

Group Administrator's Manual

Groups with
2-50 Employees



**BlueCross BlueShield
of Alabama**

An Independent Licensee of the
Blue Cross and Blue Shield Association.

Blue Cross and Blue Shield of Alabama Group Administrator's Manual

Groups with 2-50 Employees

Preface

This manual is designed to help you handle your Blue Cross and Blue Shield group health care plan in the most efficient manner.

Individual sections contain several pages of important information about each subject as it relates to your responsibilities as "Group Administrator" of your group health care plan.

We hope this manual will help you further understand the administration of your Blue Cross benefits plan.

Blue Cross and Blue Shield of Alabama is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans. There are Blue Cross and Blue Shield Plans located throughout the country which are all owned and operated independently but work together to provide uniform administration of benefits and claims processing.

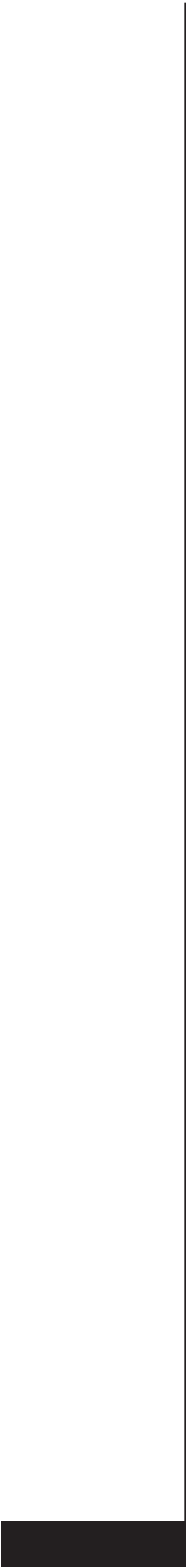


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GENERAL INFORMATION

We hope that this manual will answer most of your questions. However, if you have questions about your coverage, or need additional information, please don't hesitate to call Blue Cross and Blue Shield of Alabama. To help you know who to call to receive the most expedient service, please note the information listed below.

Who to Call When You Need Help

Marketing Representative

Your Marketing Representative is the individual who sold you your plan. You should contact your Marketing Representative if you have general questions or questions about the cost of your plan. Marketing Representatives may be difficult to reach by phone because they are out of their offices calling on customers, but will always respond to you when needed.

Your Marketing Representative is:

Name: _____

Telephone Number: _____

Fax Number: _____

E-mail Address: _____

Service Representative

Your Service Representative works closely with your Marketing Representative to handle your service needs. From time to time, you will receive calls from your Service Representative to check on your satisfaction with the plan. You should contact your Service Representative if you have questions about how your benefits work and if you need help explaining benefits to your employees. Questions about billing or claims that cannot be handled by Customer Service or Customer Accounts should also be referred to your Service Representative.

Your Service Representative is:

Name: _____

Telephone Number: _____

Fax Number: _____

E-mail Address: _____

Customer Accounts

Our Customer Accounts Department handles your member eligibility and enrollment (adding and deleting employees) and billing (your invoice). A Customer Accounts Representative has been assigned to work with your group. If you have questions about member eligibility and enrollment, or your invoice, refer first to the **ELIGIBILITY AND ENROLLMENT** section or the **BILLING PROCEDURES** section of this manual. If you need additional assistance regarding billing or adding and deleting employees, you should call your Customer Accounts Representative.

Your Customer Accounts Representative is:

Name: _____

Telephone Number: _____

Fax Number: _____

E-mail Address: _____

Customer Service

Our Customer Service Center in Birmingham is open for phone inquiries from 7:30 a.m. to 6:00 p.m. Monday through Friday to handle inquiries about your benefits and eligibility as well as questions about specific claims. When employees have questions about their coverage, please encourage them to call our Customer Service Center.

Customer Service in Birmingham

1-800-292-8868 toll-free

988-2200 in Birmingham

Have the following information handy when calling Customer Service:

- Your group number
- Your company's name
- The contract number as shown on the I.D. card including any prefix (if it is in reference to a specific claim)
- The date of service
- The name of the provider of that service

WHERE OUR OFFICES ARE LOCATED

Main Office

Our headquarters and main office are located in Birmingham, Alabama in the Riverchase area of Hoover. You may write to us at:

**Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway East
P.O. Box 995
Birmingham, AL 35298-0001**

District Offices

Blue Cross and Blue Shield of Alabama Marketing and Service Representatives work out of our four district offices in Birmingham, Huntsville, Mobile and Montgomery. These offices also have Customer Service Representatives available to answer questions from 8:00 a.m. to 4:30 p.m. The address, phone and fax numbers for each of our district offices are listed below.

Birmingham District Office

936 South 19th Street
Birmingham, AL 35205-3704
Phone: (205) 220-5400
Fax: (205) 220-5597

Huntsville District Office

495 Wynn Drive
Huntsville, AL 35805
Sales: (256) 726-9100
Customer Service: (256) 722-0057
Fax: (256) 726-9117

Montgomery District Office

4465 Park Boulevard
Montgomery, AL 36116-1626
Sales: (334) 244-1117
Customer Service: (334) 244-0230
Fax: (334) 213-6635

Mobile District Office

4750 Airport Boulevard
Mobile, AL 36608
Sales: (251) 344-2115
Customer Service: (251) 343-4001
Fax: (251) 460-4451

Local Sales Offices

Marketing Representatives and Service Representatives also work out of each of our local sales offices. The address, phone and fax numbers for each of these offices are listed below.

Andalusia Office

1805 North Three Notch, Suite 2
Andalusia, AL 36420
Sales: 334-222-9031
Fax: 334-222-9128

Gadsden Office

Lancaster Building
645 Walnut Street #6
Gadsden, AL 35901
Sales: 256-543-8929
Fax: 256-543-7014

Anniston Office

24 East 12th Street
Anniston, AL 36201
Sales: 256-236-3818
Fax: 256-236-6946

Opelika Office

2218 Executive Park Drive
Opelika, AL 36801
Sales: 334-745-9310
Fax: 334-745-0435

Dothan Office

3124 West Main Street, Suite 13
Dothan, AL 36305
Sales: 334-712-9056
Fax: 334-793-5022

Selma Office

104-A Executive Park Place Lane
Selma, AL 36701
Sales: 334-874-4454
Fax: 334-875-0841

Florence Office

2614 Hough Road
Florence, AL 35630
Sales: 256-764-6673
Fax: 256-760-9275

Tuscaloosa Office

3093 Palisades Court
Tuscaloosa, AL 35405
Sales: 205-507-4100
Fax: 205-507-4122

Foley Office

1117A North McKenzie Street
Foley, AL 36535
Sales: 334-943-9222
Fax: 334-943-9223

HOW TO REACH US ON THE INTERNET

Because many people rely on the Internet for information, Blue Cross and Blue Shield of Alabama has added services to our web site for the convenience of customers. Our web address is:

www.bcbsal.com

Services on our web site are available 24 hours a day, seven days a week. The information is updated constantly with a special emphasis on customer education and administrative functionality. Some of the current services available online include:

- Reach Customer Service by e-mail
- Download and order blank claim forms

NOTE

Check us
on the web at
www.bcbsal.com

- Order forms and materials
- Order replacement ID cards
- Find a Preferred Care provider
- Access “For Your Health” Information
- Verify Student Eligibility online
- Request Certificate of Creditable Coverage
- Submit Other Coverage Information (for Coordination of Benefits)

GroupAccess is a secure Internet connection for group administrators. Through GroupAccess you will be able to view your group’s enrollment and group invoice. Limited access is already available with more functions being added. Contact your Customer Accounts Representative for more information about this access to confidential information for your group.

HOW TO ORDER FORMS AND SUPPLIES

Rapid Response

When you need additional forms and other supplies to administer your group health care plan, you can call a special 24 hours, 7 days-a-week automated request line, Rapid Response. The number for Rapid Response is:

988-5401 (in Birmingham)
or 1-800-248-5123 (toll-free outside Birmingham)

Rapid Response is easy, fast and convenient. Your request will receive special, prompt attention and the materials you need will arrive within a few days. You and your employees can use Rapid Response for any of the following services:

- ordering claim forms,
- ordering provider directories,
- ordering I.D. cards,
- ordering brochures, and
- ordering other supplies for your group health care plan.

A voice activated system will ask for your name, complete mailing address, daytime telephone number, materials you are requesting, contract number (if an individual is requesting materials) or group number (if you are requesting materials for your group). If possible, request materials by the stock number which can be found on the bottom of the item.

Your order is recorded and the item you request will be mailed to you the next working day if you answer all the questions completely. Allowing mailing time, you should receive your requested materials within 3-5 days (excluding weekends or holidays). If you have any problems with Rapid Response, please call our Customer Service support area at (205) 985-5365.

Group Administrator’s Supply Request

We also have a Group Administrator’s Supply Request available for you to use to order forms and supplies. This is a form (stock number MKT-30) that you can

complete and mail or fax to us. Call Rapid Response to order a supply or make copies using the sample found in the **EXHIBITS** section. This form lists most of the items available and is a good reference item.

Online at www.bcbsal.com

Many forms and materials are available on our web site 24 hours a day, seven days a week. To access materials online, go to:

www.bcbsal.com

You and your employees can use the web site for any of the following services:

- ordering claim forms
- ordering ID cards
- verifying student eligibility
- ordering Certificate of Creditable coverage
- submitting other coverage information for Coordination of Benefits

HOW TO KEEP YOUR GROUP INFORMATION UP-TO-DATE

To keep our records current and ensure that you receive important mailings from us, we need your help. If you have a change in any of the following please notify our Underwriting Department in writing:

- Company name
- Address (mailing address or physical location)
- Contact person(s) (decision maker, person who handles your benefit plan and person who handles billing)
- Telephone number of contact person(s)

Send this information to: Blue Cross and Blue Shield of Alabama
Underwriting Department
450 Riverchase Parkway East
P.O. Box 995
Birmingham, Alabama 35298-0001

If you have a change in the name or address to which your invoice should be mailed, contact your Customer Accounts Representative by phone, fax or mail.

Send this information to: Blue Cross and Blue Shield of Alabama
Customer Accounts Department
450 Riverchase Parkway East
P.O. Box 995
Birmingham, Alabama 35298-0001

HOW WE WILL KEEP YOU INFORMED

***Group Update* – A Newsletter for Group Administrators**

A newsletter designed especially for Blue Cross and Blue Shield of Alabama Group Administrators will be mailed to you each quarter. The name of the newsletter is *Group Update*.

In *Group Update* you will find information on pertinent issues you face as a Group Administrator. For example, there may be articles on specific changes in your benefits, new directions of the health care industry, healthy lifestyle information or recent legislation that may effect your group coverage.

Customer Satisfaction Surveys

Customer satisfaction is our highest priority at Blue Cross and Blue Shield of Alabama. We routinely conduct customer satisfaction studies because it is important to us to know our customer's perceptions about our service. After your group plan has been in place for six months and again after 18 months, you will receive a New Group Customer Satisfaction Survey. We hope that you will respond to these written questionnaires, to let us know how we are serving you.

