



**Arkansas  
BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

# **Blues*Enroll* Group Administrator's Manual**

Arkansas Blue Cross and Blue Shield  
P.O. Box 2181  
Little Rock, AR 72203-2181

Revised October 25, 2007

## *Section 1 - INTRODUCTION*

As the administrator of your group's health benefits, we know that your employees look to you for answers to their health insurance questions. In an effort to make your job easier, we have designed the Arkansas Blue Cross and Blue Shield Group Administrator's Reference Manual especially with you in mind.

We realize, that there are times when you will need to utilize the expertise of your Group Marketing Representative or your Group Service Representative. However, we also know that with reliable, current information, you are perfectly capable of answering many of your employees' questions. Not only does this save you time, but it also can strengthen the relationship you have with your employees in the administration of your group's health insurance.

We hope you will find this manual useful. As always, please let us know if there are additional steps we can take to improve our working relationship with you.

**This Group Administrator's Manual is only a guide. This description is not legally binding. The controlling terms of the Plan are set forth in the Benefit Certificate incorporated in the Arkansas Blue Cross and Blue Shield Group Policy. Any discrepancies between this guide and the Benefit Certificate will be resolved in favor of the Benefit Certificate.**

## Section 2 - GROUP ADMINISTRATOR'S RESPONSIBILITIES

Listed below are important points to remember as you perform your duties as group administrator. By following these guidelines, you assist us in providing you with the best service possible. Your cooperation is greatly appreciated.

- All permanent, full-time employees (minimum of 30 hours per week) are eligible for group coverage. Please ask new employees to complete the on-line electronic enrollment process. (See Section 3 for guidelines).
- **Arkansas Blue Cross and Blue Shield (Arkansas Blue Cross) will accept on-line applications transmitted no more than sixty days before the effective date of coverage. All other requirements for "timely" status will be observed**
- Please verify the accuracy of information submitted on Employee applications and change forms and assure this information is transmitted to the Company.
- Applications and changes in coverage must be communicated to the Company in a timely manner in the format required by the Company in order to be effective. The Company shall not be responsible for any applications or changes in coverage or errors in such applications or changes if proper procedures as required by the Company are not followed. The Company shall be entitled to rely upon any data submitted by an Employee or Policyholder in on-line format.
- Please obtain and maintain the documents described in Section 3 to support eligibility status of Employees and Dependents. You shall provide these documents to the Company upon request.
- If the new employee had prior creditable coverage from a former insurance carrier, a Certificate of Creditable Coverage, issued by the prior carrier or prior employer, should be maintained and available upon request of the Company
- Explain all eligibility periods to new applicants.
- Make sure all employees understand how effective dates are assigned. Arkansas Blue Cross calculates effective dates on a calendar month basis. The Employer Group Application has been revised to offer only a "monthly" option for waiting periods. For example: If the date of hire is 06-15-01 and the group has a 3 month waiting period, the effective date will be calculated as June 15-July 15 (first month), July 15-August 15 (second month), and August 15-September 15 (third month). If your group has a 15<sup>th</sup> of the month billing, the effective date would be September 15<sup>th</sup>. For first of month groups, the effective date would be October 1<sup>st</sup>. If your group has special needs regarding waiting periods, please contact your Marketing Representative. The request will need to be faxed or mailed on your company letterhead. This documentation will be placed in your group's file for verification of your request.
- Explain all waiting periods to new applicants.

- Make sure your payment reflects the total amount of your group billing. Please submit only one check for payment. Also, please write your group number and billing invoice number on your check.
- Do not add an employee's name to your group billing or pay for an employee whose name does not appear on the billing.
- Make premium payments to Arkansas Blue Cross for covered employees and their dependents every month, in advance (**before the due date**).
- Submit a Change Request form to change an employee's type of coverage (family, individual, etc.) and **remit the corrected amount when the change appears on the billing**.
- Remember to accurately and timely report employee and dependent eligibility changes and other information to Arkansas Blue Cross. If you fail to do so, your group is liable to Arkansas Blue Cross for any claims paid in error on behalf of such employees or dependents.
- Please remit Page #1 of your bill noting all adjustments to billed amount.
- Retain a copy of Page #1 for your records and send original to:

**ARKANSAS BLUE CROSS AND BLUE SHIELD**  
**P.O. BOX 2181**  
**LITTLE ROCK, AR 72203-2181**  
**ATTN: CUSTOMER ACCOUNTS**

- If there is any change in your address, phone number, etc., please notify your Group Service Representative as soon as possible.
- Remember, all correspondence to Arkansas Blue Cross should include your group's name and number and, if applicable, the identification number of employees.
- Make sure that the percentage of eligible employees covered by your group policy stays at or above the minimum number of insured employees as specified in your Group Policy. If the percentage of the eligible employees becomes less than the percentage of employee participation specified in your Group Policy, your Group Policy is subject to termination. Upon request, you will furnish Arkansas Blue Cross with information regarding current participation and contribution, and if required, provide documents to validate those numbers.
- Make sure that the percentage of your company contribution to employees' premium stays at or above the minimum percentage specified in your Group Policy. If the percentage of contribution becomes less than the percentage of contribution specified in your Group Policy, your Group Policy is subject to termination. (Minimum contribution to the employee premium is fifty percent (for groups 2-50), but your

group may elect to contribute a greater amount. (Also, for groups that contribute 100% of the employee premium, all full-time employees MUST enroll.)

- Fulfill legal COBRA obligation (See Section 9). Please remember that Arkansas Blue Cross shall not assume your (the employer's) obligation to provide benefits under COBRA if you fail to provide the required COBRA notices at the times specified in your Group Policy, nor shall Arkansas Blue Cross be responsible for providing any COBRA notices to employees or dependents.
- Fulfill legal HIPAA obligations. Your group agrees to indemnify and hold Arkansas Blue Cross harmless if any action or inaction of your group results in Arkansas Blue Cross being charged with violating HIPAA.
- Provide all employees and dependents appropriate communications and notices from Arkansas Blue Cross.
- The Group Policy is the legal, binding group agreement.
- Guidelines will be applied as indicated in this manual. Revisions will be made as policies and procedures are updated.

## Section 3 - GROUP COVERAGE GUIDELINES

### ENROLLING NEW EMPLOYEES

All permanent, full-time employees (minimum of 30 hours per week) are eligible for group coverage. Please ask new employees to complete the on-line enrollment process. All full-time employees should either enroll or waive coverage, if eligible. For groups that pay the entire employee premium, NO waiver of enrollment is allowed.

- On-line enrollment for insurance coverage should be completed and transmitted to Arkansas Blue Cross no more than sixty (60) days prior to the employee's effective date of coverage. Applications may be submitted less than sixty days before the effective date of coverage, but will still be required to be received within thirty days of the end of the Waiting Period to be considered timely.

### COVERAGE EFFECTIVE DATES

#### NEW EMPLOYEES

A new employee will be given coverage following the new employee waiting period, provided the on-line Application is transmitted in a timely manner. A timely Application is one that is received during the eligibility period or within (30) days following the end of the waiting period.

#### EXISTING EMPLOYEES

Employees may not apply for coverage or a change to family coverage except during a special enrollment period or the open enrollment period.

**Dental** policies are not subject to medical underwriting and do not have preexisting condition exclusion periods; therefore, there is no late enrollment in dental groups. Enrollment must occur at initial eligibility or at the group's open enrollment period (application must be received by Arkansas Blue Cross before the last day of the open enrollment period to be given the month of the anniversary as the effective date).

### IDENTIFICATION CARDS

Identification cards are sent directly to you, the group administrator, by Arkansas Blue Cross for distribution to appropriate employee(s). Please encourage your employees to keep their identification cards with them at all times.

