents have the same birthday, the plan that covered the parent longer is primary
- ▶ If a plan uses a rule based on gender of the parent, then the plan of the male parent is primary

**NOTE:**

Most insurance plans use the birthday rule to determine which plan pays first when the member has more than one active insurance policy. TPAs (Third Party Administrators) may use the male primary rule to determine which policy is primary for self-insured plans. Insurance policies issued in New York state must use the birthday rule.

▶ **Rules for children of separated or divorced parents**

- ▶ The policy of the parent who the court has made responsible for health care insurance is primary
- ▶ The policy of the parent who has custody of the child is primary
- ▶ If the court has not placed responsibility on one parent to insure the children and the parents have joint custody, the birthday rule applies
- ▶ If the natural parent elects to have coverage under the policy of the stepparent, we will consider the policy to be that of the natural parent

**NOTE: In some instances, we may ask for a copy of a member’s court decree.**

**Rules for an active and non-active employee**

- ▶ The plan that covers the policyholder as an active employee is primary
- ▶ If the policyholder has the same employment status (active/retired) under both plans, the plan with the earliest effective date is primary

## ▶ RETROACTIVE POLICY

The retroactive policy governs the length of time you have to submit transactions to us. It allows us to review and make possible exceptions to membership additions, terminations and changes in group benefits beyond the (30 day) event date.

There are many reasons why we have established this policy, but most important are:

- ▶ Prevent adverse selection
- ▶ Subscriber and group satisfaction
- ▶ Reimburse our providers on time and accurately for the services rendered to our members
- ▶ Limitations regarding the ability to retract claims.
- ▶ Reduce administrative and provider costs when we must adjust or retract claims
- ▶ Comply with Federal and NYS requirements
  - ▶ Rescission law and regulation
  - ▶ Ensure that only eligible persons are covered per NYS insurance law and our subscriber certificates

August						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

## Rescission

The rescission provisions of ACA apply regardless of whether the product is grandfathered or non-grandfathered. The provisions apply to all group health plans including HMOs, Healthy New York group products and Medicare Complimentary products. The rescission provisions do not apply to HIPAA excepted products, such as freestanding dental and vision, Medicare Advantage and Medicare Supplemental products.

If you do not comply with the rescission limitations in ACA, the federal government may assess fines on your group or the issuer of coverage. You may find more details at [healthcare.gov](https://www.healthcare.gov) and at [hhs.gov](https://www.hhs.gov).

The information provided in this document does not provide regulatory compliance or legal advice. The intent is to raise your awareness of important issues so that you may seek guidance from your own legal counsel or tax advisor, as needed.

### Q: What is a rescission?

**A: A rescission occurs when a health plan or issuer initiates:**

- ▶ A cancellation or discontinuance of coverage that has a retroactive effect; or
- ▶ A cancellation that voids a policy as of the enrollment date for the subscriber or member

The ACA regulations provide an example where an employee's hours dropped below the threshold to qualify for health insurance, except that the employer did not find the change until later. The employee continued to contribute towards the health insurance plan, so the employer is not entitled to cancel the coverage retroactively. The regulations and guidance also reference retroactive terminations when an employee or member has paid any portion of the premium or has a "reasonable expectation of coverage."

### Q: What is not a rescission?

**A: A cancellation or discontinuance of coverage is not a rescission if it relates to a:**

- ▶ Cancellation or discontinuance of coverage that is prospective (e.g., for a current or future date)
- ▶ Failure to pay premiums or required contributions to the cost of coverage on time, in which case the cancellation or discontinuance of coverage may be effective retroactive to the date of default

### Q: When is a rescission permissible?

**A: A rescission is permissible when the person completing the application has:**

- ▶ Performed an act, practice, or omission that constitutes fraud, or
- ▶ Makes an intentional misrepresentation of material fact, as prohibited by the plan or coverage

**NOTE: in New York state, cancellations for fraud must be prospective, with 30-calendar days advance notice.**



# ▶ RETROACTIVITY – COBRA, NY STATE CONTINUATION OF COVERAGE & YOUNG ADULT OPTION (YAO)

## COBRA:

The COBRA law provides for an extensive notice and election period. We will honor a request to reinstate a member to coverage as a COBRA continuant for a period of up to 179 days for an employee-related event and 239 days for a dependent-related event.

We encourage you to wait until the continuant pays his or her first premium before you reinstate the coverage or you may be liable for the premium.

Please note that you must still submit the original transaction to terminate the individual within the standard 30 days. The reinstatement to coverage as a COBRA continuant is the only portion that is an exception.

## NY STATE CONTINUATION OF COVERAGE:

The notice and election period for NYS continuation is much shorter than COBRA. We will honor a request to reinstate a member to this coverage for a period of up to 95 days for a subscriber event and 125 days for a dependent event.