COMMENTS ABOUT THIS MANUAL

Our Marketing Support Department coordinates publication of this Group Administrator's Manual, as well as other materials to help you and your employees understand your group benefits. If you find information in this manual that is confusing or unclear, please let us know so that appropriate changes can be made for later printings. Please direct these comments to Marketing Support in Birmingham at (205) 220-2611.

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ELIGIBILITY AND ENROLLMENT

Group Health Eligibility Requirements

To be eligible as a group for Blue Cross and Blue Shield of Alabama coverage in the Small Employers Group category, there must be a minimum of two eligible employees and a maximum of 50 employees eligible and covered for the group benefits on a common payroll. The employer must be licensed to operate and have employees located in the state of Alabama. All eligible employees must be enrolled under the same contract of benefits.

IMPORTANT

If you have dental coverage as a rider to your health coverage, all of the following provisions apply. If your dental coverage is freestanding, please refer to the Dental Enrollment Guidelines portion of this section.

Eligibility Guidelines for a Two-Person Group

If your group only has two eligible employees, we need the information described below in order to document that your group qualifies as an eligible two-person group. If a husband and wife are both eligible employees for the same employer, they must enroll as one family contract.

You should provide one of the following items:

1. A copy of your Form A-1 or A-6 Alabama Department of Revenue Employer's Return of Income Tax Withheld. Form A-1 is used quarterly and Form A-6 is used monthly. Line two of these forms will show the number of employees who had Alabama tax withheld from their wages; or
2. If you are a self-employed individual, partnership, or limited liability company, we need a copy of the Form A-1 or A-6 to report employee wages and a Form 1040 schedule SE to report owner wages. Normally a partner or owner would not report their individual wages on Form A-1 or A-6. For a two or more person partnership, we need a copy of each partner's individual form 1040 schedule SE.

In some rare situations, an employee may be exempt from Alabama income tax. If this prevents you from using the forms mentioned above to document that you are a two-person small employer group, you should provide a copy of Federal Form 941, Employer's Quarterly Federal Tax Return.

Enrollment Percentage Requirements

Each group must meet and continue to meet the following requirements for group coverage.

Employee:	Total Number of Eligible Employees	Employee Participation Requirement
	2-3	100%
	4-50	75%

Those employees currently covered by another Blue Cross and Blue Shield contract (such as C Plus or group coverage through another employer group) or Plan (such as Blue Cross and Blue Shield of Georgia or any other Blue Cross and/ or Blue Shield Plan) will not be included in your enrollment percentage requirements.

NOTE

Group:
Employee groups with a minimum of 2 employees on a common payroll.

See the **Dental Enrollment Guidelines** portion of this section if you have a freestanding dental program.

Dependents:

A minimum of 75% of those eligible for family coverage must enroll for family coverage unless their spouse is covered under a group health contract.

See the **Dental Enrollment Guidelines** portion of this section if you have a freestanding dental program.

Employer Contribution Requirements

The employer must contribute toward the cost of the plan. The minimum employer contribution toward the individual and family rates for health coverage is an amount equal to at least one-half (1/2) the individual rate. Payroll deduction is required for employer groups when the employer does not contribute the full premium.

The employer may require a qualified beneficiary to pay the total premium for continuation of benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). More information on COBRA can be found under **Continuation of Benefits through COBRA** later in this section.

See the **Dental Enrollment Guidelines** portion of this section if you have a freestanding dental program.

Who Is Eligible For Coverage

Eligible Employees

All active full-time employees (30 hours a week or more, including vacation and certain leaves of absence) designated eligible in your Group Benefits Contract Application may enroll for coverage through your group. A married employee under a group plan with a minimum of three eligible employees may elect individual or family coverage. If your group only has two eligible employees, and both the husband and wife are eligible employees for the same employer, they must enroll as one family contract. A minimum of 75% of those eligible for family health coverage must enroll for family coverage unless the spouse is covered under a group health contract.

Eligible Dependents

Eligible dependents are the employee's spouse and unmarried children under the age of 19 (or age 19 to 23 if eligible for the Student extension described below). Also see Permanently Disabled Children below.

Spouse

The term "spouse" includes:

- a married spouse,
- a common law spouse, and
- a separated spouse.

NOTE

Independent contractors are not eligible employees under your plan.

Divorced spouses and non-married partners are not eligible dependents. A spouse must be of the opposite sex from the employee.

Common-law Spouse

A spouse by common-law marriage is an eligible dependent. The employer (not Blue Cross and Blue Shield of Alabama) will make eligibility determination as to whether a Common Law marriage exists. An Affidavit of Common-Law Marriage (stock number MKT-262) can be used by the group to help determine eligibility. An example of this can be found in the **EXHIBITS** section of this manual. The employer may also require additional proof that a common-law marriage exists (such as a copy of their income tax forms, bank accounts, driver's license and social security cards).

According to Alabama laws, the couple is not required to live together for any predetermined length of time before they can be considered man and wife. In order to determine the common-law spouse's date of eligibility, Blue Cross and Blue Shield of Alabama requires the date the couple began living together as husband and wife.

IMPORTANT

A common-law spouse can only be removed from a contract because of divorce or death. A copy of the divorce or death certificate will be required before the spouse can be removed.

Dependent Children

The term "child" includes:

- a natural child,
- a stepchild residing in the household with the eligible employee,
- a legally adopted child
- a child placed for adoption
- any other unmarried child who depends solely on the employee for support and regularly and permanently resides with the employee in a parent-child relationship and for whom the employee has permanent legal custody, and

In the case of divorced parents, children are eligible for coverage under either (or both) parent's contract. Guidelines for Coordination of Benefits govern the payment of benefits if the child is covered by both parents' contracts. (Refer to **Coordination of Benefits** in the **BENEFITS AND CLAIMS** section of this manual for specific information.)

Grandchildren are not eligible for coverage unless they meet all of the following guidelines for third generation dependents:

- They must be under 19 years of age and unmarried.
- They must be chiefly dependent on the employee for support, reside in the same household full-time with the employee in a parent-child relationship, and must not be employed on a regular full-time basis.

- The grandchild's parent is not covered on the employee's contract unless the grandchild has been adopted by the grandparents and the parent meets all other conditions to be covered as a dependent.

Any changes in the family status affecting additions or deletions of dependents must be received within 30 days of the date of occurrence (e.g., marriage, birth, adoption, placement for adoption, etc.). Refer to **How To Make Changes in Enrollment Status** in this section for details.

Student Extension

Your group plan extends the age 19 limit to age 23 for a dependent child who is a full-time student at an accredited institution. A child is eligible for extension as a student if the child meets all of the following criteria:

- unmarried,
- attending a high school or accredited college or university on a full-time basis (if other than a college or university, approval must be obtained from Blue Cross and Blue Shield of Alabama),
- not a full-time employee of a company,
- chiefly dependent upon the employee for support, and
- not covered by group insurance other than coverage restricted to students.

Full-time status is to be determined by the appropriate school.

A child will remain qualified for student extension if no more than one semester/quarter break is taken during any twelve-month period.

A child who is denied attendance by a school due to academic or disciplinary reasons is not eligible for student extension benefits.

At initial enrollment, the employee must certify in writing that the dependent child is a full-time student. This can be done by completing:

- a new application form (stock number ENR-1)
- student dependent certification form (stock number CAD-12)
- or a letter from the employee containing the necessary information: the contract number, group number, child's name and Social Security number, name of institution attending and anticipated date for graduation.

If an existing employee has a child who reaches age 19 while covered, the employee will receive a letter from us advising the date the child will be removed from the contract. The employee should check with Blue Cross and Blue Shield of Alabama to determine if any continuation coverage is available through COBRA or the Conversion Contract discussed later in this section. If the child is a full-time student, the employee should call our Customer Accounts Department **within 30 days**. The contract number, child's name and Social Security Number, name of institution attending and anticipated date of graduation must be provided.

If an existing employee has a child who is currently a student, the employee will receive a letter annually on the child's birthday to update the student eligibility information. The letter asks the employee to call a toll-free, automated voice

NOTE

Student Extension: Continued coverage on the parent's contract for children ages 19-23 who are unmarried, full-time students.

response line at (205) 733-7150 or 1-800-762-3071 and give the needed student information. This information may also be provided on our web site at www.bcbsal.com.

Should any change occur in a dependent's eligibility for student extension, the employee should contact Blue Cross and Blue Shield of Alabama **within 30 days** to receive information about coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or a direct-pay ("Conversion") contract. (See ***Continuation of Benefits through COBRA and Adult Rate Contract*** later in this section for details on COBRA and Adult Rate coverage.)

If a dependent on student extension leaves school or loses his/her eligibility and later regains eligibility, the employee should notify Blue Cross within 30 days of the date the dependent again becomes eligible.

Permanently Disabled Children

Your group plan also includes coverage for permanently disabled or incapacitated children regardless of age. The incapacity must occur prior to age 19, or to age 23 if a full-time student. A child is eligible for this coverage if:

- unmarried,
- mentally or physically disabled or incapacitated,
- incapable of self-support because of mental retardation or physical incapacity,
- totally dependent upon the employee for support and living with the employee in a regular parent-child relationship, and
- the condition occurred prior to the dependent's attaining 19 years of age or age 23 if a full-time student.

Neither a reduction in work capacity nor inability to find employment are, of themselves, evidence of eligibility. If a mentally or physically disabled dependent is working despite his disability, the extent of his earning capacity will be evaluated.

To request eligibility for coverage as an incapacitated dependent, the employee and the dependent's physician must complete an Incapacitated Dependent Certification form (stock number CAD-22), and send it to our Underwriting Department for final approval.

Special Rules for Qualified Medical Child Support Order (QMCSO)

Coverage under Qualified Medical Child Support Order (QMCSO)

If you receive an order from a court or administrative agency directing your plan to cover a child of one of your employees, you (as Plan Administrator) should determine whether the order is a Qualified Medical Child Support Order (QMCSO). A QMCSO is an order, judgment or decree (including the approval of a settlement agreement) from a court or administrative agency directing the plan to cover an employee's child regardless of whether the employee has enrolled the child for coverage. The Plan must cover the child if required to do so by a QMCSO without waiting for the next open enrollment period. Because your Plan does not cover a child unless the parent is enrolled, the employee must also

NOTE

If an employee requests coverage for a permanently disabled child, complete an Incapacitated Dependent Certification form.

enroll in the Plan if the child is added pursuant to a QMCSO. If, however, your Plan has a waiting period which the employee has not yet met, the enrollment of the child and parent may be delayed until the waiting period has been served. The child may also be subject to a pre-existing condition exclusion.

Rules for Determining Whether Order or Notice is a QMCSO

An order must meet certain criteria set forth under ERISA Section 609 (a) to be a QMCSO. You must have written procedures for determining whether an order or notice constitutes a QMCSO. You may use the document entitled "Notice of Receipt of Order and Procedures for Determining Whether Order is a QMCSO" in the Exhibits section of this Manual for this purpose.

If the order you receive does not meet the criteria set forth in the "Notice of Receipt of Order and Procedures for Determining Whether Order is a QMCSO", you must send a copy of your procedures to the court or agency that issued the order or notice, the employee who is the subject of the order, and the custodial parent of the child or children proposed to be covered by the order, and advise them as to why the order or notice does not qualify as a QMCSO.