### PREEXISTING CONDITION LIMITATIONS

#### APPLICATION OF PREEXISTING CONDITION EXCLUSION PERIOD

No benefits or services of any kind are provided under the Benefit Certificate for treatment of a preexisting condition, for a period of 12 months. This twelve (12) month period is referred to as the "look forward period." If the employee submits an on-line application for coverage during the Waiting Period, the twelve (12) month look forward period starts on the first day of the Waiting Period. If the employee did not apply within the Waiting Period, the look forward period starts on the employee or dependent's Effective Date.

This exclusion is not applicable to:

1. pregnancy
2. a newborn child who is covered under this group insurance contract or other creditable coverage within 90 days of the date of birth and continues to be covered without a sixty-three (63) consecutive day break in coverage.
3. an adopted child who is covered under this group insurance contract or other creditable coverage within 60<sup>1</sup> days of the date of adoption or the date the child is placed for adoption and continues to be covered without a sixty-three (63) consecutive day break in coverage.

Periods of Creditable Coverage will reduce the preexisting condition exclusion period. Please, refer to the Schedule of Benefits.

## CHANGES IN COVERAGE

### INCREASE OR DECREASE IN GROUP BENEFITS

If you would like to increase or decrease your group's benefits, please contact your Group Marketing Representative prior to your group's anniversary date. If you are increasing or adding benefits, a new application may be required<sup>2</sup>. **Changes must coincide with your anniversary date.**

### LOSS OF CONCURRENT COVERAGE

Plans and insurers must allow employees and/or their dependents who are eligible for, but not enrolled in, the group health plan to enroll in the plan when individuals are losing other coverage (including COBRA) and all the following conditions exist:

- A. The individual was covered under another group health plan or other health insurance when the employer's plan was first offered.
- B. The employee at that time provided a waiver that enrollment was declined due to existing other group health coverage or other health insurance, but only if the plan or insurer required the statement and the employee had received notice of the requirement.

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<sup>1</sup> Within 60 days of the date of adoption of the date the child is placed for adoption is more lenient than Federal guidelines.

<sup>2</sup> In some instances employees will be asked to complete the medical and health history questions on the application in order to allow our underwriters to assess if there is an additional or unusual risk in providing this group coverage which will cause an adjustment in the group's premium.

- C. The coverage was either COBRA coverage that was exhausted or other group health coverage terminated due to loss of eligibility or due to termination of the employer contributions toward coverage.
- D. The employee requests enrollment within 30 days of the end of the other health coverage.

## **NEW ENROLLMENTS OR CHANGES DUE TO SPECIAL EVENTS**

### **CHANGE DUE TO MARRIAGE**

If one of your employees marries, an on-line Application must be received within 30 days of the date of marriage to be considered a timely addition. The new spouse will be added to the Group Policy effective at the beginning of the policy month following the date of marriage. A timely addition is subject to a 12-month preexisting condition exclusion period that may be offset by prior creditable coverage.

If the Application is not received within 30 days of the date of marriage, the new spouse will be considered a late enrollee. The new spouse will have to wait until a Special Enrollment Period or the next open enrollment period to apply for coverage. The spouse added late is subject to a 12-month of preexisting condition exclusion period that may be offset by prior creditable coverage. Please obtain a certificate of marriage and make available to the Company upon request.

### **CHANGE DUE TO NEWBORN**

In order for coverage to commence on the date of the newborn child's birth, the member must enroll the child within 90 days of the date of birth. The timely addition of a newborn child is not subject to a preexisting condition exclusion period.

If an employee fails to enroll the newborn child within 90 days of the date of birth, it will be considered a late enrollee. The newborn child may not be enrolled until the next open enrollment period. Late addition newborns will be subject to a 12-month preexisting condition exclusion period. Coverage effective date will be the premium due date after approval. Proof of paternity (birth certificate listing the contract holder's name as father or mother, court order for child support, or paternity test results) will be required when the employee is unmarried and the child's last name differs from that of the employee. Please obtain the above referenced forms and make available to the Company upon request.

### **CHANGE DUE TO ADOPTION**

In the case of an adopted child, an employee must enroll the newly adopted child within 60 days of the date of adoption or the date the child is placed for adoption for the child to be considered a timely addition. The timely addition of an adopted child is not subject to a preexisting conditions exclusion period.

If an employee fails to enroll the newly adopted child within 60 days of the event, it will be considered a late enrollee. The newly adopted child will have to wait until the next open enrollment period to apply for coverage. A late enrollee is subject to a 12-month preexisting condition exclusion period. The employee will be asked to complete the medical questions on the application. **Adoption papers will be required in all instances.** The coverage shall terminate upon the dismissal, denial, abandonment or withdrawal of the adoption, whichever occurs first.

#### **CHANGE FROM FAMILY TO INDIVIDUAL COVERAGE**

If one of your employees would like to change from family coverage to individual coverage, he or she may only do so during a Special Enrollment Period or an open enrollment period. The change will be effective on the premium due date following the date of receipt in the home office.

A change from individual to "other" (employee/spouse, employee/child, or family) will require an on-line application be completed to add the dependent during a Special Enrollment Period in limited instances or during the open enrollment period.

#### **CHANGE DUE TO DIVORCE**

In the event of divorce, an Application/Change form must be completed to remove the former spouse. A divorced spouse is no longer eligible and must be removed by the end of the month of the date of divorce. In order to document the termination of eligibility, you will need to obtain and maintain a copy of the divorce decree and make this document available to the Company upon request.

**IMPORTANT: Please refer to Section 9 for COBRA information.**

#### **DEPENDENT COVERAGE**

A dependent is covered under the family coverage from birth to the end of the billing period in which the child becomes age 19, unless other provisions in the Group Policy have been agreed to in writing. *Note that a dependent child that reaches the limiting age is eligible for COBRA continuation. See Section 9.* It is the employee's responsibility to ensure that the employee's dependents are covered. Dependent age coverage is listed on the Schedule of Benefits.

A dependent is defined as the employee's natural child, a **stepchild** who is living in the home of the employee, or a legally adopted child. **Dependent children** who marry, lose their dependent status. Employees who have been awarded permanent custody of a child must furnish a copy of the court order stating such. **Temporary custody of a child** is not considered a basis for coverage.

#### **STUDENT DEPENDENTS**

A dependent child who is 19 years old but under the maximum dependent age as stated in your Group Policy (usually age 23), may be considered a

dependent, as long as he/she is attending an accredited 2 year or 4 year college or university (offering an Associates, Bachelors, or Masters) or an AR **State** vocational technical school. Proof of accreditation may be required. These do not include trade schools, such as beauty colleges, cooking schools, etc. A list of approved schools can be obtained from your Group Marketing Representative. Dependent students who are not attending school because of summer vacation are still considered dependents, if their intent is to enroll for the next semester. Enrollment registration documents will be required if the dependent has not enrolled one or more semesters and is now enrolling. Students will lose their dependent status if they fail to enroll in the next semester.

### **FORFEITING DEPENDENT STATUS**

If a child who is over age 19 but under the maximum age of your group policy quits school, he or she is no longer eligible for coverage. His or her coverage will be terminated, and the child has the right to elect COBRA, other continuation, or conversion option.

### **INCAPACITATED DEPENDENTS**

Continuation of insurance for a handicapped dependent child:

- A. If a Dependent is not capable of self-sustaining employment due to mental retardation or physical handicap, his insurance shall not terminate when the Child reaches the limiting age for dependency. The insurance shall continue as long as the Child remains handicapped, unless coverage terminates as described in the Termination of Dependent Insurance provision. The employee must give Arkansas Blue Cross proof that the Child is (1) incapable of self-sustaining employment and (2) chiefly dependent on the employee for support and maintenance.
- B. The employee must give Arkansas Blue Cross written proof after the Child reaches the limiting age for dependency and at any time after as BCBS may require. Arkansas Blue Cross shall not require proof more than once per year after the two (2) year period following the date the Child reaches the limiting age for dependency.