The subscriber/dependent must pay the premium at the time he or she elects NYS continuation.

### Young Adult Option (YAO)

The election period for initial enrollment allows for retroactive enrollment. We will honor a request to enroll a Young Adult if we receive the request within 60 days of termination date.

The subscriber/dependent must pay the premium at the time he or she elects this option.

### Tips regarding the termination of an Employee

There are actions your group can take to protect itself from the likelihood that an employee can claim that his/her termination of coverage is a rescission and therefore prohibited. Here are a few suggestions:

- ▶ Remind employees frequently that coverage ends when employment ends, unless the employee elects COBRA or NYS Continuation, as appropriate
- ▶ When an employee is terminated or otherwise leaves employment, provide the employee with the COBRA or NYS Continuation notice immediately
- ▶ Be certain to stop withholding employee contributions immediately at the point the employee loses eligibility for coverage

### Tips regarding the termination of a Dependent

Though agencies of the federal government have issued some guidance about the ACA, rescissions and the applicability to dependents who lose eligibility, much remains uncertain. It is prudent for your group to educate itself regarding the ACA. Consult with your own legal advisors and consultants in situations where the right to terminate a dependent is not clear. There are still actions your group can take to protect itself from a prohibited rescission, as follows:

- ▶ Remind employees frequently that it is their responsibility to report a change to a dependent's eligibility within 30 days
- ▶ Provide the dependent with a COBRA or NYS Continuation notice immediately
- ▶ Submit cancellation transactions through our website to ensure timeliness
- ▶ Immediately adjust the employee's withholding for any change in rate tier

### Regarding cancellation dates:

- ▶ When cancelling members with ID numbers that begin with a “2” and do not contain an alpha character, use the last day of the month as the cancel date
- ▶ When cancelling members with ID numbers that are eight digits long with an alpha character in the middle, use the first day of the next month

## RETROACTIVITY EXCEPTIONS – WHEN RETRO REQUEST IS NOT REQUIRED

**Death:** We will terminate coverage for a deceased member who is not an active employee up to 90 days without a death certificate, and up to one year after the date of death with a death certificate. We expect you to submit terminations due to the death of an active employee within 30 days of the date of death.

**Divorce:** We will terminate the coverage for a divorced spouse retroactively up to 90 days from the current date of divorce. A request that exceeds 90 days from the date of divorce must be submitted for retroactive review. We may require a copy of the divorce decree or a divorce certificate as part of our review.

## SELF -FUNDED GROUP REQUESTS

If your group is self-funded, and you have questions regarding retroactive activity, please contact your Account Manager or Account Service Consultant.

## ▶ INFORMATION ON REPORTING REQUIREMENTS UNDER THE AFFORDABLE CARE ACT (ACA)

### INFORMATION REPORTING BY HEALTH COVERAGE PROVIDERS

(Section 6055 of the Internal Revenue Code)

For more information go to:

<http://irs.gov/Affordable-Care-Act/Employers/Information-Reporting-by-Providers-of-Minimum-Essential-Coverage>

<http://irs.gov/Affordable-Care-Act/Questions-and-Answers-on-Information-Reporting-by-Health-Coverage-Providers-Section-6055>

Excellus BlueCross BlueShield must report certain health coverage information to the IRS for individual direct pay members off exchange, SHOP (Small Business Health Options Program), small groups and large groups insured beginning in January 2016 for calendar year 2015. The information provided will include any months when individuals were covered by minimum essential coverage and will be used to verify the individual shared responsibility requirement.

In addition to the IRS reporting, Excellus BlueCross BlueShield must also send statements to individuals (Form 1095-B) who had minimum essential coverage in the reporting year. These statements are similar to W2 forms and will include the same information that is reported to the IRS. They give individuals information they will need when they file their taxes – only these statements are used to determine if they will have to pay the Individual Shared Responsibility Payment for not having minimum essential coverage.

Excellus BlueCross BlueShield is also now required to ask for individual Social Security numbers in order to meet new reporting obligations under the Affordable Care Act. The IRS will use the individual name and Social Security number combination to match coverage reported on Form 1095-B to the coverage reported

on tax Form 1040. As a result, new Social Security number solicitation letters have been created and will be mailed periodically by Excellus BlueCross BlueShield to individuals who have a missing or invalid Social Security number.

\*Self-funded plan sponsors can use a combined form (Form 1095-C, including Part III) to file reporting information for both Sections 6055 and 6056.

\* Upon request, Excellus BCBS will provide available data for Part III of form 1095-C to self-funded employers.