If you determine that the order or notice does meet the criteria to be a QMCSO, you must notify the employee and the custodial parent of the receipt of the order (again, by using the document entitled "Notice of Receipt of Order and Procedures for Determining Whether Order is a QMCSO"), and advise them when the child will be added to the coverage.

The Department of Labor and the Department of Health and Human Services recently adopted a National Medical Support Notice for use by certain state agencies. If you receive one of these National Notices, it will be deemed to be a QMCSO if it is properly filled out. These notices require that Part A (Notice to Withhold for Health Care Coverage) and Part B (Medical Support Notice to Plan Administrator) be completed by you and returned to the issuing agency within certain time limits. The forms require you to determine if certain withholding limits apply and whether the child is otherwise eligible to participate in the Plan. You must follow the detailed directions on the forms.

You should contact the Customer Accounts Department of Blue Cross if you need assistance with determining whether an Order is a QMCSO.

Enrollment Procedures for Child Added Pursuant to a QMCSO

If you determine that the order is a QMCSO, the child will be enrolled for coverage effective as of the date you specify, but not earlier than the later of the following:

If we receive a copy of the order or notice within 30 days of the date on which it was entered, along with instructions from you to enroll the child pursuant to the terms of the order, coverage will begin as of the date on which the order was entered.

If we receive a copy of the order later than 30 days after the date on which it was entered, along with instructions from you to enroll the child pursuant to the terms of the order, coverage will begin as of the date on which we receive the order. We will not provide retroactive coverage in this instance.

Coverage may continue for the period specified in the order up to the child's attainment of age 19 or age 23 if a "full-time" student. While the QMCSO is in effect, Blue Cross will provide benefits, send information and forms, and send claims reports directly to the child or the child's custodial parent or legal guardian.

Special Rules for Persons Eligible for Medicare

Sometimes an employee or covered dependent on your group plan may also be eligible for Medicare. The group coverage may be primary over Medicare, depending on the circumstances.

For Groups of Fewer Than 20 Employees

As a general rule, if you employ fewer than 20 employees and your group is not part of a larger multi-group employer, the following Medicare coordination guidelines will apply:

Active employee (and covered spouse) age 65 or older:	Group health plan coverage will not be continued. CPlus, our Medicare supplement is available for members with both Part A & B of Medicare who live in Alabama.
Active employee (or spouse or covered dependent) under age 65 and eligible for Medicare due to disability:	Group health coverage will not be continued. CPlus, our Medicare supplement may be available if the member has both Part A & B of Medicare and lives in Alabama.
Active employee (or spouse) or covered dependent) eligible for Medicare due to End-stage Renal Disease.	Group coverage is primary during the 30 month ESRD coordination period; thereafter Medicare is primary, and the group plan is secondary.

For Groups of 20 or More Employees

If your group employs 20 or more employees, coordination with Medicare is the same as for groups of less than 20, with the following exceptions:

Active Employees Age 65 or Older

A group of 20 or more is considered by Medicare to be an Employer Group Health Plan (EGHP). As such, your active employees over age 65 (and their covered spouses over age 65) continue to be covered for the same benefits available to employers under age 65. In this case, group plan benefits will pay all eligible expenses first. If the employee or spouse is enrolled in Medicare, Medicare will pay for Medicare eligible expenses, if any, not paid by the group benefits plan.

If the member chooses Medicare as his or her primary carrier, he or she cannot have any coverage by the employer group. The employer is prohibited by law from purchasing a supplemental contract for active employees.

If the member chooses the group plan as the primary carrier, Medicare is secondary until the member retires.

Active Employees Under Age 65, on Medicare Due to Disability

If an employee, the employee's spouse or a dependent of the employee is actively covered under your group health plan, but is under age 65 and on Medicare due to disability the order of benefits is determined as follows:

- **If your group has fewer than 20 to 99 employees**, Medicare is primary in disability situations and the group plan is secondary.
- **If your group has 100 or more employees**, the group is subject to Medicare's Large Group Health Plan (LGHP) guidelines, and Medicare is secondary in disability situations.

IMPORTANT

Because of the complicated nature of these entitlement situations, please contact your Customer Accounts Representative if you have a question about the order of benefits determination for your covered members who are eligible for Medicare.

Portability of Coverage Due to HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 provides protections involving health coverage, most importantly portability of coverage from one plan to another. HIPAA requires that individuals must be notified that a plan has a pre-existing exclusion period before it may be imposed. HIPAA also requires that rights for persons declining health coverage be disclosed. Group health plans and issuers must notify members of their right to show evidence of prior coverage which may be used to reduce pre-existing exclusion periods. Important new terminology for health plans was introduced by HIPAA.

Annual Open Enrollment

The period during which individuals who declined coverage when first eligible can enroll as a late enrollee.

Certificate of Creditable Coverage

A document which provides evidence of prior health coverage when coverage under a health plan ends which is used to demonstrate creditable coverage to the new plan or issuer.

Late Enrollee

An eligible individual who does not enroll during the first 30 days he or she is eligible for health coverage or during a special enrollment period.

Regular Enrollee

An eligible individual who enrolls for health plan coverage during the first 30 days of eligibility.

Pre-existing Condition Exclusion Period

The period of time that pre-existing conditions may be excluded from health plan coverage. The pre-existing exclusion period may run no longer than 12 months (365 days) for new and special enrollees and no longer than 18 months (546 days) for late enrollees.

Special Enrollee

An individual who enrolls during a special enrollment period.

Special Enrollment Period

The period when persons who previously declined coverage due to other health insurance coverage lose that coverage; when a person becomes a dependent through marriage; birth of a dependent child; and adoption or placement for adoption of a child under age 18.

How and When to Enroll Eligible Members

New Employees

New employees of your company should apply for Blue Cross and Blue Shield coverage upon employment by completing an Application for Enrollment (stock number ENR-1). Please assist us by making sure the employee completes all information requested and signs the second page of the application.

The application must be signed within 30 days of the date of eligibility and received by Blue Cross within 40 days in order to be accepted as a newly hired employee.

Remember, it is important that the employee sign the application. The employee's coverage will be effective after completion of any waiting periods. See the section on *When Coverage Starts* for more information.

Special Enrollees

A special enrollment period can occur if a person with other health coverage involuntarily loses that coverage. A special enrollment period also occurs for the employee or new dependents when he or she marries or has a new child (as a result of birth, adoption, or placement for adoption). The application must be received by Blue Cross within 30 days of the special enrollment event.

Special enrollees are subject to a maximum of a 12 month pre-existing condition exclusion period.

Late Enrollees

Employees (and dependents of employees) not enrolling within 30 days of their date of Eligibility or during a Special Enrollment Period will be allowed to enroll as late enrollees. A late enrollee is any eligible person who does not enroll during the first 30 days eligible for coverage or during a special enrollment period. Late enrollees can only be enrolled during their Annual Open Enrollment Period. The application should be received by Blue Cross within the open enrollment period.

Late enrollees are subject to a maximum of an 18 month pre-existing condition exclusion period.

NOTE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that individuals be notified that a plan has a pre-existing exclusion period.

IMPORTANT

It is important to emphasize to employees that they should enroll for group coverage within 30 days of their Date of Eligibility or they must wait until the group's next Annual Open Enrollment Period.

How to Handle Your Annual Open Enrollment Period

Each group with 2–50 employees will have an annual health coverage open enrollment period during the anniversary month of the original effective date of your group contract. **If you have a freestanding dental program, employees or dependents may not enroll for dental coverage during this time.**

During the Annual Open Enrollment Period, employees or their dependents who did not enroll for health coverage when they became eligible may apply for coverage as late enrollees. An 18-month (546 day) pre-existing exclusion period for pre-existing conditions will be required for all those applying during this period. It is important that all eligible employees who did not enroll when first eligible enroll at this time since this is the only time during the year that enrollment is permitted unless they qualify to enroll through a special enrollment period. Also, this may be important to ensure your group does not fall below the 2 employee minimum.

Any application forms for employees applying for coverage during the Annual Open Enrollment Period should be submitted to our Customer Accounts Department in one of the following ways:

- If the applications are completed during the month *preceding* the Annual Open Enrollment Period they should be faxed or mailed to the Customer Accounts Department to be billed on the Annual Open Enrollment month invoice; or
- If the applications are completed *during* the Annual Open Enrollment month they should be faxed or mailed to the Customer Accounts Department and we will adjust the next month's invoice.

Applications submitted during the Annual Open Enrollment Period must be received by the Customer Accounts Department no later than the **tenth** of the month following the Annual Open Enrollment month. If they are not received within that period they will not be accepted, which means that the employee or dependent will have to wait until the next Annual Open Enrollment Period to enroll.

When Coverage Starts

New Employees

Coverage for new employees (and their eligible dependents) will be effective on the date they meet the plan's eligibility requirements specified in the Group Benefits Contract Application. The effective date will be specified on the identification card. Check your Group Benefits Contract Application for the provisions applicable to your group.

NOTE

Be sure to submit applications received during the Annual Open Enrollment Period by the tenth of the month following the Annual Open Enrollment month.

Special Enrollees

Coverage for special enrollees will be effective as follows:

- **Marriage** – Coverage is effective on the date of marriage or no later than the first of the month following the date of marriage.
- **Birth, Adoption or Placement for Adoption** – Coverage is effective on the date of birth, adoption or placement for adoption.
- **Loss of Health Coverage** – Coverage is effective on the date the other coverage ends or no later than the first of the month following the date other coverage ends. The application must be received by Blue Cross within 30 days of the special enrollment event. For more information about the events which make up a loss of coverage refer to the section ***How to Make Changes in Enrollment Status – Enrollment Due to Loss of Coverage.***

Note: When a member (employee, spouse or child) requests a transfer of coverage from one Blue Cross and Blue Shield group (or plan) to another group where they initially declined enrollment in that health plan because of other health insurance coverage, Blue Cross and Blue Shield of Alabama will not be able to complete the transfer request until the former group provides us with the date coverage will be discontinued. This date must be received from the previous group in order for a special enrollment period to exist through your group health plan.

Late Enrollees

Coverage for late enrollees is effective on the first of the month of the annual open enrollment period.

IMPORTANT

Please note that there may be a delay in the issuance of coverage for your new member if the former group has not discontinued the coverage. Coverage on your group will be effective on the day coverage ends with the prior group.

Waiting Period

The waiting period is the period of time a person must serve as a new, active employee before becoming eligible for group enrollment (this was previously referred to as a probationary period). The waiting period can be 0, 30, 60, 90 days or as specified in your Group Benefits Contract Application. The waiting period must be the same number of days for all new employees.

Pre-existing Exclusion Periods

Newly eligible employees and dependents will have a 12 month (365 days) pre-existing condition exclusion period before benefits are available for pre-existing conditions, if they do not have enough prior creditable coverage (documented by a Certificate of Creditable Coverage) to completely eliminate the pre-existing exclusion.

NOTE

Pre-existing Exclusion Period:
The time a person must wait after the enrollment date to become eligible for coverage for pre-existing conditions.