## **SPECIAL CIRCUMSTANCES REGARDING COVERAGE**

### **MILITARY SERVICE**

If an employee is called to active duty in the armed services of the United States of America, the Employee's (and any covered dependents) coverage may be continued on COBRA for a period of 18 months or under the Uniformed Services Employment and Reemployment Rights Act (USERRA). A former Employee returning from active military service may enroll in the Plan within 90 days of his or her return to employment, provided the Employer continues to sponsor the Plan and payment of premium is timely made. The Company may require a copy of the return member's orders terminating the active duty or other proof of the active duty or termination date thereof.

**OVER AGE 65**

A full-time (works 30 hours or more per week) employee who reaches age 65 has the choice of either continuing Arkansas Blue Cross group coverage or becoming a Medi-Pak member. An employee who chooses Medi-Pak must be billed to that employee's home address.

If one of your employees would like to become a Medi-Pak member, delete the employee from your group billing and submit a Medi-Pak Application within 31 days of the last billing. If there is no lapse in coverage, the employee can transfer to Medi-Pak. If the employee chooses to continue Arkansas Blue Cross group coverage, no action is necessary.

An employee turning 65 years of age also may take advantage of Medicare coverage. As the group administrator, you need to know which health plan pays first for people with Medicare. If you would like a copy of Medicare Secondary Payer: Information for Employers, or would like to receive an updated copy every year, please write to the address below and ask for CMS Booklet #02193:

**CENTERS FOR MEDICARE/MEDICAID SERVICES  
7500 SECURITY BOULEVARD  
BALTIMORE, MD 21244-1850**

**UNDERWRITING****ADDITIONS TO THE GROUP AFTER INITIAL ENROLLMENT****NEW HIRES**

New hires may be added to the group by completing and submitting an on-line Application, requesting coverage.

**REQUESTING EXCEPTIONS**

Exceptions requesting waiver of the eligibility period will **not** be granted. A group may, however, request their contract be amended to reflect the creation of multiple eligibility periods for **future** new hires and additions. These eligibility periods must be created for classes of employees only. For instance, Sole Proprietor, Partner, or Corporate Officer would be an identifier for executives. The word "Key Employee" is disallowed as an identifier.

**OMISSIONS AND ERRORS**

Arkansas Blue Cross bills every group one time each month. That bill lists each covered employee in the group and an amount due. It is very important that you, as the group administrator, verify that all covered employees are listed on the bill and that any terminated employees are indicated on page 1 of your bill (please refer to Section 5 for instructions on making adjustments to amount billed). Incorrect removal of an

employee may require the submission of payroll records to verify continued employment.

### **REFUNDS OF PREMIUMS**

If Arkansas Blue Cross terminates the coverage of an employee and/or dependent, premium payments received on account of the terminated employee and/or dependent applicable to periods after the effective date of termination shall be refunded to the Group within 30 days, and Arkansas Blue Cross shall have no further liability under your Group Policy.

If the Group terminates coverage of an employee and/or dependent, you must request Arkansas Blue Cross refund premiums paid for such employee and/or dependent's coverage within 60 days from the effective date of termination of such coverage. Failure of the Group to make a refund request within 60 days of the effective date of termination of the employee and/or dependent's coverage shall result in the Group waiving refund of any premiums paid for such coverage. If claims have been paid past the termination date, the payment amount of the claims will be deducted from premium refunds.

## **Section 4 - MANAGED DRUG PROGRAM**

### **OVERVIEW**

In an effort to help hold the line on escalating prescription medication costs, Arkansas Blue Cross and Blue Shield provides a Managed Pharmacy Program that will help maintain quality health care.

The information in this section will give you an overview of the Managed Pharmacy Program and help you find answers to questions about how employees can best utilize their benefits. Specific details about the employee's pharmacy benefits should be discussed with a Customer Service Representative of Caremark.

The Managed Pharmacy Program is designed to eliminate the need for claim forms when using a participating pharmacy. If an employee uses a non-participating out-of-state pharmacy, a claim form will be necessary for reimbursement of these charges. Pharmacy claim forms are provided upon request.

The Arkansas Blue Cross/Health Advantage Managed Pharmacy Program, administered through Caremark, contracts with more than 57,000 pharmacies nationwide to help ensure employee have access to the medications they need wherever they go.

Once a prescription is filled, the pharmacist will store the personal prescription history in a state-of-the art system to alert the pharmacist to dangerous drug interactions, allergies, sensitivities to medications, and chronic ailments. These quality assurance measures help to protect the employee and enhance the quality of care.

### **BENEFITS**

The Managed Pharmacy Program offers customers and their covered dependents benefits, including the following:

- Cost savings
- No claim forms
- Nominal co-payments and/or coinsurance
- Specialized customer service
- Access to an extensive pharmacy network

When an employee presents an ID card, participating pharmacists (working with the employee's physician) can closely monitor medication therapy. Pharmacists will be able to determine whether:

- The medication to be dispensed may combine in a harmful way with another medication currently prescribed.

- A prescription duplicates another prescription.
- The dosage or amount is being over-used or under-used.

**PRESCRIPTION IDENTIFICATION CARDS**

Arkansas Blue Cross members will receive a prescription identification card in addition to their medical ID card.

**COVERED MEDICATIONS**

The Managed Pharmacy Program generally covers most medications that require a prescription from a physician or other legally qualified person. Covered medications include:

- FDA-approved prescription medications.
- Prescriptions filled by a participating pharmacy.
- Insulin and insulin syringes.
- Some injectable medications, if approved in advance.

**MEDICATIONS NOT COVERED**

Medications not covered by the pharmacy program vary according to the group's benefit package. Please refer to your benefit certificate and Schedule of Benefits for more information about each plan.

**USING THE PROGRAM**

Employees with the Managed Pharmacy benefit have access to thousands of participating pharmacies throughout the nation, including most local and national chain pharmacies. Participating pharmacies collectively are referred to as the *pharmacy network*.

To find a participating pharmacy, an employee may ask their pharmacist if he or she is a member of the Caremark network. Or, he may call the toll-free number on the back of their ID card for information on the nearest participating pharmacies. Or access the on-line pharmacy locator at [www.arkansasbluecross.com](http://www.arkansasbluecross.com).

**PARTICIPATING PHARMACY PROCEDURE**

When employees go to a participating pharmacy to have their prescription filled, they must present their ID card to the pharmacist along with their prescription. At the time of purchase they will be expected to pay coinsurance and/or a co-payment and/or deductible, based on their group's Schedule of Benefits. The pharmacist will submit an electronic claim for reimbursement for the remainder of the payment.

There are no claim forms to complete, but employees will be asked to sign a log at the pharmacy as evidence they received the medication for insurance verification.

## NON-PARTICIPATING PHARMACY PROCEDURE

### IN-STATE

If employee use a non-participating pharmacy in their state of residence, the prescription is not covered through the Managed Pharmacy Program and is not eligible for reimbursement from the insurer.

### OUT-OF-STATE

If an employee uses a non-participating pharmacy outside their state of residence, the employee may pay at that time and then submit a prescription claim form. For reimbursement, please submit a claim form with a detailed medication receipt attached and send to the address indicated on the form.

## GENERIC VS. NAME BRANDS

Choosing generic medications, rather than brand-names, will save the employee money.

Brand-name medications are those for which a pharmaceutical company holds a patent. Once the patent expires, other manufacturers may produce the same drug. These medications bear the same chemical or *generic* name and, by law, must meet the same standards for purity, strength, quality and safety.