Section 6055 - Reporting to IRS		
Form #:	Filed by:	Filing Due Date:
<p><b>Form 1094-B</b> Transmittal of Health Coverage Information Returns  <a href="https://irs.gov/pub/irs-pdf/f1094b.pdf">irs.gov/pub/irs-pdf/f1094b.pdf</a>            Instructions:  <a href="https://irs.gov/pub/irs-pdf/i109495b.pdf">irs.gov/pub/irs-pdf/i109495b.pdf</a></p> <p><b>Form 1095-B</b> Health Coverage  <a href="https://irs.gov/pub/irs-pdf/f1095b.pdf">irs.gov/pub/irs-pdf/f1095b.pdf</a>            Instructions:  <a href="https://irs.gov/pub/irs-pdf/i109495b.pdf">irs.gov/pub/irs-pdf/i109495b.pdf</a></p>	<p><b>Excellus BlueCross BlueShield</b> will submit Form <b>1094-B</b> and data from Form <b>1095-B</b> to the IRS.</p> <p><b>NOTE:</b> SSNs reported to the IRS cannot be masked for privacy.</p>	<p>If filing electronically*:  <b>March 31st</b> of the year following the coverage year            If filing by paper:  <b>February 28th</b> of the year following the coverage year            The first returns are due March 31<sup>st</sup>, 2018</p> <p>*Providers that file more than 250 forms must file electronically.</p>
Section 6055 - Statements to Individuals		
Form #:	Filed by:	Filing Due Date:
<p><b>Form 1095-B</b> Health Coverage  <a href="https://irs.gov/pub/irs-pdf/f1095b.pdf">irs.gov/pub/irs-pdf/f1095b.pdf</a>            Instructions:  <a href="https://irs.gov/pub/irs-pdf/i109495b.pdf">irs.gov/pub/irs-pdf/i109495b.pdf</a></p>	<p><b>Excellus BlueCross BlueShield</b> will send <b>Form 1095-B</b> statements to individuals that had minimum essential coverage in 2017.</p> <p><b>NOTE:</b> SSNs on Statements to Individuals can be masked for privacy. <b>Excellus BlueCross BlueShield</b> will partially mask the SSN in the following format (example: XXX-XX-1234)</p>	<p>The <b>Form 1095-B</b> statements are due to individuals by <b>January 31st, 2018</b>.</p>

## ▶ THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) PRIVACY AND SECURITY RULES

The HIPAA privacy regulations protect the security and privacy of an individual's PHI. PHI is individually identifiable health information transmitted or maintained in any form or medium. Some examples of protected health information are name, address, birth date, Social Security number, unique subscriber ID number, claim payment and diagnosis. Unless the member expressly authorizes release, or as otherwise permitted by the regulations, the disclosure of PHI is restricted to the member or his/her health care provider.

## How HIPAA affects you as the group administrator

In accordance with privacy regulations, we must use due diligence in verifying the identity of our caller. We obtain the information in order to authenticate calls to our Enrollment Processing department:

1. The group leader's name
2. The name of the company (group)
3. The group number associated with the group

We need the above information to protect the privacy of your group and eligible employees. Please advise your members that they will have to authenticate themselves when calling our Customer Care department by providing their Social Security number, unique subscriber ID number, name and address.

## PHI DISCLOSURE

We cannot disclose Protected Health Information (PHI) to anyone other than a member without a completed Authorization to Share Protected Health Information form on file. The form authorizes us to disclose information to the person whom the member has designated. Members may download this form from our website and return it to our mailing address.

Please advise your eligible employees that our Customer Care Advocates are unable to assist a spouse without an authorization form on file. We recommend that you include an authorization form when submitting the initial enrollment request for married or domestic partnered couples. If a member has a dependent child 18 years or older, an authorization must be on file for Customer Care to discuss the child's PHI with the child's parent or stepparent.



## FAMILY MEMBERS

When a member calls Customer Care regarding family members, please note the below information:

- ▶ If family member is age 18 or older, we need an authorization on file
- ▶ If a person is calling regarding a family member under age 18, we can release the information, unless a protected health diagnosis is involved

## PROTECTED HEALTH DIAGNOSIS

If the call is regarding one of the protected diagnoses below, other laws apply that prevent the release of information without the member's authorization.

The following diagnoses require specific authorization to release the information, even when the patient is under the age of 18. Extenuating circumstances, particularly with infants and very young children, will be addressed on a case by case basis.

- ▶ Sexually transmitted diseases - New York Public Health Law
- ▶ Substance abuse - Federal law
- ▶ Abortion - New York Public Health Law (this does NOT include pregnancy)

The following diagnoses have a protected age of 18, so information can be released to the personal representative (most commonly, the parent) without an authorization on file. Once the minor turns 18, a specific authorization will be needed for these three conditions, along with the release of any other protected health information.