A pre-existing condition is any condition, no matter how caused, for which medical advice, diagnosis, or care was received, or for which treatment was recommended or received during the six months before the date coverage began or, if earlier, the first day of any waiting period (probationary period) employees are required to serve before their coverage began. We call this six-month period of time the "six-month look back period."

In some cases, we will treat a condition as pre-existing even though it is not diagnosed until after the six-month look back period. Specifically, if treatment was recommended or received during the six-month look back period for symptoms that are consistent with the presence of a condition that is not diagnosed until after the six-month look back period, we will consider the condition to be pre-existing.

Pre-existing conditions do not apply to newborns enrolled within 30 days of birth or children under age 18 who are enrolled within 30 days of the date of adoption or placement for adoption. Pre-existing conditions do not apply to pregnancy.

As a general rule, for the first 12 months (365 days) after the employee or dependent's "enrollment date" (as defined below), there are no benefits for pre-existing conditions. If the member is a late enrollee, there are no benefits for the first 18 months (546 days) after the enrollment date for pre-existing conditions. If the employee or dependent is a regular enrollee, the enrollment date is the earlier of the first day of any waiting period or the first day on which the employee or dependent becomes covered. If the employee or dependent is a special or late enrollee, the enrollment date is the first day on which the employee or dependent becomes covered.

The 12 month or 18 month pre-existing condition exclusion periods are reduced by any credit the employee or dependent receives for prior creditable coverage (as described below).

Credit for Prior Creditable Coverage

If an eligible employee or dependent was covered by another health plan before becoming covered by your plan, we will credit the time toward the 12 (365 days) or 18 (546 days) month pre-existing conditions exclusion period, if:

- There is no greater than a 63 day break in coverage, and
- the last coverage was "creditable coverage," i.e., under an individual or group health plan including COBRA, Medicare, Medicaid, U.S. Military, Champus, Federal Employee Program, Indian Health Service, Peace Corps Service, a State risk pool or a public health service.

If necessary, we will assist in obtaining a Certificate of Creditable coverage from any prior employer, insurer, or Health Maintenance Organization (HMO).

Identification Cards

When your employees enroll for coverage in your Blue Cross and Blue Shield group health care plan, they will receive a Blue Cross and Blue Shield identification card.

The identification card shows the name of the contract holder (employee) even though the contract may also cover dependents. The identification card shows

the contract number, group number, Blue Cross and Blue Shield Plan Codes (showing that your contract is with Blue Cross and Blue Shield of Alabama) and the effective date of the most current benefits.

Encourage your employees to carry their Blue Cross and Blue Shield identification card at all times. If an identification card is lost or misplaced, a duplicate card may be obtained by calling Rapid Response at (205) 988-5401 in Birmingham or 1-800-248-5123 or submitting a request on our web site, www.bcbsal.com.

IMPORTANT

If your group has both health and dental coverage, your employees may have separate identification cards. If this is the case, it is important that they understand they should carry both cards.

How to Make Changes in Enrollment Status

So that the invoice we send you is as current as possible, we prefer that you phone, fax or mail your requests for new coverage, changes in coverage, terminations and transfers as soon as they occur. Changes sent after the 10th of the month or with your payment may not appear on your next invoice.

Our mailing address for enrollment changes is:

Blue Cross and Blue Shield of Alabama
Customer Accounts Department
P.O. Box 995
450 Riverchase Parkway East
Birmingham, Alabama 35298-0001

Our fax number is: 1-800-526-8529
or 220-7254 in Birmingham

The following lists the information that we need to make different types of contract changes. Unless otherwise indicated, a new Application for Enrollment (stock number ENR-1) is not required.

Address Change

To change an address be sure to provide the following items:

1. Employee's Name
2. New Home Address
3. Phone Number
4. Employee's Social Security Number

The employee may also call our Customer Service Department to change his or her address.

NOTE

Making Enrollment Changes?
If so, please telephone, fax or mail any changes to your Customer Accounts Representative as soon as they occur.

Marriage

A new Application for Enrollment (stock number ENR-1) must be received within 30 days of the date of marriage in order to change marital status.

Marriage results in a special enrollment period for health coverage in which an eligible employee can enroll. Any new dependents from a marriage also can enroll as special enrollees. Notice to us of the marriage should be received within 30 days after the date of marriage. The new dependents' coverage will be effective on the date of marriage.

Special enrollees have a 12 month pre-existing condition exclusion period. If we are not notified within 30 days of the marriage, the new dependents can only be added as late enrollees (see ***How and When to Enroll Eligible Members/Late Enrollees***).

Be sure to complete the following items on the Application for Enrollment.

1. Employee's Name
2. Marital Status
3. Employee's Social Security Number
4. Type of Medical Coverage Selected
5. Type of Dental Coverage Selected (if applicable)
6. Dependents' Names
7. Relationship
8. Dependents' Social Security Number
9. Dependents' Date of Birth
10. Nature of Application-Under "Add Dependent" check box for "Add Spouse". List the date of marriage in the space labeled "Date Event Occurred". If a common-law marriage exists, list the date the couple began residing together as husband and wife.
11. Coordination of Benefits Information

Birth of a Child

A completed Application for Enrollment (stock number ENR-1) must be received by Blue Cross within 30 days of the birth of the child.

The birth of a child results in a special enrollment period for health coverage in which an eligible employee, the spouse and the new dependent can enroll for coverage as special enrollees. A newborn added at birth would have no pre-existing exclusion period. Other special enrollees have a 12 month pre-existing exclusion period. If we are not notified as required, the new dependent can only be added as a late enrollee (see ***How and When to Enroll Eligible Members/Late Enrollees***).

Be sure to complete the following items.

1. Employee's Name
2. Employee's Social Security Number
3. Type of Medical Coverage Selected
4. Type of Dental Coverage Selected (if applicable)

5. Dependent's Name and Birthdate
6. Dependent's Relationship to Employee
7. Dependent's Social Security Number
8. Dependent's Date of Birth
9. Nature of Application– Under "Add Dependent" check the box "Add Dependent Child."

Adopted Child

A legally adopted child (or a child placed for adoption) should be added to the parents' contract within 30 days of becoming eligible for coverage by submitting an Application for Enrollment (stock number ENR-1) along with a copy of the legal papers certifying the adoption or placement of the child for adoption. The date of adoption or placement for adoption is the date used in determining when the adopted child is eligible for coverage.

The adoption of a child or placement for adoption results in a special enrollment period for health coverage in which an eligible employee, the spouse and the new dependent can enroll for coverage as special enrollees. An adopted child under age 18 added within 30 days of the date of adoption or placement for adoption would have no pre-existing exclusion period. Other special enrollees have a 12-month pre-existing exclusion period. If we are not notified as required, the new dependent can only be added as a late enrollee (see **How and When to Enroll Eligible Members/Late Enrollees**).

Stepchildren

Stepchildren of either the employee or spouse are eligible dependents provided they regularly and permanently reside with the employee. Stepchildren must be added within 30 days of becoming eligible for coverage or they cannot be added until the next Annual Open Enrollment Period. Stepchildren can be added by completing an Application for Enrollment form (stock number ENR-1). The same items should be completed for adding a stepchild as listed for **Birth of a Child**.

Enrollment Due to Loss of Coverage

An employee or dependent (1) who doesn't enroll during the first 30 days of eligibility because the employee or dependent has other coverage, (2) whose other coverage was either COBRA coverage that was exhausted or coverage by other health plans which ended due to "loss of eligibility" (as described below) or failure of the employer to pay toward that coverage, and (3) who requests enrollment within 30 days of the exhaustion or termination of coverage, may enroll in the plan. Coverage will be effective as of the date on which the other coverage ended. A member who enrolls under this paragraph is called a "special enrollee."

Loss of eligibility with respect to a special enrollment period includes loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility that is measured by reference to any of these events, but does not include loss of coverage due to failure to timely pay premiums or termination of coverage for cause (for example, making a fraudulent claim or intentional misrepresentation of a material fact.)

NOTE

The date of adoption or placement for adoption is the adopted child's Date of Eligibility.

NOTE

Notice of divorce must be received within 30 days in order to offer COBRA coverage.

Divorce

The spouse will be removed from coverage on the first of the month following the date the divorce decree becomes effective (according to the judge) regardless of when we receive notification. Notice of a divorce (including divorce of a common-law spouse) must be received within 30 days of the date of occurrence in order to offer continuous coverage.

Blue Cross must have a copy of the last page of the divorce decree in order to remove a common-law spouse or a spouse on a COBRA contract. This must include the names of the divorced couple, the judge's signature and the date of divorce. The divorced spouse may be eligible for continuation of benefits under COBRA. See ***Continuation of Benefits through COBRA*** in this section for more information.

To change family status as a result of divorce or to remove a spouse only, be sure to provide the following information:

1. Employee's Name
2. Marital Status
3. Employee's Social Security Number
4. Type of Medical Coverage Selected
5. Type of Dental Coverage Selected (if applicable)

IMPORTANT

Divorced spouses cannot remain as dependents on the contract.

Death

In order to keep our records as current as possible, please notify Blue Cross of a death of a member within 30 days of occurrence. Coverage will end the day after the date of death for the deceased. If the employee dies, coverage for any dependents will end the first of the month following the date of death.

Please provide the employee's name and Social Security Number along with the name of the deceased and the date of death.

(Surviving spouses and dependent children may be eligible for continuous coverage. See ***Continuation of Benefits through COBRA*** in this section for more information.)

How to Terminate a Contract

To terminate coverage of an employee and his dependents, Blue Cross prefers that you call your Customer Accounts Representative or mail or fax the information as soon as possible. You should also delete the employee's name from your group's invoice should it appear after the termination. Blue Cross will adjust your next invoice to reflect the termination.

Generally coverage is discontinued the first of the month following the termination of the employee. Retroactive cancellation for more than 30 days will not be allowed. See other sections for specific instructions.

