



# **Health Advantage**

An Independent Licensee of the Blue Cross and Blue Shield Association

# **GROUP ADMINISTRATOR GUIDELINES**

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Issued by

HMO Partners, Inc.  
d/b/a Health Advantage  
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# HEALTH ADVANTAGE GROUP ADMINISTRATOR GUIDELINES

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## 1.0 INTRODUCTION

These Group Administrator Guidelines are for use by Employer Groups that enroll on-line or submit paper enrollment forms that provide eligibility to Health Advantage directly or through a third party eligibility vendor. The purpose of the guidelines is to assist Group Administrators in the administration of the health benefits for their employees. These guidelines are not contractual or binding in nature, but are intended to provide procedures for administering health benefits to eligible employees. The Health Advantage Group Contract and Evidence of Coverage contain all contractual obligations of an enrolled group. Please refer to the Group Contract and Evidence of Coverage for the terms, conditions, limitations, and exclusions of the contract.

### **Membership materials included with the first premium billing statement to the Group:**

1. **Group Contract** - Covenants of the Group.
2. **Evidence of Coverage** - Contractual requirements for administration of the contract.
3. **Benefit Riders (if applicable)**
  - Managed Pharmacy Benefit Rider - contains benefits, limitations, and exclusions for prescription medication coverage
  - Mental Health/Substance Abuse Rider, Hearing Aid Rider, or TMJ Rider (if applicable) – Specific Riders replace benefits in the Evidence of Coverage
4. **Any other group specific Information**

***The Group Administrator Guidelines manual and all Health Advantage forms may be printed from web site [HealthAdvantage-hmo.com](http://HealthAdvantage-hmo.com), located on the Employers tab.***

## 2.0 GENERAL INFORMATION ABOUT HEALTH ADVANTAGE

Health Advantage is a Health Maintenance Organization and offers health plans to employers located in the state of Arkansas. The Service Area includes the entire state of Arkansas with seven regional offices, each having a Customer Service Department:

CENTRAL REGION: Little Rock, AR - 1-800-843-1329

NORTH EAST: Jonesboro, AR - 1-800-299-4124

NORTH WEST: Fayetteville, AR - 1-888-847-1900

SOUTH CENTRAL: Hot Springs, AR - 1-800-588-5733

SOUTH WEST: Texarkana, AR - 1-800-470-9621

SOUTH EAST: Pine Bluff, AR - 1-800-236-0369

WEST CENTRAL: Fort Smith, AR - 1-866-254-9117

**Customer Service** - Group Administrators should call a Customer Service Representative (CSR) or log on to the Employer Web site to update the following:

- Verification of health plan or pharmacy eligibility
- Benefit questions
- Change in address
- Order ID cards
- PCP change
- Claims questions
- Update other insurance information

**Marketing and Sales** - Each regional office has marketing and sales personnel assigned to provide local service to groups enrolled in Health Advantage. Call your Marketing Representative for the following:

- General questions about the group contract
- Marketing packets and extra Employee Applications
- Renewal procedures and rates

**Customer Accounts** - (FAX 501-301-6869 and FAX #2 501-378-3029). Customer Accounts is a corporate function and manages all membership and premium accounting for enrolled groups statewide. It is responsible for maintenance of Member records, mailing of Identification Cards and benefit materials, billing, accounts receivable and reconciliation of monthly group billing. Call your assigned Customer Account Representative for the following:

- Eligibility issues
- billing questions/problems
- Delays in paying premium

**Claims** - Claims is a corporate function and pays all medical claims for enrolled groups statewide. Claims questions should be directed to Customer Service.

**Health Advantage Web Site** - All forms are available to groups and members at [Health Advantage-hmo.com](http://HealthAdvantage-hmo.com). Subscribers may access personal information on-line by registering for *My Blueprint*. A log-in ID and password will allow Members to check membership eligibility, benefit information and claims status, print an Explanation of Benefits on a paid claim, order a Certificate of Coverage letter, order a replacement ID card, and review Primary Care Physician information.