Generic medications are therapeutically equivalent to the original brand-name but usually cost significantly less. When employees select the less expensive generic form of a medication, they save money by reducing the co-payment and/or coinsurance amount they pay.

Most groups have a generic incentive as part of their benefit package. The generic incentive works this way:

1. When a brand-name medication is dispensed and there is no generic available that is suitable for substitution, or the physician has indicated on the prescription "Dispense as written," the employee pays the brand-name co-payment and/or coinsurance.
2. If a Brand medication is dispensed when a Generic medication is available and the physician has not indicated "dispense as written", the Member will pay the coinsurance (if applicable) and the 2<sup>nd</sup> or 3<sup>rd</sup> tier copayment plus the difference in price between the Generic and the Brand dispensed, or the cost of the medication, whichever is less.

## WHERE TO CALL FOR HELP

- Information on participating pharmacies
- What to do about lost cards
- Covered and non-covered medications
- How to receive additional claim forms

### **Caremark**

**Toll Free Number 1-800-863-5561**

***(This number is listed on the back of employees' ID cards)***

## FREQUENTLY ASKED QUESTIONS

### **Q. What does the covered employee do?**

A. The employee gives the pharmacist the membership card when requesting the prescription, new or refill. The employee provides the pharmacist with: patient name, date of birth and sex. The employee pays the pharmacist the appropriate amount (deductible or co-payment and/or coinsurance) in accordance with the group's benefits.

### **Q. Why should I use a participating (network) Pharmacy?**

A. You receive maximum benefits (and processing convenience) when you use a participating pharmacy.

### **Q. What if I obtain my prescription medications from a non-participating (non-network) pharmacy?**

A. If the pharmacy is located in your state of residence, you will have to pay for the prescription yourself, but if it is an out-of-state pharmacy, you may be reimbursed for your purchase by submitting a claim form.

### **Q. How do I get my prescriptions filled when I am traveling?**

A. If you plan to travel out of state and are on maintenance (ongoing, planned) medication, you may be able to obtain enough medication to last until you return home by contacting your usual pharmacy in advance. If you become ill or injured while traveling, you may use any pharmacy, pay for the medication "out-of-pocket" and submit a claim for reimbursement when you return home. (Note: Ask if the pharmacist is a member of the Caremark network. It may save you the trouble of filing.)

### **Q. Can a family member pick up my prescription?**

A. Yes, another responsible member of your family may obtain your medication at your request.

- Q. **My employee's college student dependent son or daughter is not listed on the pharmacy card. How do I correct that?**
- A. You must notify your Group Service Representative that the child is a full time dependent student. A new card will be issued.
- Q. **Do purchases of prescriptions with the pharmacy program go toward meeting the calendar year coinsurance maximum?**
- A. No.
- Q. **On a newly enrolled group, does the deductible that an employee met with the previous carrier count toward meeting the pharmacy program deductible (if any)?**
- A. Meeting a drug deductible with a previous carrier does not count towards the annual drug card deductible when the group enrolls with Arkansas Blue Cross.

## Section 5 - GROUP BILLING PROCEDURES

### GROUP REMITTANCE DUE DATE

The payment of your group billing is due on the first day of the billing cycle<sup>3</sup>. You should receive your group billing approximately ten (10) days prior to the due date. Payment for health care protection is, therefore, paid in advance. For example, if your due date is the first of the month, payment is received and credited for the first day through the end of the month. If your due date is the fifteenth of each month, pre-payment would extend from the fifteenth of the month through the fourteenth of the next month.

### GROUP BILLING INSTRUCTIONS

PLEASE REFER TO THE SAMPLE BILLING (Pages 5-3 through 5-5).

### PAGE 1 & 2 OF GROUP BILL - INSTRUCTIONS

Page 1 is for all adjustments for employees terminating employment prior to receiving the bill ONLY. to the invoice which change the amount due. Page 2 is a duplicate of Page 1 for your records.

**Example:**

Deletions

To complete adjustment area, enter employee name, ID number, amount of adjustment "Minus". Adjustment should only be taken for employees that have termed employment since the last billing.

***Failure to provide timely notice of a change in the eligibility status of an employee or dependent shall result in the group being liable to Arkansas Blue Cross and Blue Shield for any claims paid in error.***

1. Your **Group Number** will appear in this position on each page of the group billing.
2. **Invoice Number** - An invoice number is assigned to every statement.
3. **Group Billing Summary** - The summary includes the roster total, amounts due/credited from prior billings, adjustments, and the total amount due.

Calculate your amount of adjustments and enter in the space provided under the amount due. Subtract the "total of adjustments" from the amount due and enter in the space provided for total premium remitted<sup>4</sup>.

### PAGE 3 OF GROUP BILL - DESCRIPTION

This page provides a roster listing of each member of your group.

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<sup>3</sup> Payment by the due date will ensure that changes are reflected on your next billing.

<sup>4</sup> Please ensure that your check matches the total premium remitted and that your group and invoice numbers are on the check. Also please return Page 1 with your check.

4. **Benefit Package** - A detailed description of the health benefits provided within your group's policy.
5. **Contract Type** - Examples of Contract Types are employee, employee/children, employee/spouse, and family.
6. **Employee Adjustments** - These will be listed following the member roster.
7. **Outstanding Invoices** - If at the time the billing was generated your group had outstanding invoices (billings), those invoice number(s), due date(s), and amount(s) due would be recapped in this area.

**PAGE 4 OF GROUP BILL - DESCRIPTION**

**Contract Type Counts** - This section contains benefit package descriptions, which are descriptions of each benefit package listing all contract types provided in each package and the total number covered in each package.

**PAGE ONE OF GROUP BILL  
SAMPLE**

NOTE: PAGE TWO IS A  
DUPLICATE  
OF PAGE ONE FOR YOUR  
RECORDS

PAGE:	1
GROUP NUMBER:	000005
INVOICE NUMBER:	10000463
COVERAGE PERIOD:	09/01/97 TO 10/01/97
DATE PREPARED:	08/21/97



ANYWHERE ARKANSAS  
000 EAST BROADWAY  
NORTH LITTLE ROCK AR 72203

FOR BILLING QUESTIONS:  
UNIT ID:

PAYMENT DUE: 09/01/97

PLEASE RETURN THIS PAGE WITH YOUR PAYMENT  
USE THE RETURN ENVELOPE TO MAIL YOUR PAYMENT  
REMEMBER TO WRITE YOUR GROUP NUMBER ON YOUR  
CHECK

\*\*\* GROUP BILLING SUMMARY \*\*\*

ROSTER TOTAL	\$492.00
CARRY FORWARD	
Deletions due to terminations	\$246.00



AMOUNT DUE \$246.00

NOTE: ALL ADJUSTMENTS TO THE INVOICE AMOUNT MUST  
BE RECORDED BELOW OR ON A SEPARATE SHEET. IN LIEU  
OF THIS, A PHOTOCOPY OF YOUR BILLING WITH THE  
ADJUSTMENTS INDICATED MAY BE FORWARDED WITH YOUR  
PAYMENT.

ADJUSTMENTS \_\_\_\_\_

TOTAL PREMIUM REMITTED \_\_\_\_\_

\*\*\*\*\*

ADJUSTMENTS:

<u>NAME</u>	<u>ID NUMBER</u>	<u>AMOUNT</u>	<u>+/-</u>
-------------	------------------	---------------	------------

TOTAL OF ADJUSTMENTS	\$	_____
		_____

\*\*\*\*\*

## E-Billing (BluesEnroll)

**eBill Manager** is an on-line invoice presentation, adjustment and payment system. The software works in conjunction with BluesEnroll to provide total electronic capabilities for maintaining and updating your health plan. **eBill Manager** provides:

- Secure invoice delivery
- Ability to make adjustments to the invoice
- Online payment capabilities
- Consolidated invoices (health, dental , life, etc)
- Accrue up to 18 months of invoice history on line
- Ability to download invoices into Excel or PDF formats
- Ability to construct reports from invoices

Due to the electronic delivery of invoices, **eBill Manager** allows for invoices to be created two weeks later than traditional paper invoices, resulting in more time for transactions related to the health plan to be created and processed. The result is invoicing that more accurately reflect the status of your health plan membership.