IMPORTANT

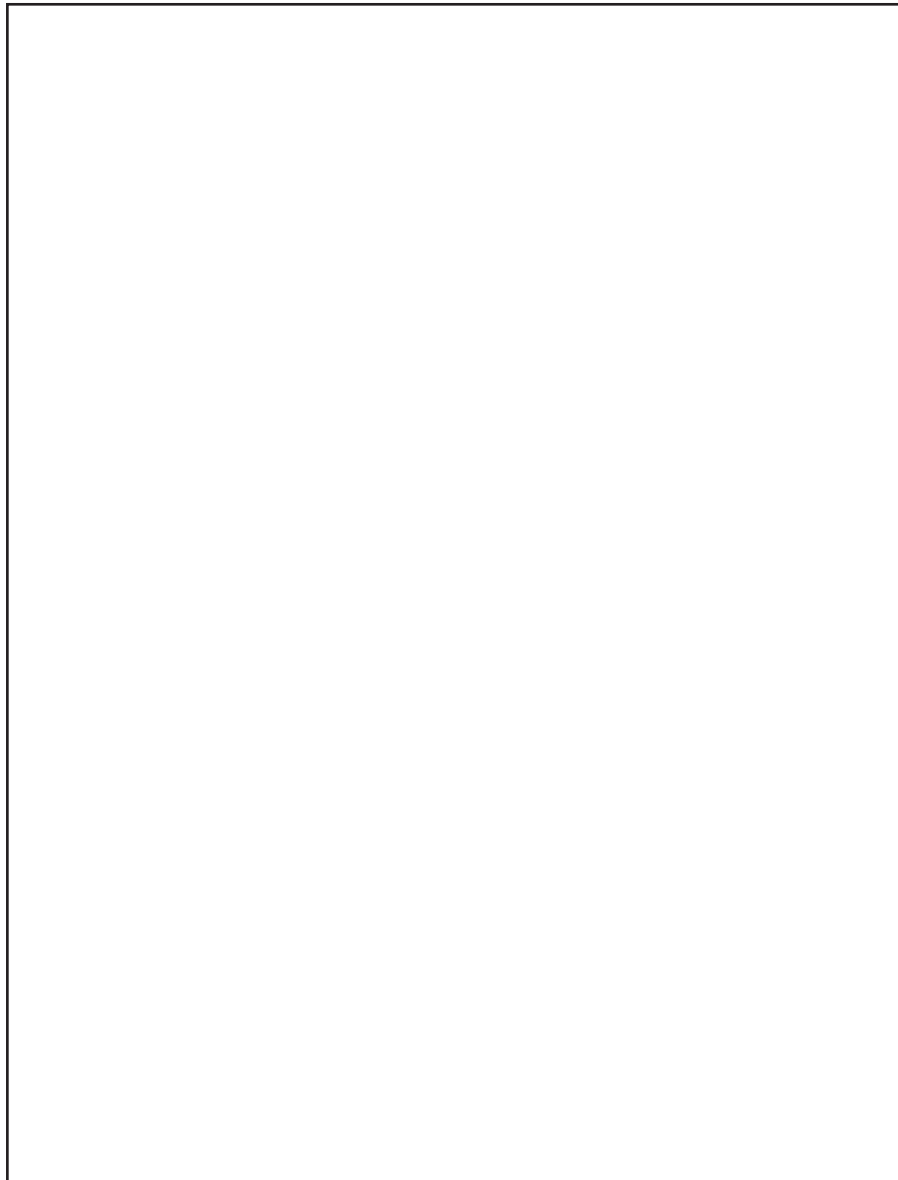
Note: Be sure to include the effective date and sign all applications.

NOTE

Blue Cross and Blue Shield of Alabama issues Certificates of Creditable Coverage.

Certificates of Creditable Coverage

Blue Cross and Blue Shield of Alabama will issue Certificates of Creditable Coverage to individuals who lose or terminate coverage which we administer. Certificates will be issued at the member level (i.e. for each dependent, as well as contract holder). Because we automatically give credit to individuals who transfer from one plan we administer to another, we will not issue Certificates to them. We will not issue Certificates for periods when benefits were administered by another carrier, third party administrator or HMO. Certificates of Creditable Coverage are mailed within 30 days of cancellation of coverage. Certificates will also be provided upon request to an individual within 24 months after coverage ends. A sample of the information needed in a Certificate of Creditable Coverage is shown on the following page .



Continuation of Benefits through COBRA

Blue Cross and Blue Shield of Alabama is committed to taking necessary steps to assist you in complying with Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. Please refer to the Notice of Right to Elect Continuation Coverage (MKT-116) for a summary of the key provisions of COBRA (the "COBRA Notice").

Guidelines

Not all group health plans are subject to COBRA. As a general rule, COBRA applies to all employer-sponsored group health plans (other than church plans) if the employer employed 20 or more full or part-time employees on at least 50% of its typical business days during the preceding calendar year. If you are uncertain about whether you are subject to COBRA, you should consult with your legal counsel.

Summary of COBRA Notification Provisions

As Plan Administrator, you have the following notification responsibilities under COBRA:

Notice upon Enrollment. you must provide a COBRA Notice to each covered employee and spouse on or prior to the time their health plan coverage becomes effective. This is a continuing requirement as you hire new employees. The Notices should be sent separately addressed to the employee and spouse by first class or certified mail to the employee's home address. If you are aware that the spouse resides elsewhere, you should send the spouse's notice to his or her address.

Notice upon Qualifying Event. If the employee loses health plan coverage due to **termination of employment, a reduction in hours, Medicare enrollment, or death**, you should notify the employee and spouse of their right to elect COBRA coverage. Notification to a covered spouse is deemed to be notification to all covered family members living with the spouse. Covered dependents that do not live with the spouse should receive a separate notice.

Within 14 days after one of these qualifying events, you should send the employee and spouse a COBRA Notice (stock number MKT-116), a Continuation of Coverage Application (stock number ENR-270) and a copy of the Summary Plan Description Certificate Booklet. The Group Health Plan COBRA Election form (stock number MKT-365) is available also if you would like to use it for your documentation. Please refer to the **EXHIBITS** section for a sample of the COBRA forms.

You should request that the COBRA application be returned to you. The individual has 60 days from the later of (i) the date the individual would lose coverage, or (ii) the date on which you notify the individual of their COBRA election rights, to elect coverage. A child's parent or guardian can make an election on behalf of a child.

If the qualifying event is the employee's **divorce or legal separation, or a dependent's loss of dependent status under the plan**, the employee or any member of the employee's family is required to notify you within 60 days of the

NOTE

COBRA applies to employers with 20 or more employees.

NOTE

It is important to notify individuals about COBRA immediately when their regular group coverage ends.

event, or within 60 days of the date on which coverage would be lost because of the event, whichever is later. Within 14 days of receiving this notice, you must send the spouse and/or qualifying dependents all of the information described above, and follow the above rules of giving notice and the response time.

Billing and Collection Procedures

If you wish, Blue Cross and Blue Shield of Alabama can handle all billing and collection procedures. There will be a 2% administrative fee added to the premium rate of the COBRA participant.

If you wish to handle the billing and collection of COBRA premiums, we will charge you for the premiums via your monthly invoice. The COBRA participants will show up on a separate division on your group invoice and there will not be a 2% administrative fee for this service.

If coverage is extended to 29 months on account of disability, 150% of the applicable premium will be charged after the 18th month of coverage.

Remember, regardless of who bills or collects COBRA premiums, claims on COBRA subscribers will be included with your group's claims experience.

If Blue Cross and Blue Shield of Alabama handles the billing and collection procedures, we will do the following:

- Set up a COBRA division and process all COBRA subscribers of your group plan on this division after receiving the COBRA applications from you.
- Apply all premiums received with the COBRA application and begin billing the subscriber for all premiums due. Claims experience for COBRA subscribers will be charged to your group's claims experience.
- Include a COBRA division page in your monthly invoice so that you will know who is being billed as a COBRA subscriber on your group. Unless you are handling the billing for your COBRA subscribers, you do not need to pay the amount shown for the COBRA division. It is for your records only.
- Notify the COBRA subscriber of group rate changes when necessary.
- Send the COBRA subscriber a letter if your group's benefits change informing them the benefits are changing and that they should contact you to receive a new Summary Plan Description or benefits summary.
- Process subsequent enrollment (e.g. new dependents added) and address changes on COBRA contracts upon request from the subscriber. These should be sent to us on a COBRA application form that clearly indicates that it is a change to an existing COBRA contract.
- Cancel the COBRA contract for non-payment of the COBRA premiums and take them off your monthly invoice COBRA division. Each COBRA payment is due by the first of the month. Contracts are cancelled once they become delinquent by 30 days and will not be reinstated.
- Send late notices to COBRA subscribers who have not paid dues current.

- Cancel the COBRA contract by request from the subscriber, or when they receive other coverage.
- Notify the subscriber of the expiration date of COBRA coverage and offer coverage through our Conversion Contract at the end of the COBRA benefit period.

Steps for Handling COBRA Easily and Correctly

- Notify currently covered employees (and their dependents) about COBRA continuation coverage under your group health plan. Notify new employees about eligibility for COBRA continuation coverage when they become eligible for coverage by the plan. Use the Notice of Right to Elect Continuation Coverage (MKT-116) for these notices.
- Inform members about their continuation of coverage options when they, or dependents, qualify for COBRA. Give them a COBRA Continuation of Coverage application (stock number ENR-270), a Notice of Right to Elect Continuation Coverage (stock number MKT-116) and a copy of their summary plan description certificate booklet and a written statement as to the COBRA premiums.
- Be sure to tell them the amount of time they have to elect COBRA is 60 days from the date they are notified.
- Write in the number of months for which the applicant is eligible for COBRA coverage, the date that COBRA billing is to begin and the correct monthly rate, including a 2% administrative charge (50% after 18 months on disabled individuals.) Check with your Blue Cross Customer Accounts Representative to confirm that you are using the correct COBRA rate.
- Indicate the benefits elected on the COBRA application if your group has both health and dental coverage. If you have freestanding dental coverage, be sure to list both contract numbers if health and dental are both requested and include the total amount in the monthly rate space.
- If the individual has indicated that he/she has other health coverage or Medicare, please ensure that he/she completes the Coordination of Benefits information. Be sure all sections have been completed, especially the contract/policy number or Medicare number.
- Review the application for accuracy and completeness after it is returned to you and sign it. **The COBRA application cannot be processed without your signature and the date the COBRA coverage is to begin.** We will remove the individual from your invoice as of this date.
- Remind applicants that the initial payment (by check or money order) should cover the premium for the period of time from when their group coverage ended to the next current billing date. All future payments must be made to Blue Cross within 30 days of the due date.
- Send COBRA applications as soon as you receive them. Be sure to include the applicant's initial payment to Blue Cross and Blue Shield of Alabama.
- Report the employee termination or dependent removal on your monthly

invoice. Please note the date they should be cancelled. Indicate that the employee or dependent is to be cancelled and they are electing COBRA coverage. Group premiums must be paid for the individual up to the date of termination of group coverage.

- Make sure the effective date of the COBRA contract on the application is the same date as the employee or dependent's removal date from the group's coverage.
- Do not include the COBRA premium payment with your group's premium payment check unless your group chooses to do the billing for all your COBRA subscribers.

IMPORTANT

If you are subject to COBRA, we strongly recommend that your company have in place a tracking system in order to monitor the status of any COBRA notification.

Continued Coverage Under State Law

Your employees may qualify for coverage under state law. In Alabama coverage may be available through the Alabama Health Insurance Plan (AHIP) for employees who are not eligible for COBRA or who exhaust their COBRA coverage. Call the State of Alabama at 1 877-619-2447 for more information.

Conversion Coverage

Conversion Health Contract

Conversion Health Contract is offered to employees who terminate group coverage except when:

- the employee cancels his group coverage but remains an active employee,
- Blue Cross and Blue Shield terminates the group coverage because of non-payment of premium, or
- the employer terminates the group plan for any reason.

The benefits and rates for the Conversion contract differ from your group coverage. For example, Major Medical coverage is not offered under the Conversion contract and there is no Dental Conversion coverage. To receive this coverage, the terminating employee must apply to Blue Cross and Blue Shield of Alabama within 30 days of termination of employment (or within 30 days of the date the employee's eligibility for COBRA "Continuation of Coverage" ends).

Because you act as the remitting agent for your company's group health plan, we ask that you give the Conversion Health Contract information to employees when they terminate employment so they can apply for Conversion coverage within 30 days after their employment or COBRA coverage ends.