### 3.0 GROUP ADMINISTRATOR RESPONSIBILITIES

As a Group Administrator, you are responsible for the following functions:

#### 1.) Enrollment

- Schedule enrollment/open enrollment meetings
- Distribute Marketing materials so employees can make informed choice of health care coverage
- Monitor enrollment of Members and accuracy of completed member applications
- Submit applications to Health Advantage for eligible newly hired employees
- Submit changes to Health Advantage for existing members
- Provide required legal documentation for addition of newly eligible members

#### 2.) Required Legal Documentation

- Adding spouse - Marriage Certificate; Certificate of Coverage if for loss of coverage
- Court ordered coverage - copy of court order or divorce decree ordering coverage
- Adopted child - petition for adoption or adoption papers
- Grandchild - proof of court appointed custody/guardianship with date filed with court
- Disabled Dependent – proof of mental or physical incapacity must be submitted to Health Advantage for determination and current IQ Score

#### 3.) Terminations

- Submit terminations in timely manner (FAX 501-301-6869 for paper groups)
- Send COBRA Notifications (first class mail) with COBRA rates to Subscribers and Dependents losing eligibility to inform them of their COBRA continuation rights if COBRA rules apply to group
- 120 days, Arkansas State continuation coverage when applicable (for groups under 20) and return form within 10 days. Please see Page 30 for additional information.

#### 4.) Group Billing/Premium Collection

- Remit premium by first day of the contract month for month that coverage is in effect
- Complete Health Advantage Billing Adjustment Form for monthly billing and submit with premium check, and last page of bill and any other documentation.

#### 5.) ID Cards and Benefit Materials

- Ensure Members receive Benefit Materials - Subscribers will receive packet with Benefit Materials and ID Card will be mailed separately.
- Distribute Member materials that are returned for bad addresses (Return Mail)

#### 6.) Miscellaneous

- Submit changes in business ownership, group administrator, or billing contact.
- Post notices for employees of proposed changes in health care coverage as required by law

## 4.0 PREMIUM COLLECTION PROCEDURES

### How to Read Your Bill

Check this information for accuracy and make changes accordingly.

AN ARKANSAS COMPANY  
123 HERE DR  
ANYWHERE, AR 01234  
  
ATTN: GROUP ADMIN

HEALTH ADVANTAGE  
ATTN: PREMIUM ACCOUNTING  
P O BOX 8069  
LITTLE ROCK, AR 72203-8069

When contacting Health Advantage please have this number available.

DIVISION# 1234560000  
INVOICE# PP040000000  
INVOICE DATE MM/DD/YY ← 1  
PAYMENT DUE ON/BEFORE: MM/DD/YY ← 2  
BILL PERIOD: MM/DD/YY - MM/DD/YY  
BILLING CYCLE CODE: A9  
BILLING METHOD: WASHOUT

TOTAL CONTRACTS	2
TOTAL MEMBERS	2
-----	
PREVIOUS BALANCE	\$5,276.57 **
PAYMENTS	\$5,019.96 ← 3
-----	
BALANCE FORWARD	\$256.61 ← 4
MISC CHARGES	\$0.00
ADJUSTMENTS	\$256.61 ← 5
CURRENT PREMIUMS	\$4,536.54 ← 6
-----	
PLEASE PAY THIS AMOUNT	\$4,536.54 ← 7
=====	

--Please make premium checks payable to: Health Advantage  
**Mail to: Attn: Premium Accounting 3-UCC, P.O. BOX 8069, Little Rock, AR 72203**  
For questions regarding your bill, please contact a member of the Customer Accounts Leadership Team, Angie Winstead at (501)301-6880 (akwinstead@arkbluecross.com) or Wanda King at (501)301-6860 (wdking@arkbluecross.com). Reminder: Health Advantage is a prepaid health care plan. Premiums are due on/before the bill period.  
\*\*Bottom line from previous bill