- ▶ Genetic testing - New York Civil Rights Law
- ▶ Mental health - New York Mental Hygiene Law
- ▶ HIV - New York Public Health Law

*This information does not intend to dispense legal advice. If you are uncertain how the various state and federal privacy rules apply to your organization's group health plan, please seek legal counsel as necessary. If you would like more information about the HIPAA Privacy Rule, you can obtain information at [hhs.gov/ocr/privacy/index.html](https://www.hhs.gov/ocr/privacy/index.html).*

## ► FREQUENTLY ASKED QUESTIONS

Should I wait to submit a termination request for an employee until after the employee responds to the COBRA offering?

No. Please submit termination requests as they occur. If an employee later opts for COBRA within the guidelines, we will reactivate his or her coverage.

Is the addition of a newborn child a qualifying event to add a spouse to coverage?

Yes, the addition of a newborn is a change in family status that is a qualifying event to add a spouse.

If a member wants to change his or her last name, what is required?

Please submit the change in writing or as a Web request. You should maintain documentation to establish the basis for the name change.

If a group receives a court order to add a dependent, what is required to add the dependent?

When you submit an application to add an eligible dependent pursuant to a court order such as a Qualified Medical Child Support Order (QMCSO), the court order is required, along with a completed application and QMCSO Enrollment Form.

Can I send activity requests with my bill?

No, please submit activity via our website, secure email process or a group enrollment form.

If I feel my bill is incorrect, what do I do?

Check the activity changes listed on the invoice and if you find a discrepancy, please contact your Account Service Consultant immediately. Remember, most activity is subject to the 30-day retroactivity period.

Should I adjust my payment based on activity requests that are not reflected on the bill?

No, please pay as billed. This activity will appear on the next bill.

How do I obtain a benefit summary?

Please contact your Account Service Consultant to obtain a benefit summary.

Can members of my group change their addresses?

Yes, if they sign up for online member access, they can do this themselves. Please note, the group representative will be notified of this request.

## Notice of Nondiscrimination

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please refer to the enclosed document for ways to reach us.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Advocacy Department  
Attn: Civil Rights Coordinator  
PO Box 4717  
Syracuse, NY 13221  
Telephone number: 1-800-614-6575  
TTY number: 1-800-421-1220  
Fax: 1-315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 1-800-537-7697 (TDD)  
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Attention: If you speak English free language help is available to you. Please refer to the enclosed document for ways to reach us.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Consulte el documento adjunto para ver las formas en que puede comunicarse con nosotros.

注意: 如果您说中文, 我们可为您提供免费的语言协助。  
请参见随附的文件以获取我们的联系方式。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. В приложенном документе содержится информация о том, как ими воспользоваться.

Atansyon: Si ou pale Kreyòl Ayisyen gen èd gratis nan lang ki disponib pou ou. Tanpri gade dokiman ki nan anvlòp la pou jwenn fason pou kontakte nou.

주목해 주세요: 한국어를 사용하시는 경우, 무료 언어 지원을 받으실 수 있습니다. 연락 방법은 동봉된 문서를 참조하시기 바랍니다.

Attenzione: Se la vostra lingua parlata è l'italiano, potete usufruire di assistenza linguistica gratuita. Per sapere come ottenerla, consultate il documento allegato.

אויפמערקזאם: אויב איר רעדט אידיש, איז אומזיסטע שפראך הילף אוועילעבל פאר אייך ביטע רעפערירט צום בייגעלייגטן דאקומענט צו זען אופנים זיך צו פארבינדן מיט אונז.

নজর দিন: যদি আপনি বাংলা ভাষায় কথা বলেন তাহলে আপনার জন্য সহায়তা উপলভ্য রয়েছে। আমাদের সঙ্গে যোগাযোগ করার জন্য অনুগ্রহ করে সংযুক্ত নথি পড়ুন।

Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Patrz załączony dokument w celu uzyskania informacji na temat sposobów kontaktu z nami.

تنبيه: إذا كنت تتحدث اللغة العربية، فإن المساعدة اللغوية المجانية متاحة لك. يرجى الرجوع إلى الوثيقة المرفقة لمعرفة كيفية الوصول إلينا.

Remarque : si vous parlez français, une assistance linguistique gratuite vous est proposée. Consultez le document ci-joint pour savoir comment nous joindre.

نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے زبان کی مفت مدد دستیاب ہے۔ ہم سے رابطہ کرنے کے طریقوں کے لیے منسلک دستاویز ملاحظہ کریں۔

Paunawa: Kung nagsasalita ka ng Tagalog, may maaari kang kuning libreng tulong sa wika. Mangyaring sumangguni sa nakalakip na dokumento para sa mga paraan ng pakikipag-ugnayan sa amin.

Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Δείτε το έγγραφο που εσωκλείεται για πληροφορίες σχετικά με τους διαθέσιμους τρόπους επικοινωνίας μαζί μας.

Kujdes: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Drejtojuni dokumentit bashkëlidhur për mënyra se si të na kontaktoni.