The Conversion Health Contract Application (stock number CAD-17) explains the coverage and how to apply. **Please keep a supply on hand at all times and give them to employees who terminate and who are no longer eligible for group coverage.**

You should caution employees that the benefits provided by the Conversion Health Contract are not the same as your group benefits. Also, if the employee had family coverage under the group plan, family coverage must be retained under the Conversion Health Contract unless the spouse or dependent dies, the employee becomes divorced, the spouse becomes disabled under Medicare or the dependent children covered previously are no longer eligible.

Adult Rate Contract

The "Adult Rate" Contract is a direct-pay health contract offered to eligible dependents when they are no longer eligible for coverage as a dependent under their parent's group contract, or through a COBRA "Continuation of Coverage" contract (there is no dental coverage). The dependent cannot be eligible for a contract through an employer group, another individual policy or eligible for Medicare, and, the dependent must be an unmarried resident of Alabama and between 19 and 23 years of age. Once an application is received and processed, he or she will be converted to an "Adult Rate" Contract and billed at home for the coverage.

The benefits and rates provided under the Adult Rate Contract are not the same as your group coverage. To receive this coverage, the eligible dependent must apply within 30 days of cancellation from the parent's contract or immediately prior to the date eligibility for COBRA "Continuation of Coverage" ends.

C Plus Medicare Supplement Contract

C Plus is a Medicare Select Plan B supplement that can be offered to retired employees who become eligible for Medicare benefits at age 65 or older or due to disability (not including End-Stage Renal Disease-ESRD).

The benefits and rates for C Plus differ from your coverage. To enroll in C Plus, an individual must apply within the three month period following the date of enrollment in Medicare Part B. If an individual does not enroll in this time period, he or she must wait to enroll during a C Plus Open Enrollment.

This type contract can either be paid directly by the individual to Blue Cross or billed through the group with the group paying one total amount for all their C Plus enrolled individuals. (For Active Employees age 65 or older see the **Who Is Eligible for Coverage** section under Special Rules for Persons Eligible for Medicare in this manual.)

NOTE

C Plus:
A contract designed to supplement Medicare coverage.

NOTE

If you do not currently have a dental plan and want information, call your Marketing or Service Representative.

Dental Enrollment Guidelines

If dental is a rider to your health coverage, the regular health guidelines apply. The following guidelines apply when you have a freestanding dental program.

Enrollment Percentage Requirements

All eligible employees must be enrolled in dental and continue to be enrolled as long as they are eligible, or for the duration of the program.

Enrollment Contribution Requirements

The minimum employer contribution for dental coverage is 100% of the cost of an individual dental contract and at least 25% of the additional dependent cost toward a family dental contract. Payroll deduction is required for employer groups when the employer does not contribute the full premium.

Enrolling Members

A new employee and any eligible dependents must enroll for dental coverage within 30 days of the date of eligibility. New dependents by marriage, birth, adoption or placement for adoption must enroll for dental coverage within 30 days of the date of eligibility. **Dependents not enrolled for dental during their initial eligibility period may not be allowed to enroll in dental at a later date.**

Removing Members

Once enrolled as a family dental contract, the dependents cannot be removed except for one of the following reasons:

- Remove spouse because of divorce, death or eligibility under another Blue Cross dental contract.
- Remove dependent children because of death, marriage, age 19 or end of student extension, or eligibility under another Blue Cross dental contract.

Pre-existing Exclusion Period

There are no pre-existing exclusion periods for dental coverage.

Coverage For Persons No Longer Eligible For Dental Coverage

Continuation of dental coverage is available on COBRA contracts. However, dental coverage is not available on Conversion, Adult Rate or C Plus contracts.

BILLING PROCEDURES

The Billing Procedures section of the Group Administrator's Manual includes the following:

▪ Invoice Information	
• Interpreting The Invoice	2
• The Billing Account Number (BAN)	3
▪ Invoice Explanation	
• Adjusted Previous Balance	3
• Current Period Amount Due	4
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▪ Guide to Interpreting a Group Invoice	5
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NOTE

You will receive both a Group Invoice and Enrollment Listing every month. Please pay the Total Due on the Invoice, not on the Enrollment Listing.

BILLING PROCEDURES

Invoice Information

Blue Cross and Blue Shield of Alabama sends a Group Invoice and Enrollment Listing to your group every month. The Group Invoice provides information regarding billing and payment history for the groups and divisions assigned to your Billing Account Number (BAN). The Enrollment Listing provides a detailed listing of each division's current enrollment, as well as enrollment changes made during the previous month.

Please verify that all employees listed are eligible and that all information is correct. Audit your Invoice monthly against your payroll information and if you detect any errors, call your Customer Accounts Representative or write:

Blue Cross and Blue Shield of Alabama
Customer Accounts Department
450 Riverchase Parkway East
P. O. Box 995
Birmingham, Alabama 35298-0001

Invoices are mailed approximately 10 days before the due date and are due on the first of each month. We bill in advance. Our invoice is designed to be paid as billed. However, we do allow you to adjust the invoice if a copy of the adjusted invoice is forwarded to us. The adjusted invoice should reflect the additions and deletions. These adjustments plus/minus the invoiced amount should equal the remitted premium.

Each month you will receive an Enrollment Listing in addition to your Group Invoice. The Enrollment Listing will reflect each member's name and their monthly premium. Also, any membership activity affecting the prior month will be reflected on the Enrollment Listing. **You will be responsible for paying the "total due amount" on the Invoice, not on the Enrollment Listing.**

Premiums are due on the first of each month. For instance, payment for coverage for the month of January, is due on or before January first. We have a 30-day grace period during which payment can be made.

IMPORTANT

Prepayment ensures that your employees will have continuous coverage. If your payment is not current, claims will be suspended or rejected and not paid, and any additions of new employees will not be covered. If payment is not received in 30 days, your group will be subject to cancellation.

Interpreting the Invoice

Adjustments to the balance of your account are made from the enrollment changes submitted by you and processed by us. Payments applied are credited to your account balance

Your Invoice reflects the charges and credits adjusting your account balance. Payments received are applied against your account balance. If this calculation does not create a balance of \$0.00, the shortage or overpayment is reflected on

the next Invoice you receive. This previous balance is then combined with the premiums owed for the current billing period to determine the total amount due.

It is important to resolve any previous balance immediately. If your Invoice shows an adjusted previous balance, verify that all your payments have been properly applied. Then check the enrollment changes shown on the Enrollment Listing.

Make sure that they agree with your records. If you cannot account for any differences, you may want to audit previous Invoices for payments and enrollment changes. If you are still unable to resolve the differences, contact your Customer Accounts Representative immediately.

If you allow your adjusted previous balance to accumulate over time, it may interfere with payment of your claims.

To help us credit your payment promptly and accurately, please include the following in the envelope provided:

1. Include payment with your Billing Account Number
2. Monthly Invoice and Enrollment Listing reflecting adjustments
3. Reconciliation sheet

The Billing Account Number (BAN)

The Billing Account Number is an eight-digit number assigned to groups/divisions. Billings will be generated and premium payments applied based on your Billing Account Number.

Invoice Explanation

For more information about your Group Invoice, please refer to the **Guide to Interpreting a Group Invoice** which follows. The items are explained below.

Adjusted Previous Balance

This section represents any amount still due or overpaid from the last Invoice. This includes all completed enrollment changes and payments that have been received and applied.

A. Previous Balance

The ending balance from your previous Invoice.

B. Adjustments to Previous Balance

The total of all charges and credits for any retroactive changes in the previous month(s). These include any additions, deletions, changes in status, etc. These changes are listed by subscriber on the Enrollment Listing attached to your Invoice in the column titled **Adjustments**. You are responsible for verifying all adjustments for accuracy. Members' effective dates or cancel dates determine if your bills are correct. This column is subtotaled for each division. You must add all division totals to

NOTE

Adjusted Previous Balance:
The sum of the previous balance, the adjustments to previous balance and the payment activity. If the balance does not equal zero, a discrepancy exists.

agree to the total shown on page 1 of your Invoice. The amount on page 1 may also include account level charges or credits which will be discussed later.

C. Payment Activity

All payments received and applied to your billing account between the previous and current Invoices.

D. Adjusted Previous Balance

Enrollment activity which was not completed and payments not processed before the Invoice was produced will not appear. This may cause an Adjusted Previous Balance to appear on your Invoice. Verify that all payments have been properly applied. Then verify that enrollment changes shown agree with your records. Call your Customer Accounts Representative if you have any questions.

Current Period Amount Due

The Current Period Amount Due is the total amount due for all persons enrolled during the current Invoice period. This amount does not include any retroactive adjustments-see Adjusted Previous Balance. A detailed list of all active subscribers billed can be found on the Enrollment Listing under the column Current Amount. This column is subtotaled for each division. If you have multiple divisions included in your BAN number, you must add all division totals to agree with the total shown on page 1 of your Invoice.

Total Due (PLEASE PAY THIS AMOUNT)

The total of the Adjusted Previous Balance plus the Current Period Amount Due.

Message Field

Blue Cross will occasionally use this field to communicate with you. Messages will appear above the Payments section.

Payments

This section lists individual payments posted to your account. It includes the amount of the check and the date it was applied to your account. Other activity affecting payments will be detailed here also. A negative amount (e.g., bad check) shown in this section denotes a reduction in the cash applied to your account. This will increase the balance due.

Enrollment Listing Explanation

Please refer to the Guide to Interpreting an Enrollment Listing on the following page. The Enrollment Listing lists all current and retroactive charges and credits for each subscriber included on the Invoice. Also listed are contract number, name and status (e.g., individual, family, C Plus, etc.). An explanation of each column follows.

A. Employee Name

The name of the contract holder.

B. Contract Count (CC)

Status of the Contract:

I = Individual

F = Family

C = C Plus

C. Contract Number

A numerical identification with a three character prefix assigned to a contract (usually the employee's Social Security number).

D. Detail of Adjustments to Previous Balance

A message which explains the reason and dates affected by any enrollment adjustments for the previous month(s).

E. Adjustment Amount

Dollar amount of the contract adjustment(s) outlined in D.

F. Current Amount

Payment due for each contract for the current month.

Note: Please do not pay based on this total.

IMPORTANT

At the end of each group and division, both the Adjustment Amount and Current Amount columns are subtotaled. The subtotals are then combined and reflected as a BAN total on the Group Invoice (page one).

The Contract Count is also totaled and indicates the total number of subscriber contracts billed for the current period only. These are not combined to reflect a BAN total.

DETAIL OF ADJUSTMENTS TO PREVIOUS BALANCE

A message will appear on the Enrollment Listing which explains the type of adjustment made to the subscriber's contract and the dates for which the premium is being adjusted. Listed below are some of the messages which you will see.

New Applicants

If the applicant is added for the date of the current billing, the message will appear as:

"Start of Coverage"

If the applicant is added prior to the date of the current billing, the message will appear as:

"Start of Coverage
From date to date"

Cancellations

If the contract is discontinued for the date of the current billing, the message will appear as:

"Contract Removed"

If the contract is discontinued for a date prior to the current billing, the message will appear as:

"Contract Adjusted
From date to date"

"Contract Removed
Effective date"

Changes in Coverage

Changes in coverage may occur from subscriber changes (individual to family, family to individual, change to C Plus, etc.) and/or group level changes (change in rates or benefits).