See next page for instructions



## How to Read Your Bill

1. **Invoice date:** If any changes to the group were processed after this date they will reflect on the following bill. This includes terminations, additions and payments.
2. **Payment Due On:** Premium payments are due on this date. *Health Advantage is a prepaid health care plan.* If the payment has not been received 20 days after the payment is due, a delinquency letter will be mailed and all medical claims will be placed on hold. After 30 days the pharmacy claims will be placed on hold and the group will be subject to cancellation.
3. **Payments:** Any payments made after previous bill and before the **Invoice Date**.
4. **Balance Forward:** Any balance left over after all payments were received prior to this **Invoice Date**. If the prior month's premiums have been paid after the **Invoice Date**, then subtract the amount paid from the **Balance Forward**. If the remaining amount is not zero then it should be deducted from or added from the **Current Premiums** amount accordingly.
5. **Adjustments:** These are adjustments to the bill from prior months. Most of these are credits for terminations or debits for additions. These amounts **are not** included in the **Current Premiums** amount and need to be added or subtracted accordingly. Please refer to the bills **Adjustment Page** for details.
6. **Current premiums:** This amount is strictly referring to premiums for the current month. It does not include previous months shortages/overages or adjustments.
7. **Please pay this amount:** This amount includes everything, such as **Balance Forward**, **Current Premiums** or **Adjustments**. It is important to do an analysis of numbers 1-6 before paying this amount. Many times this amount includes premiums already paid or premiums for members that are terminated but have not yet shown on the **Adjustment Page**. If a member is no longer employed, please note this on the **Billing Adjustment Form**. The form will need to include SSN, name, last day physically worked, reason or termination, and the amount that is being deducted from the bill. If an application has been sent to add an employee or member and payment is being made before he/she is on the bill please also note this on the **Billing Adjustment Form**. Include the SSN, name, effective date and amount of the member's premium.

**Note:** If the group has deducted or overpaid premiums for certain members due to terminations or additions on prior payments and the adjustment has not shown on the current bill please do not pay or deduct these amounts. Depending on the date the change was made in our system and the **Invoice Date**, the adjustment could be delayed until the next billing cycle and it should show on the next billing cycle. **If these items have been on the bill multiple times please feel free to contact us to verify that the member has been added or terminated.**

## Billing Procedures

1. New groups are billed the day after all Members are active and/or entered into the system.
2. Renewal groups are billed after the group has renewed or when new Members (open enrollment additions) have been loaded and/or are entered into the system, whichever is later.
3. All Commercial Groups are billed monthly. Group billing is run automatically.
4. Health Advantage uses the 15/16 rule, or wash method for billing:
  - Member is effective between the first and the fifteenth day of the billing period, premium is billed for entire month (billing period)
  - Member is effective between the sixteenth and the thirtieth day of the billing period, premium is not billed for entire month
  - Member's termination is effective between the first and the fifteenth day of the billing period, premium is not billed for entire month
  - Member's termination is effective between the sixteenth and the thirtieth day of the billing period, premium is billed for entire month (billing period)

## Premium Collection

1. Premium is always due on the first of the contract month in which coverage is provided. Failure to pay premium when due will result in claims being held any month that premium is not paid.
2. Groups have a 31-day grace period in which to submit premium.
3. For new groups and renewals, this time period may be extended for the first bill to ensure correct membership counts and accurate billing/reconciliation.

## Premium Payment Procedures

To ensure accurate posting of monthly premium, groups must be consistent in method of payment. The following procedures are recommended:

### Premium Payment by Check

1. Make check payable to "Health Advantage Membership"
2. Always include last page of bill to ensure accurate posting of premium
3. Submit premium for amount billed, plus or minus adjustments.
4. Submit Premium to: Health Advantage Membership/Accounting, P.O. Box 8069, Little Rock, AR, 72203-8069.
5. Complete Billing Adjustment Form and submit with payment
  - Terminations, line off bill (line through name, not contract number)
  - Add-ons – submit Employee Application
  - Contract type change – document explanation of premium difference

### **For groups submitting paper forms only:**

- Terminations, line off bill (line through name, initial, ID#)
- Add-ons – Submit employee application
- Contract Type Change – document explanation of premium difference

Submit Premium Backup. This is a listing for whom and how premium should be applied.