In addition, **eBill Manager** allows you to make adjustments to the invoice for situations where cancellations or coverage reductions were not already created. Follow the on-line instructions to remove employees that no longer are on the health plan or to adjust the coverage level (employee only, family coverage, etc). Your payment due amount will be appropriately adjusted.

**eBill Manager** will create an email to your BluesEnroll message center alerting you to make the adjustments on the BluesEnroll system to match those adjustments made on the invoice. Please remember that a condition of using **eBill Manager** is the requirement to obtain and retain all "change form" documents (signed by the employee) authorizing changes to coverage levels or for dropping health coverage.

Note that additions to the health plan membership must be made through BluesEnroll, and the invoice cannot be adjusted to reflect new enrollees (these will be adjusted on the next invoice).

**eBill Manager** is supported by the regional Internal and External Group Service Representatives. For help in obtaining access to **eBill Manager** or for assistance in using the product, please contact your local regional office.

## Section 6 - TERMINATION OF GROUP INSURANCE

### TERMINATION FOR NON-PAYMENT OF DUES

All premium payments are due and payable in advance. Any premium for this insurance which is not paid on or before the date it becomes due is in default. After the first premium payment, the Group may be allowed a 30-day Grace Period. During the Grace Period, there is no interest charge. Although the insurance shall remain in force during the Grace Period, Arkansas Blue Cross shall have the right to delay the processing of claims for services received by employees or dependents during the Grace Period, pending the payment of the premium due.

If your group health insurance is canceled for non-payment of premium, your company will be liable to Arkansas Blue Cross and Blue Shield for the following:

- A. Payment of all premiums which are due or unpaid at the time of termination, or
- B. For reimbursement of all claims incurred and paid during the grace period, whichever is greater.

In addition, if coverage does terminate, you will be responsible for providing notification of termination to all covered employees.

The following is a brief overview of our delinquency and reinstatement procedures:

### DELINQUENCY PROCEDURES

1. Approximately 20 days after the premium due date, a delinquency letter will be sent to the group.
2. If payment has not been received by the end of the group's grace period on the 32nd day after the premium due date, a cancellation letter will be sent via certified mail, confirming the group's cancellation for non-payment of premium.

### REINSTATEMENT PROCEDURES

In the event your group is canceled for non-payment of premium, your group coverage may be eligible for reinstatement. The following is required for reinstatement to be **considered**:

1. Payment for all premium due by Cashier's Check.
2. Payment of a non-refundable reinstatement application fee in the amount of \$350 to cover reinstatement processing, and
3. Completion and return of a signed Group Application for Reinstatement.

The above requirements must be met within fifteen (15) days of the date of the cancellation letter. Your request will then be forwarded to a designated

Underwriter for review. Within 3-5 working days, your group will be notified of our decision regarding the reinstatement request.

All efforts will be made by Arkansas Blue Cross to collect either past due premium, or reimbursement for all claims incurred and paid during the grace period, whichever is greater. If payment is not made, delinquent accounts will be referred to a Collection Agency.

#### **TERMINATION OF INSURANCE PER GROUP REQUEST**

The group may elect to terminate the group's insurance policy with Arkansas Blue Cross on any advance premium due date. If your group wants to terminate your group insurance on any premium due date you must give Arkansas Blue Cross **written notice of termination** in advance of the premium due date. Please fax notices to **(501) 378-3248** or mail to:

**ARKANSAS BLUE CROSS AND BLUE SHIELD  
ATTN: CUSTOMER ACCOUNTS  
P. O. BOX 2181  
LITTLE ROCK, AR 72203-2181**

If written notice of termination is not received in advance of the group's premium due date, the group will be liable to Arkansas Blue Cross for payment of all premiums which are due but unpaid or for reimbursement to Arkansas Blue Cross for all claims incurred and paid during the grace period, whichever is the greater amount.

A group that terminates for any reason will not be allowed to re-enroll for a period of six months.

If this policy terminates because the Policyholder has failed to pay the premium, the Policyholder shall not be eligible to reapply for another Policy with the Company for a period of six months from the date this policy terminated. If the Policyholder wishes to reapply, and still owes premium or claims from a previous cancellation, no reapplication will be considered until the Policyholder pays, via Cashiers Check, either all premiums which were due but unpaid at the time of termination, or reimbursement to the Company for all claims incurred and paid during the grace period, whichever is the greater amount; and a **\$500** fee to cover the various costs resulting from the termination and reinstatement.

**Section 7 - COORDINATION OF BENEFITS (COB)**

**COB SAVINGS**

COB Savings is the difference charged to the utilization of the group based on Arkansas Blue Cross and Blue Shield's status as the **primary payer** versus the **secondary payer**.

For example, if one of the employees had a \$1,000 claim, and Arkansas Blue Cross is the primary payer, we would pay 80% or \$800 (assuming the co-pay is 80% and the deductible has been met and the charge is less than the maximum allowance set by Arkansas Blue Cross).

**EXAMPLE 1:** Arkansas Blue Cross as the Primary Payer

Arkansas Blue Cross would pay  
80%  
 $\$1,000 \times 80\% = \$800$

If Arkansas Blue Cross is the secondary payer, we will pay contract benefits (80%), or the balance of the bill, whichever is less. In the above example, \$800 would be the 80% contract benefit; however, the balance of the bill, \$200, would be paid because it is the lesser amount.

**EXAMPLE 2:** Arkansas Blue Cross as the Secondary Payer

The other insurance company would pay 80%<sup>5</sup>  
 $\$1,000 \times 80\% = \$800$

Arkansas Blue Cross pays the  
difference  
 $\$1,000 - \$800 = \$200$

Charge	\$1,000	Our allowance	\$800
Other paid	<u>\$ 800</u>	Secondary pay	\$200
Balance	\$ 200		

<sup>5</sup> Other insurance companies may or may not pay 80%

Remember, the COB Savings is the difference charged to the utilization of the group based on Arkansas Blue Cross's payment status. Therefore, in **Example 2**, instead of \$800 being charged to the utilization of the group, only \$200 is charged — a COB Savings of \$600.

### **COB LETTERS**

In order to determine Arkansas Blue Cross's liability (primary or secondary payer), our Coordination of Benefits Division will mail letters to your employees asking for assistance. Because the requested information plays a role in determining your group's utilization, it is important that these letters are completed and returned as soon as possible.

If we have not received a response in 15 days, the claim(s) will be denied until the requested information is received.

Listed below are some examples of the most common COB letters:

- Our letter labeled C-00010 asks if dependents or the policyholder are covered by any other insurance policy.
- Once a year, our COB files are updated using the information provided in response to our letter labeled C-00020 it asks if there have been any changes in your employees' coverage by other insurance companies.
- Our letter labeled C-00030 asks for clarification of custody in regard to the insurance of your employees' children. (In case of divorce, the parent with custody of the child is primary unless the court has declared otherwise.)

Please encourage your employees to respond as quickly as possible to the COB letters.

## ***Section 8 - HOW TO FILE A CLAIM***

We have made it easier for you and your employees to file a claim. Whenever medical treatment is received at a physician's office or a hospital, present the Arkansas Blue Cross identification card. This is the first step towards receiving benefits under the benefit program.