If the change is made for the date of the current billing, the message will appear as:

"Changes in Coverage"

If the change is made for a date prior to the current billing, it will be shown as two separate adjustments to the subscriber's contract. The first adjustment will show the removal of the previously billed amounts from the first of the month in which the change is effective. The second adjustment will show the addition of the corrected amount due from the date in which the change is effective. The messages will appear as:

"Contract Adjusted
From date to date"

"Contract Adjusted
Form date to date"

Invoice Reconciliation

To ensure quality service to our customers, Blue Cross and Blue Shield of Alabama will be implementing an invoice reconciliation process. This process is designed to ensure that our records and those of our customers reflect current and accurate billing information.

Our billing system is designed to display invoice and enrollment information clearly and accurately. To help us maintain this standard we ask all accounts to pay the total due amount as reflected on your invoice.

Enclosed with your monthly billing you will receive an invoice reconciliation worksheet. If you elect to manually adjust your invoice, you will be required to complete the invoice reconciliation worksheet each month. If you choose to pay the total due amount or if your group is being drafted monthly for premiums, you will not be required to complete the worksheet.

If you have questions regarding this process, please contact your Customer Accounts Representative.

Frequently Asked Questions About Billing

Why does the billing appear in two sections?

The first section is the **Group Invoice**. It provides information regarding billing and payment history for the groups and divisions which are assigned to your Billing Account Number (BAN). You should calculate your payment from the **Group Invoice**. The next section, the **Enrollment Listing**, provides a detailed listing of each division's current enrollment and any enrollment changes made during the previous month.

Why do I Have an "Adjusted Previous Balance" on my Invoice?

For one or more of the following reasons:

1. You have adjusted your payment for enrollment changes which Blue Cross has not yet processed.
2. Blue Cross has processed enrollment changes for which you have not adjusted your payment.
3. Enrollment changes made by the group and Blue Cross do not agree.
4. Payments were not credited to the account when the Invoice was produced.
5. You have taken credit or paid for enrollment changes twice.

What amount on the Invoice do I pay?

The **Total Due** on the Group Invoice is the amount which should be paid to Blue Cross and Blue Shield of Alabama. This amount includes any unpaid balance plus the current period amount due.

NOTE

Call your Customer Accounts Representative with questions about eligibility or billing procedures.

How do I make enrollment changes so they will appear on my next Invoice?

So that the Invoice we send you is as current as possible, please send any enrollment changes as soon as they occur. We encourage groups to submit information as often as they can to enhance service, however, we can accommodate any frequency. You may telephone, fax or mail changes in coverage and terminations; and fax or mail requests for new coverage and transfers. Changes received after the 10th of the month may not appear until next month's Invoice. If you have a deletion, please call us as soon as possible to ensure claims payment is terminated on the appropriate date.

The mailing address for enrollment changes:

Blue Cross and Blue Shield of Alabama
Customer Accounts Department
450 Riverchase Parkway East
P. O. Box 995
Birmingham, Alabama 35298-0001

The fax number: 1-800-526-8529 or (205) 220-7254 in Birmingham.

I added/deducted an employee from my billing last month and adjusted my payment for this. Why are you charging/crediting me this month?

The charge or credit you see in the Adjustment Amount column on the Enrollment Listing is an adjustment to your account balance. This is done to offset the adjustment already made in your payment so your account balance and payment made are the same.

Why do we need a Billing Account Number?

Blue Cross uses your Billing Account Number as an identifier to help us ensure payments are quickly and accurately credited to your account. This number is used in addition to group and division numbers. In most cases, a single Billing Account Number will represent the amount due for all divisions.

When I get a "late" message on my Invoice, is my group already canceled?

No. Your contract allows a 30-day grace period for payments to be made. This message notifies you that we have not processed your payment when the invoice generated. If you have any questions regarding your payment, contact your Customer Accounts Representative.

When do I need to have my payment at Blue Cross?

Payments are due on the first of the month. We encourage payment to be received no later than the 10th day of the month to provide you with an accurate Invoice and Enrollment Listing.

Are my claims paid when my payment has not been received by Blue Cross?

Claims incurred on or beyond the date to which the account is paid will not be paid until payment is received and processed.

What specific months are my payments for?

Payments are applied to an account balance and not necessarily to a specific month. If an account is current and no adjusted previous balance is owed, the payment will be applied to the current month. If, however, an adjusted previous balance is owed, any money received will first be applied to this balance and the remainder will be applied to the current month's dues. If your account is not paid in full, your paid to date may not be advanced, resulting in your employees' claims payment being delayed.

Can you tell which subscriber I owe dues for?

Payments are applied at the account level, not at the subscriber level. A detailed Enrollment Listing is provided for you each month so that you can verify that you have been correctly charged or credited for each employee. It is important that you audit your Invoice monthly and report any discrepancies to your Customer Accounts Representative immediately.

We realize that the primary method of payment is by check, are there other methods of payment?

We have several other payment methods available. The financial arrangement selected would determine the options available. For your convenience we offer automatic bank draft, wire transfers and automated clearing house (ACH) transactions. We do not have the capability to provide credit card transactions.

BENEFITS AND CLAIM FILING

The Benefits and Claim Filing section of the Group Administrator's Manual includes the following:

▪ Important Benefit Programs and Terms	
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• Care Management	2
• Case Management	3
• Concurrent Utilization Review Program	3
• Coordination of Benefits (COB)	3
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▪ Claim Filing	
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NOTE

Refer to your Certificate Booklet for complete coverage information.

BENEFITS AND CLAIM FILING

Our total service concept includes a commitment to administer your benefits and claims as quickly and accurately as possible. As Group Administrator, you can help ensure that your benefits are administered efficiently by helping your employees (and their dependents) understand their benefits and how claims are processed. Your Certificate Booklet contains detailed information on your benefits and on claim filing procedures. The following information should be used as a quick reference supplement to your Certificate. Please keep in mind that your specific benefit program may not include all the benefits described in this section. Refer to your Certificate Booklet for complete coverage information.

Important Benefit Programs and Terms

The following benefit programs and definitions of commonly used terms are listed in alphabetical order to help you refer to them quickly.

Blue Cross Preferred Care

Blue Cross Preferred Care is a Preferred Provider Organization (PPO) designed to encourage the efficient use of health care services and offer increased benefits when a participating provider is used. Preferred Medical Doctors, Preferred Outpatient Facilities, Preferred Radiologists and Preferred Laboratories have agreed to accept reduced rates for their services to Preferred Care members. Preferred Care includes all hospitals in Alabama and over 8,000 physicians. Hospitals and physicians are also available in some of the contiguous counties in the bordering states. Preferred Care providers agree to handle all paper work including claim filing and Preadmission Certification.

Care Management

Care Management is a state-of-the-art program designed to improve health outcomes and elevate the quality of care. The purpose is to control and/or reduce medical costs associated with selected conditions by targeting individuals who have been diagnosed with the conditions. The program initially focuses on four common chronic conditions:

Diabetes (Type I and II)
Asthma (Adult and Pediatric)
Coronary Artery Disease
Congestive Heart Failure

There is no cost to the member, and participation is voluntary and confidential. Appropriate participants are identified through a confidential review of claims data. Members can also self-refer by calling a toll-free number. When members are identified for the program, they are mailed a letter explaining the program and a form to complete if they want to participate. Members who take advantage of the program receive:

- A health assessment, if needed, to assist in better managing the condition;
- Educational materials such as helpful self-monitoring charts, resource listings, self-care tips and quarterly newsletters;

- Access to a toll-free help line providing consultation services 24 hours a day, 7 days a week. The program is administered by Registered Nurses specially trained in chronic disease management.

Case Management

The Individual Case Management Program is designed to identify members who suffer from long-term, catastrophic, and/or complex illnesses or diseases, and to assist them in accessing the most appropriate health care services while maximizing benefit dollars. Because these members often have special needs that could easily be met in an alternative health care setting or in their own homes, this approach can significantly reduce the financial burden caused by long-term medical expenses. Additionally, it provides comfort and support for the member and his or her family. This program is voluntary and the decision to participate is left up to the member or family, attending physician, employer group and the Blue Cross case manager.

Concurrent Utilization Review Program

Our Concurrent Utilization Review Program (CURP) is designed to ensure that inpatient admissions and continued stays are medically necessary. The purpose is to reduce over-utilization of inpatient services and encourage less expensive outpatient services when consistent with the health care needs of the individual patient.

Blue Cross nurses work on-site in participating hospitals to review admissions within 24 hours and evaluate and establish that appropriate medical necessity criteria has been met. As part of this program, we negotiated a “hold harmless” agreement which prohibits participating hospitals from billing a patient when Blue Cross and Blue Shield denies payment for care determined to be medically unnecessary or inappropriate, unless the patient continues the hospital stay on a voluntary basis after being told that the stay is not medically necessary.

Coordination of Benefits (COB)

A provision that prevents duplicate payments for the same claim when an employee and dependents are covered by more than one group health or dental program. The benefits provided by the program are not payable to the extent they are provided under any other group plan or if the other plan is the primary plan. The primary plan is decided by the rules listed below:

IMPORTANT

If the other plan has no COB provision, it is primary.

- Employee/Dependent: The plan covering the patient as an employee is primary over the plan covering the patient as a dependent.
- Dependent Child/Parents Not Separated or Divorced: If both plans cover the patient as a dependent child, the plan of the parent whose birthday

falls earlier in the year will be primary. If the parents have the same birthday, the plan covering the patient longer is primary. If both plans do not use this birthday rule the other plan's rule will be used.

- **Dependent Child/Separated or Divorced Parents:** If two or more plans cover the patient as a dependent child of divorced or separated parents, benefits are determined in the following order:
 - a) First, the plan of the parent with custody;
 - b) Then, the plan of the spouse of the parent with custody;
 - c) Last, the plan of the parent without custody.

If there is a court order that specifically states that one parent must provide the child's health expenses, that parent's plan is primary.

- **Active/Inactive Employee or Dependent:** The plan covering a person as an active employee is primary over a plan covering the patient the longer time is primary.
- **Longer Shorter Length of Coverage:** If none of the above rules determine the order of payment, the plan covering the patient the longer time is primary.

Expanded Psychiatric Services (EPS)

Expanded Psychiatric Services is a capitated benefit program which provides enhanced coverage for mental health and chemical dependency services when a participating EPS provider is used. These organizations specialize in adult, adolescent and child psychiatry. Participating EPS providers are available statewide to provide a full range of hospital inpatient and outpatient services.

Medically Necessary or Medical Necessity

Benefits are provided only for those services and supplies determined by Blue Cross and Blue Shield to be medically necessary. To be medically necessary, the service or supplies must be:

- appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition;
- provided for the diagnosis and direct care and treatment of the condition;
- in accordance with standards of good medical practice;
- performed in the least costly setting required by your condition;
- not primarily for convenience and/or comfort; and
- not experimental or investigational.

Evidence to help decide whether the services are medically necessary may be required from the providers of service before benefits are provided.