- For smaller groups, this may be a copy of the bill with the corrections made and the Billing Adjustment form completed.
- For larger groups, a file on a disk or CD, OR BY EMAIL MAY BE SUBMITTED. Excel Spreadsheet is preferred format. Email (password protected) is the preferred method

### **Reconciliation Procedures**

1. The amount of premium received for the month is reconciled against the premium billed plus or minus adjustments.
2. Discrepancies in premium paid and premium billed are listed on a worksheet.
3. The Group Administrator or billing contact is contacted to resolve discrepancies.
4. Balance forwards (credits or debits) will appear on the next monthly billing.
5. Repeat unresolved discrepancies or failure to pay premium will result in cancellation of coverage back to paid to date. The member is responsible for all medical and pharmacy claims incurred after the paid to date.

### **Delinquency Procedures**

1. Premium is due on the first day of the month that coverage is provided. When premium is 20 days past the due date:
  - Group is notified by letter that premium is past due.
  - Medical claims are flagged back to the paid to date. All claims for dates of service after the paid to date will be pended.  
Pharmacy claims are flagged after grace period ends when the group is identified as delinquent.
  - Flags are released when payment is received.
2. When grace period (31 days) has passed and premium is not received:
  - Group is cancelled on its “paid to” date. Coverage for all Members is cancelled on paid to date.
  - Group is notified by letter of cancellation.
  - Pharmacy is notified that group is cancelled; no further claims will be paid.
  - Group must pay any premium due at the time of cancellation.
  - Members are responsible for all claims incurred after the “paid to” date.

3. If a group contract is terminated for non-payment of premium, the group is:
  - Responsible for providing notification of termination to covered employees.
  - Liable for payment of all premiums which is due but unpaid at the time of termination.
  - May not be eligible to reapply for another contract with Health Advantage for a period of 6 months from the date of termination.

### **Premium Checks with insufficient funds**

Groups will be assessed a charge of \$50 for any premium check for which the bank notifies Health Advantage of insufficient funds. Payment of medical and pharmacy claims will be held for dates of service after the Group's "paid to" date until required payment is received. If a second premium check is received with insufficient funds for the same month or for any other month during the same Contract Year, the group is required to sign an amendment requiring premium payments by cashier's check to continue coverage with Health Advantage..

### **Reinstatement Procedures**

1. A group that is cancelled for non-payment of premium may be eligible for reinstatement. The cancelled group must submit a request for reinstatement, a cashier's check for premium due at the time of cancellation, a cashier's check for current month premium, and a non-refundable \$350 reinstatement fee.
2. The reinstatement request is reviewed by the Underwriting Unit for a reinstatement decision.
3. If a group is denied reinstatement, the group is not eligible for another group contract with Health Advantage for a period of 6 months from the date of termination.

### **E-Billing**

**eBill Manager** is an on-line invoice presentation, adjustment and payment system. The system allows you to receive and pay your health plan invoices electronically. **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.

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. While these documents no longer are required to be submitted to create these transactions, it is required that these documents be retained by the employer as a condition of the eBilling contract.

Note that invoices cannot be adjusted for additions to the health plan membership; all additions to the health plan still required the submission of an employee application. Subsequent invoices will show the results from the additions.