In most cases, the hospital or physician will file a claim. All participating (in-network) providers have agreed to file claims on behalf of their patients covered under one of our plans. Arkansas Blue Cross will then pay the provider of the health care and send the employee an Explanation of Benefits (EOB) showing the amount of payment and the amount the employee is responsible for paying.

If a physician will not file a claim directly, the employee should obtain an itemized bill, complete the top section of the claim forms, attach the itemized bill, and send to:

***ARKANSAS BLUE CROSS AND BLUE SHIELD  
P.O. BOX 2181  
LITTLE ROCK, AR 72203-2181  
ATTN: CLAIMS***

## Section 9 - GENERAL GUIDELINES ON COBRA

If your group is subject to COBRA, there are a number of requirements with which you, the employer or plan administrator, must comply. These include, but are not limited to, the following:

- notifying all employees and their covered dependents of all of their rights under COBRA when they first become covered under the group health plan, using correct and up-to-date verbiage;
- notifying, within 14 days of a Qualifying Event, all employees and their covered dependents of their continuation rights, benefits, and premium rates for the plan(s) in which they are eligible, using correct and up-to-date verbiage;
- adhering to election rights of Qualified Beneficiaries;
- correctly administering coverage of COBRA continuants on an ongoing basis until rights to benefits are exhausted.

Please remember that the above information is a summary, only. For full details please refer to the actual COBRA regulations.

Under our contract with your group, Arkansas Blue Cross and Blue Shield does not assume your (the employer's) obligation to provide benefits under COBRA if you, the employer, fails to provide these notices at the time specified, nor shall Arkansas Blue Cross be responsible for providing any COBRA notices to employees or dependents.

Questions regarding COBRA require Application of a complex and constantly changing set of federal regulations. Therefore, acquiring competent COBRA advice requires legal counsel with expertise in COBRA. This is why we have contracted with Ceridian, the nation's largest COBRA administrator, to assist you in administering your COBRA obligations. If you choose not to use Ceridian, we ask that you seek legal counsel competent in the area of COBRA law.

***Please remember, if you are not in full compliance with COBRA, you may be liable for an IRS excise tax of up to \$200 per employee for each day of noncompliance, and ERISA penalties of \$110 per employee per day of noncompliance. Court awards may involve claims costs, attorneys' fees, and other expenses.***

Following is a brief summary of the process which occurs between Arkansas Blue Cross, Ceridian, and the employer.

### GENERAL NOTICES OF COBRA RIGHTS AND OBLIGATIONS

- A. Employer notifies Ceridian of the newly covered employees and dependents, by either submitting electronic forms to Ceridian via the Web, sending a file in Ceridian specifications, or sending these notices to Ceridian by fax or mail using paper forms.

- B. Ceridian sends out the General Notices via USPS first class mail with proof of mailing once the group informs Ceridian of the newly covered employees and dependents, and archives the Notices.

#### **INITIAL QUALIFYING EVENT / ELECTION OF EMPLOYEE**

- A. Employer notifies Ceridian of the Qualifying Event, within 14 days of the Qualifying Event, by either submitting electronic forms to Ceridian via the Web, sending a file in Ceridian specifications, or sending these notices to Ceridian by fax or mail using paper forms.
- B. Ceridian sends out the Qualifying Event Notices via USPS first class mail with proof of mailing once the group informs Ceridian of the Qualifying Event, and archives the Notices.
- C. Employer notifies Arkansas Blue Cross to terminate coverage by writing the employee name, ID number, amount of adjustment, and if amount is "plus" or "minus", employee's name and contract number on page 1 of your bill with a minus sign and the amount of premium.
- D. Employee/dependent(s) has 60 days to elect, from the date of the notification to the employee or the benefit termination date, whichever is later, COBRA coverage.
- E. If the employee/dependent(s) elects coverage, Ceridian bills him/her for all premiums due to current date.
- F. From the date of COBRA election, the employee/dependent(s) has 45 days to return the full payment to Ceridian.
- G. When payment is received by Ceridian, a form called a Participant Update (on PINK paper-see sample form) is sent or faxed to the employer (usually a 48 hour turnaround).
- H. Upon receipt of the Participant Update form, the employer is to fax the form to the Customer Accounts Division to re-establish appropriate coverage

**ARKANSAS BLUE CROSS AND BLUE SHIELD  
CUSTOMER ACCOUNTS FAX NUMBER:  
(501) 378-3248**

***Or mail to:***

**ARKANSAS BLUE CROSS AND BLUE SHIELD  
P. O. Box 2181  
LITTLE ROCK, AR 72203-2181  
ATTN: CUSTOMER ACCOUNTS**

## **ONGOING ADMINISTRATION**

### **Relationship between Ceridian and the employer:**

1. Ceridian bills COBRA continuants in advance, on or about the 19th of the month.
2. The COBRA continuants' premium payment must be postmarked on or before the applicable 30-day grace period expiration date.
3. Ceridian remits an activity report (Participant Status Report) and a check to the group for all premiums collected, on or about the 10th of the month after the month of coverage.
4. Ceridian notifies the group of all enrollment changes or terminations of COBRA coverage throughout the month by sending or faxing Participant Update forms (PINK in color).

### **Relationship between Arkansas Blue Cross and the employer:**

1. Arkansas Blue Cross bills the group in advance for the following month of coverage.
2. Since the COBRA premium will not be sent to the group until the following month, Arkansas Blue Cross will bill in arrears for premium due or refund the group premium paid whichever is applicable.
3. It is the responsibility of the group to notify Arkansas Blue Cross of any COBRA participant's enrollment changes or terminations by faxing the Participant Update form (PINK in color) upon receipt from Ceridian to Customer Accounts (501) 378-3248.

### **WHERE TO CALL IF YOU HAVE QUESTIONS REGARDING COBRA, IF YOU ARE UTILIZING CERIDIAN'S SERVICES.**

***Ceridian***  
***3201 34th Street South***  
***St. Petersburg, FL 33711***  
***Client Services: 1-800-488-8757***  
***Continuant Services: 1-800-877-7994***  
***www.ceridian-benefits.com***

# SAMPLE PARTICIPANT UPDATE FORM

## Ceridian National Service Center

### PARTICIPATE UPDATE FORM

### IMPORTANT: NOTIFY CARRIER OF THIS CHANGE IMMEDIATELY

TO: GROUP ADMINISTRATOR  
 GROUP NAME  
 GROUP ADDRESS

RE: CONTINUANT NAME  
 CONTINUANT ADDRESS

ACTION: i.e., CANCELLATION, TERMINATION, REINSTATEMENT, ELECTION AND REASON

Soc Sec Number:	000-00-0000	QE Date	:	08/02/96
Relationship :	EMP	Ben Term Date		08/31/96
Sex :	M	Election Date		09/04/96
Date of Birth :	07/30/61	First Paid Date		10/21/96
Benefit Class :	B02			
Reason for QE :	TERMINATION OF EMPLOYMENT			

<u>*Cov</u>	<u>Carr</u>	<u>Carrier Name</u>	<u>Option</u>	<u>Status</u>	<u>Group Number</u>
<u>Type</u>	<u>Code</u>				
M	ABC1	ARKANSAS BLUE CROSS AND BLUE SHIELD	A	Indiv+2/Fam	024281001

\* Note: M=Medical  
 D=Dental  
 V=Vision  
 H=Hearing  
 P=Prescription  
 O=Other  
 S=Same as Continuant  
 W=Sponsored Dependent  
 X=Class II Dependent

Ceridian National Service Center 34125 US Hwy 19 N. Palm Harbor, FL 34684 (800) 488-8757

## Section 10 - STATE OF ARKANSAS LAW GOVERNING CONTINUATION OF COVERAGE BEYOND TERMINATION

Groups not eligible for COBRA may be subject to the State of Arkansas' continuation of coverage law. In certain situations this Law allows the extension of coverage for up to 120 days.