NOTE

Evidence to help decide whether services are medically necessary may be required from the providers of service.

Non-Participating Hospital

A non-participating hospital means any hospital which is not a participating hospital but which is recognized or approved as a general medical and/or surgical hospital by the Alabama Hospital Association or the American Hospital Association. A general hospital does not include an institution which is a place for convalescent care, for rest, for the aged, for treatment of alcoholism or drug addiction or which is a school or college infirmary, a sanitarium, a nursing home, or a mental or similar institution.

Participating Chiropractor Program

The Participating Chiropractor Program offers Blue Cross customers the assurance that their employees are receiving quality care at the lowest cost. Blue Cross' Participating Chiropractor Program offers several advantages, including reduced out-of-pocket costs, no paper work or claims to file and a utilization review provision. Participating Chiropractors are located all across Alabama.

Participating Hospital

A Participating Hospital means any hospital which has a contract with Blue Cross for the furnishing of health care services. If the hospital is outside Alabama and participates with the Blue Cross Plan there, the benefits are the same as in a Participating Hospital in Alabama. Your employees will receive maximum benefits when using a Participating Hospital. At the time of publishing this manual, all general hospitals in Alabama are Participating Hospitals.

Payment Guidelines when not using a PMD Physician in Alabama

It is important to encourage your employees to use a PMD physician when receiving PMD eligible services in Alabama. If a non-PMD physician is used, reimbursement will be made at 50% of the PMD fee after the Major Medical deductible. In addition, the patient's payment will not count toward the Major Medical out of pocket. The routine preventive services available under PMD are only covered when using a PMD physician.

Preadmission Certification (PAC)

Preadmission Certification is the procedure used to determine whether treatment as a hospital inpatient is medically necessary prior to a member's admission. In the case of an emergency admission, we must be notified within 48 hours of the admission or the next business day. This is referred to as Postadmission Review. The patient is responsible for obtaining Preadmission Certification. If Preadmission Certification is not received prior to a hospital admission or Blue Cross is not notified of an emergency admission within 48 hours, Blue Cross and Blue Shield will not pay for the hospital stay.

Prescription Drug Point-of-Sale

In order for your employees to receive maximum prescription drug benefits, they should use Participating Pharmacies. Blue Cross and Blue Shield of Alabama has contracted with pharmacies statewide to provide prescription drugs to our customers at a reduced price. Outside Alabama, Preferred Care

NOTE

More than 8000 physicians participate in PMD.

Services, Inc. contracts with pharmacies on behalf of Blue Cross and Blue Shield of Alabama to ensure that whenever members travel outside their home state, they can find a Participating Pharmacy to provide the same prescription drug coverage and pharmacy benefits as they receive at home. Currently, 98% of all Alabama pharmacies and over approximately 50,000 pharmacies nationwide participate in the network. In addition, most chains and many independent pharmacies are participating pharmacies.

Subrogation

A provision which facilitates the proper allocation of health or dental expenditures when benefits are available from more than one source. Blue Cross and Blue Shield may pay benefits for an illness or injury for which some other person is responsible. If the covered member seeks to recover expenses from that person, Blue Cross and Blue Shield is given the right to recover its payment on behalf of the member from the other person.

Usual, Customary and Reasonable (UCR)

Usual, customary and reasonable fee (often referred to as "UCR fee") means the amount of a physician's charge that Blue Cross will recognize for payment for his covered medically necessary services. To determine the UCR fee, we look at the following:

- how much the physician charges his patient for the same or a similar service;
- the variance in the charges by most providers for the same service in the same geographics area, if possible;
- the value of the procedure compared to other services;
- out-of-state adjustments to account for the way providers charge in other states;
- the rate of inflation using any generally recognized measure. This may cap any increase in the UCR fee.

For a Preferred (PMD) service provided by a Non-PMD provider in Alabama, the UCR fee is 50% of the PMD Fee Schedule. For PMD services provided by Non-PMD Providers outside Alabama, the UCR fee is the fee amount payable.

Claim Filing

For most services, the provider will file the claim. This is one of the main advantages of using Participating Hospitals, Preferred Medical Doctors and the other network providers available under your group benefit plan. Even if your employees live or are traveling outside Alabama, as long as they use participating providers associated with the local Blue Cross and Blue Shield Plan, the provider will file the claim.

Filing Claims for Major Medical or Other Covered Services

If an employee has to file a claim, it's easy, they should just complete the Medical Expense Claim Form, stock number CL-438. A guide to completing this form is found at the end of this section. Read further for information on filing prescription drug claims and dental claims and for more information on what to do if services are received outside Alabama.

Filing Major Medical Prescription Drug Point-of-Sale Claims

If your group has the Major Medical Prescription Drug Point-of-Sale program, it is very important that your employees understand how the program works so that they can maximize their benefits. It is a simple process as long as they follow these five important steps:

- Always use a Participating Pharmacy, inside and outside Alabama.
- Show the ID card to the pharmacist.
- Pay the pharmacist for the prescriptions.
- Get the claim authorization number from the pharmacist. It is required for filing claims.
- File the claim using the CL 94 prescription drug claim form making sure they include the claim authorization number on the form.

The claim authorization number is usually printed on the receipt. The employee should check to make sure it is there, before leaving the pharmacy. If it is not on the receipt, the pharmacist will need to write it in. A sample CL-94 claim form is included in the **EXHIBITS** section of this manual.

Filing Dental Claims

If your group has the Blue Cross Preferred Dental program, your employees are relieved of filing claims when a Preferred Dentist is used. Payment will be made directly to the dentist and the dentist will accept the Blue Cross Preferred Fee amount as payment in full (after any patient deductible or coinsurance).

If a non-Preferred Dentist will not file a claim, the patient must pay the bill and send the claim directly to Blue Cross and Blue Shield of Alabama. The patient should complete the dental claim form, stock number CL-265 and attach an itemized bill from the dentist.

NOTE

BlueCard provides consistent handling of claims in different geographical areas.

What Happens When Services are Received Outside Alabama

The BlueCard program is a Blue Cross and Blue Shield system wide claims processing system. This program was designed to provide consistent handling of claims from Plan to Plan and access to local provider discounts for all Blue Cross and Blue Shield customers when receiving services outside their Plan's area.

The program includes both inpatient and outpatient hospital claims and physician claims when the other Blue Cross or Blue Shield Plan has Participating arrangements with these providers. Encourage your employees who receive services outside Alabama to use a Blue Cross Participating Provider. The best way to find out a provider's status is to simply ask the provider if he or she is a Blue Cross Participating Provider.

The alpha prefix (i.e. XAA) on ID cards is the key to this system wide electronic claims routing process. Your employees should make sure their provider includes the prefix when they file the claim. The provider will file the claim to the local Blue Cross and Blue Shield Plan. The local Plan will electronically forward the claim to us for payment authorization and processing. We approve the payment and the local Blue Cross Plan makes payment to the provider. We send a Claims Report confirming the claim was processed.

How to Request a Review

If an employee is not satisfied with the way we process a claim, he or she may contact our Customer Service Center and ask the representative to research the situation. If the employee is still not satisfied, a formal request for review through the grievance process may be made. This request should be made in writing within 60 days of the denial and should include the employee's full name, contract number and the claim number. They should also attach a copy of the Claims Report we sent them. We will re-evaluate all information and inform the employee of the decision within 60 days.

Claims Reports

After a claim is processed, the employee will receive a Claims Report showing what was paid and not paid. The Claims Report may also be referred to as an Explanation of Benefits (EOB). Claims Reports are not sent for inpatient or outpatient Preferred Care hospital claims, Preferred Care physician claims or dental claims unless some portion of the claim is not covered, other than the deductible or copayment.

Occasionally, a Claims Report for verification purposes will be mailed to an employee. These Claims Reports help detect fraud by allowing the employee to verify that the services listed on the report were actually rendered. If any of your employees wish to always receive a Claims Report, they may call our Rapid Response automated request line. The phone numbers are listed in the **GENERAL INFORMATION** section of this manual. When the automated line asks what they want, they should say "Continuous Claims Reports". You will find a guide to reading the Claims Report at the end of this section.

EXHIBITS

The Exhibits section of the Group Administrator's Manual includes the following:

- Group Administrator's Supply Request Form (MKT-30)
- Application for Enrollment (ENR-1)
- Student Dependent Certification Form (CAD-12)
- Incapacitated Dependent Certification Form (CAD-22)
- Notice of Receipt of Order and Procedures for Determining Whether Order is A QMSCO
- Request for Enrollment of Common Law Spouse in Group Coverage Form (MKT-262)
- Notice of Right to Elect Continuation of Coverage (MKT-116)
- COBRA Continuation of Coverage Application (ENR-270)
- Group Health Plan COBRA Election Form (MKT-365)
- Medical Expense Claim Form (CL-438)
- Major Medical Point of Sale Prescription Drug Claim Form (CL-94)
- Dental Expense Claim Form (CL-265)

Notice of Receipt of Order and Procedures for Determining Whether Order is a QMCSO

The (name of Health Plan) has received the attached medical child support order. Federal law prohibits the Administrator of the Plan from complying with the medical child support order unless it is a “qualified” medical child support order within the meaning of section 609(a) of the Employee Retirement Income Security Act of 1974, as amended. In determining whether an order is a qualified medical child support order (or “QMCSO”), it is the responsibility of the Administrator to determine whether the order satisfies the following requirements:

1. The order is a judgement, decree, or order (including approval of a settlement agreement) that relates to the provision of child support with respect to a child of an Employee who is eligible to participate in the Plan or provides for health benefit coverage to such child.
2. The order is made pursuant to a State domestic relations law (including a community property law) or enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by the Omnibus Budget Reconciliation Act of 1993) with respect to the Plan.
3. The order creates or recognizes the existence of an alternate recipient’s right to, or assigns to an alternate recipient the right to, receive benefits for which a participant is eligible under the Plan. An alternate recipient means any child of an employee who is recognized under a medical child support order as having a right to enrollment under the Plan with respect to such employee.
4. The order specifies the name and the last known mailing address (if any) of the plan participant and the name and mailing address of each alternate recipient covered by the order, provided that the name and mailing address of a state or local official may be substituted for the mailing address of the alternate recipient.
5. The order specifies a reasonable description of the type of coverage to be provided by the Plan to each such alternate recipient, or the manner in which such type of coverage is to be determined.
6. The order specifies the period to which such order applies.
7. The order does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by the Omnibus Budget Reconciliation Act of 1993).

A properly completed National Medical Support Notice will be treated as a QMCSO.

If the medical child support order is determined to be a QMCSO, an alternate recipient may designate a representative to receive copies of notices that are sent to the alternate recipient with respect to the medical child support order. An alternate recipient under a QMCSO shall be considered a Participant under the Plan for purposes of the reporting and disclosure requirements under ERISA, and a beneficiary for all other purposes under ERISA.

Any payment by the Claims Administrator for benefits under the Plan pursuant to a QMCSO to reimburse expenses paid by an alternate recipient or an alternate recipient’s custodial parent or legal guardian shall be made to the alternate recipient or the alternate recipient’s custodial parent or legal guardian.

ENR-270 (Rev. 1-2002)