A covered person whose employment terminates or dependency status changes shall have the right to elect continuation of coverage under the Policy as outlined below. In order to be eligible for this option, the covered person must:

- Have been continuously covered under the Policy for at least three (3) consecutive months prior to employment termination or change in dependency status; and
- Make the election by notifying the Company in writing no later than 10 days after the employment termination or change in dependency status.

### **CONTINUATION SHALL TERMINATE ON THE EARLIEST OF:**

- One hundred twenty (120) days after the date the election is made;
- The date the Covered Person fails to make any premium payments or the Policyholder fails to pay the premium to the Company;
- The date on which the Covered Person is or could be covered by Medicare;
- The date on which the Covered Person is covered for similar benefits under another group or individual Policy;
- The date on which the Covered Person is eligible for similar benefits under another group Plan;
- The date on which similar benefits are provided for or available to the Covered Person under any state or federal law;
- The date on which the policy terminates.

Should you need additional information, please contact your Group Service Representative.

## Section 11 - COMMONLY ASKED QUESTIONS

Listed below are some of the most common questions asked of our Group Service Representatives. Please feel free to telephone us with any questions that you may have. However, you may want to refer to these questions and answers for certain information.

- Q. If an employee is on disability leave, how long can the employee be covered on the group plan?**
- A. The maximum period of time an employee on disability can be covered through the group is six months. At the end of the six months, the employee would have the following options:
- Return to work;
  - State of Arkansas 120-day continuation policy;
  - Convert to COBRA, if applicable; or
  - Drop coverage.
- Q. I have an employee who was canceled from our group by mistake. How do I add them to the group again?**
- A. Contact your Group Marketing Service Representative, and request that the employee be added back to the group coverage. The underwriting department may require payroll records to prove continuous coverage.
- Q. Can an Arkansas Blue Cross and Blue Shield member transfer from one group into another group with continuous coverage?**
- A. A employee may transfer from one group into another group with time credit. A 12-month preexisting condition exclusion period will be applied to that employee, however, creditable coverage from the prior group will be applied against that exclusion period. If that creditable coverage is 12 months or more, the preexisting condition exclusion period would not apply.
- Q. How does an employee obtain a Certificate of Creditable Coverage upon termination.**
- A. A Certificate of Creditable Coverage will be automatically generated and mailed to the last known address of the employee.

Each group was mailed a generic form of the Benefit Plan Certificate of Coverage. You, as group administrator, may complete a copy of this form and present it to the terminated employee at the time of termination or at the exit interview.

- Q. Does our group have an open enrollment at the time of our anniversary?**
- A. Yes. During the Open Enrollment Period, employees covered in the Plan may change their coverage, and that of their covered dependents. Unless otherwise designated in the Group Policy, enrollments and coverage changes made during the Open Enrollment Period become effective on the anniversary date of the Group Policy.
- Q. Do you have continuous coverage if you transfer from a group policy to the Arkansas Blue Cross Conversion Policy?**
- A. Yes. Arkansas Blue Cross's conversion policy requires no medical underwriting.
- Q. An employee will soon be getting married. When can the employee change to family coverage?**
- A. If an employee marries, an Application must be received within 30 days of the marriage to be considered a timely addition. The new spouse will be added to the group policy effective at the beginning of the month of following the marriage. The spouse that is considered a timely addition is subject to a 12-month preexisting condition exclusion period that may be offset by prior creditable coverage. A copy of the marriage license will be required.
- Q. An employee just found out that she is pregnant. When should she change from an individual policy to a family policy?**
- A. Either prior to the birth of the child or as soon following the birth as possible. The employee has 90 days to add the newborn child to have the Application to be considered timely.
- Q. An employee has a family policy and needs to add a dependent. What do they need to do?**
- A. Please see sections regarding marriage, new births, and adoptions (Please refer to Section 3).
- Q. An employee would like to change their policy from family to individual. When will the change be effective?**
- A. The change will be reflected on the next billing cycle, after approval of the Change Request form.
- Q. Can a dependent student who is out of school for a period of time, converts to COBRA coverage, then goes back to school, return to his/her parent's family policy with continuous coverage with no medical underwriting?**
- A. Yes. Please contact your Group Service Representative and request that the dependent be added back to the parent's policy.

- Q. **Will Arkansas Blue Cross allow for time credit for children who are transferring from one parent's contract to the other parent's contract because of divorce custody?**
- A. Yes. Provided the dependent has had 12 months or more or prior creditable coverage, and there is not more than a sixty-three (63) day lapse in coverage between carriers.
- Q. **We have a new employee who has had other insurance that was not group coverage. Will the employee have creditable coverage from that insurance?**
- A. As defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), individuals who have any of the following types of Health Care Plans will be entitled to transferable creditable coverage:
1. Other group health plans (including COBRA)
  2. Individual Major Medical coverage
  3. Medicare Part A or B
  4. Medicaid
  5. CHAMPUS
  6. Federal Employees Health Benefit Plan (FEHBP)
  7. Medical care programs of Indian Health Services or tribal organizations
  8. State health benefits risk pools
  9. Public health plans
  10. Peace Corps health plan

## Section 12 - FORMS

### 1. **Group Enrollment Form**

This form is used to enroll an employee in your group's health program. Employees who decline coverage when it is initially offered to them must complete the medical section (Section 6) when applying for coverage.

### 2. **Change Request Form**

This form is used to make changes to a previously enrolled employee's coverage.

### 3. **Dental Application and Change Form**

This form is used to either enroll an employee in your group's dental program, or to make changes to a previously enrolled employee's coverage

### 4. **Application for Conversion Policy**

This form must be completed when you have someone who is leaving your group who wishes to continue with Arkansas Blue Cross and Blue Shield on a direct basis. Conversion is also available to employees who have exhausted their COBRA eligibility. This form must reach our offices within 31 days of the last day the employee is covered through the group.

### 5. **Health Claim Form**

This form is used to submit medical charges for benefits that were not filed by the physician or health care professional. There are step-by-step instructions on how to file charges on the reverse side of the claim form.

### 6. **Dental Claim Form**

This form is used to submit dental charges for benefits that were not filed by the dentist.

### 7. **Prescription Claim Form**

This form is used to submit prescription charges for reimbursement in cases where payment has previously been made by an insured.

Any of these forms, applications, etc., may be obtained by contacting your Group Service Representative. If you have any forms other than the ones indicated or if you need other supplies that are not listed, please check with your Group Service Representative.

As Group Administrator, you have an obligation to check each form to be submitted for completion, accuracy, and the filing of such in a timely manner. Incomplete forms cannot be processed, and will delay your employee from receiving benefits.

Sample Copies of forms:

1. GROUP ENROLLMENT FORM
2. CHANGE REQUEST FORM
3. DENTAL APPLICATION AND CHANGE FORM
4. APPLICATION FOR CONVERSION POLICY
5. HEALTH CLAIM FORM
6. DENTAL CLAIM FORM
7. PRESCRIPTION CLAIM FORM

**Section 13 – HOSPITAL ADMISSION PRE-CERTIFICATION/PRE-NOTIFICATION REQUIREMENTS**

See the member's Member card for the toll free number to call. If you have questions about any of the requirements listed on the following table, call the customer Service or Provider Service number on the membership card.

<b>Admission Pre-Certification Requirements For Arkansas Blue Cross and Blue Shield and its Affiliates</b>		
PRODUCT LINE	ADMISSION PRE-CERTIFICATION	OUTPATIENT PRE-CERTIFICATION
Arkansas Blue Cross and Blue Shield	<b>NO</b> <b>Exceptions:</b> Federal Employee Program (FEP) and out of network	<b>NO</b>
Federal Employee Program (FEP)	<b>YES</b> <b>Please note:</b> All ID cards have the Arkansas Blue Cross logo and ID #s begin with "R."	<b>NO</b>
Access Only	<b>YES</b> <b>Please note:</b> Any ID card with the Arkansas' FirstSource logo (without the Blue Cross and Blue Shield symbols) requires pre-certification.	<b>NO</b>
Health Advantage	<b>NO – All Regions</b> <b>Exception:</b> out of network	<b>NO – All Regions</b>
BlueAdvantage Administrators of Arkansas	<b>YES</b>	<b>YES</b> (Certain groups call 1-800-USAb1 to verify.)

**If you have questions regarding pre-certification requirements for any of our products, please call Customer Service in your local regional office.**

## **Section 14 - True Blue PPO**

True Blue PPO is a PPO network used by fully insured products including ABCBS, FEP and BlueCard. It is made up of doctors, hospitals, and other health care professionals who sign contracts with True Blue PPO agreeing to accept our allowance to care for covered employees. PPO stands for Preferred Provider Organization.

### **FREQUENTLY ASKED QUESTIONS**

**Q. Can employees choose their own doctor? Can they choose their own hospital?**

A. Yes, they can go to any provider they wish, whether they are PPO providers or not.

If they go to a provider that does not participate in the True Blue PPO, their Arkansas Blue Cross and Blue Shield insurance will pay less of their doctor or hospital bills, once they have met their deductible, than if they had gone to a PPO participating provider.

In other words, Arkansas Blue Cross will pay more of their bill once they meet their deductible if they go to a PPO participating provider.

**Q. How much more will an employee pay if they use an out of network doctor or hospital?**

A. Normally 20%, depending on your group contract.

**Q. Can an employee stay with their present doctor / OB-GYN / pediatrician?**

A. If their present doctor, OB-GYN, or pediatrician has contracted with True Blue PPO, they can remain with their doctor, and their covered charges will be paid on an in-network basis.

If their present doctor is not a PPO doctor, their charges will be paid on an out-of-network basis.

They can remain with their non-PPO doctor, but they will be paying more out-of-pocket for their covered medical and hospital charges once they meet their deductible if their doctor is not in the PPO.

**Q. Why should we choose a PPO?**

A. Health care costs are a major burden, and they continue to increase. The PPO holds down the cost of health care by finding doctors and hospitals, and other participating providers who will agree accept our allowance for their services, in exchange for being part of the PPO network.

**Q. What happens if an employee has an emergency medical situation and must be treated by an out of area doctor or hospital?**

A. They should go to the nearest doctor, hospital or other medical facility and seek treatment for their emergency. It will be paid as an in network (PPO) claim. Refer to your certificate for definition of medical emergency.

- Q. **What about dependent students who go to school and live outside of a PPO area? Are their claims paid as in-network or out-of-network?**
- A. Dependent students who live and go to school in an out of network area, and who seek treatment in that area will have their claims paid as if they were in-network. In order for claims to be handled as expeditiously as possible, please advise of any dependents to whom the above applies.
- Q. **How can a doctor or hospital get into the PPO?**
- A. If a doctor or hospital wants to discuss participation in the PPO, they can contact the Network Development Representative at the Regional office.
- Q. **Whose responsibility is it to call to pre-certify a hospital admission?**
- A. It is the covered employee's responsibility to call to pre-authorize a hospital admission.
- Although a covered employee's physician's office may often make the call, the employee is responsible to see that the call is made, whether by the covered employee personally, the doctor, or someone else, such as another member of the household.
- Q. **How are out of state employees covered?**
- A. Out-of-state employees who live outside our network areas are covered under a standard comprehensive major medical plan.
- This is true for newly enrolled groups and currently enrolled groups that change to the PPO.
- Q. **Does an employee have to fill out different claim forms or follow different claim filing procedures now that we are under the PPO?**
- A. The claim forms and claim filing procedures are the same under the PPO as under your old plan.
- Q. **What are the PPO areas? How does an employee know if they are in-area or out-of-area?**
- They should consult the PPO directory to see which doctors and other health professionals have contracted with the PPO. The directory may be accessed through the ABCBS website [www.arkansasbluecross.com](http://www.arkansasbluecross.com).

## ***Section 15 - THE BLUE BOOK***

The Blue Book is a periodically published directory of all health care professionals and facilities that agree to accept Arkansas Blue Cross and Blue Shield's allowances.

The agreement with physicians is called the Preferred Payment Plan (PPP). To establish payment rates for physicians and other health care professionals, Arkansas Blue Cross has established and maintains a Schedule of Maximum Allowances. Arkansas Blue Cross utilizes the Resource Based Relative Value System (RBRVS) as a guide in establishing fees. RBRVS has been developed with input from thousands of providers, and has become industry standard for establishing physician payments. Providers who appear in The Blue Book have agreed to accept the Arkansas Blue Cross fee schedule as their maximum payment, and cannot collect amounts greater than the schedule for covered services to those insured by Arkansas Blue Cross.

With hospitals, the agreement is known as the Hospital Reimbursement Program. Arkansas Blue Cross determines hospital payment rates using the Diagnosis Related Groups (DRG's) classification system which groups hospital patients according to similar diagnostic criteria and other characteristics.

By having these agreements with providers, Arkansas Blue Cross assures that the agreed payment level is paid directly to the physician or the hospital and the customer cannot be charged except for deductibles, co-payments or non-covered services established in the benefit contract. For you, the most important aspect of these unique contractual relationships is cost predictability.

## **Section 16 - THE FAMILY AND MEDICAL LEAVE ACT OF 1993**

### ***(Federal Law) Employer Responsibilities***

#### **GROUPS THAT ARE SUBJECT TO THIS ACT**

If your group has employed 50 or more employees for each working day during each of 20 or more calendar work weeks in the current or preceding calendar year, this Act applies to your group.

#### **FAMILY LEAVE**

If your group is subject to this Act, you must grant an employee up to 12 weeks unpaid leave for the following reasons:

- for the birth or placement of a child for adoption of foster care;
- to care for an immediate family member (spouse, child, or parent) with a serious health condition; or,
- to take medical leave when the employee is unable to work because of a serious health condition.

To be eligible for FMLA benefits, an employee ***must***:

- work for a covered employer;
- have worked for the employer for at least a total of 12 months;
- have worked at least 1,250 hours over the prior 12 months; and,
- worked at a location where at least 50 employees are employed by the employer within 75 miles.

If an employee takes family leave under this act, the employer must keep paying the employee's health care coverage during the leave, just as if the employee were at work.

***We suggest that the employer make sure that the employee's portion of the premium, if any, is paid during the leave, so that the employee's coverage continues unabated during the leave, even if the employee fails to pay his or her portion of the premium.***

Keeping the employee's coverage in place and paying for it during the leave of absence will keep the employer in compliance with the requirement that the coverage resume unchanged when the employee returns from the leave. If the employee's coverage were to lapse during the leave, he or she would have to reapply for coverage, subject to a 12-month preexisting condition provision, less any periods of creditable coverage which may reduce this period.

In other words, if coverage lapses for non-payment during the leave, the coverage would not resume as it was before. The employer would, therefore, have to bear the cost of coverage of any preexisting condition or find alternative coverage for the employee.

If the employee does not return to work at the end of the family leave period, the employer may recover the unpaid premium, unless the employee is not returning to work due to serious illness or other circumstance beyond the employee's control.

***For Additional Information: Contact the nearest office of the U.S. Department of Labor, Wage and Hour Division***

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