**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.

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)

## 5.0 CASE MANAGEMENT

### Case Management Program

1. Case Management is the process in which Health Advantage staff provide information and assistance to a Member and the Member's treating physician(s) about cost-effective treatment alternatives from which the Member and the Member's physician(s) may choose, including, where deemed appropriate by the Member's physician(s), outpatient or home care settings.
2. Early identification of illness or injury is important. Often the employer is the first to know that the Member is being treated for a serious illness or injury. It is important that the Group Administrator or the employee's supervisor contact the Customer Service department of the Regional Office where the member lives. Regional Office Customer Service phone numbers are listed on page 3.
3. Examples of situations in which Case Management may assist in conservation of limited benefits include, but are not limited to:
  - Emergency admission to a Hospital
  - Rehabilitation Services (Inpatient)
  - Home Health Care following catastrophic accidents
  - Drug Therapy
  - Specialty Drug Therapy
  - Pain Management
  - Terminal Care (Hospice)
  - Supplies and equipment needed for home care
  - Transplant related services

### Special Delivery

The Special Delivery Program is a prenatal care program designed to assist the expectant mother and her physician in the prevention of preterm births secondary to high-risk perinatal conditions through Member education, assessment and intervention. Expectant mothers may obtain information or enroll in the Special Delivery program by calling 1-800-742-6457. A Case Manager RN can monitor the care of high risk mothers during the pregnancy. Premature Infant Care – Special Delivery follows premature infants thru the first 12 months of life.

### HealthConnect Blue

HealthConnect Blue is a complimentary health information service designed for members who have everyday health questions, or who have questions about a chronic health condition. Health coaches help members to better understand their health problems. Members will be better prepared to make informed, confident decisions about their health care when they see their physician. HealthConnect Blue is available 24 hours a day/7 days a week at 1-800-318-2384 or at [HealthAdvantage-hmo.com](http://HealthAdvantage-hmo.com) through *My Blueprint*. Log-in ID and Password required. HealthConnect Blue can help identify candidates for the Case Management Program.

## 6.0 ENROLLMENT PROCESS FOR ADDING NEW SUBSCRIBERS AND FAMILY MEMBERS

### For Groups Submitting Paper Enrollment Forms:

**Adding Subscribers/Members Via Paper Enrollment Form** - For Subscribers, the entire application must be completed according to instructions. For addition of Members, all sections of the Employee Application that apply must be completed. The effective date and group number should always be noted on the top of application.

**Adding Members** - The reason for adding Member to existing policy/contract must be indicated. The effective date should always be noted on the top of application. This will let Health Advantage know when a payroll deduction (if applicable) is being made for health plan coverage. Health Advantage will contact the Group Administrator if the requested effective date cannot be administered.

**Reinstatement of Previously Covered Member** - The Qualifying Event and effective date must be indicated. The request must be accompanied by adequate information to determine correct effective date, and to assure no break in coverage (if applicable). If Subscriber/Member is eligible for continuous coverage, there can be no break in coverage and reduction of premium. All premiums must be submitted with next bill to provide continuous coverage.

### General Recommendations for Completion of Paper Employee Applications

1. **New hires should complete an application when initially employed to avoid delays in health care coverage.** If there is a waiting period, Health Advantage will code the application and hold it for processing. It will be processed one month prior to effective date (first of month for 15<sup>th</sup> of the month effective date).
2. Applications or copies must be legible to avoid keying errors.
3. Legal documentation must accompany the Employee Application for an adopted child, stepchild, or grandchild, etc.
4. Proof of mental or physical incapacity and IQ Score must be submitted for dependents over the maximum dependent age according to group contract for Member to be enrolled as an incapacitated dependent. Documentation provided to a previous carrier may be submitted if it was completed within last 12 months.
5. If FAXING application, do not reduce font size before faxing.
6. DO NOT USE or STAMP in space reserved for "office use only."
7. Applications and changes submitted should always include:
  - Reason for addition/change
  - Group number
  - Name and SSN of Subscriber and each family member

- Effective date of enrollment or change according to Evidence of Coverage
- Address if changed since enrollment
- The group's assigned group account representative name if known.

8. Applications that are incomplete or have missing support documentation. When an Employee Application is received that is missing required information, a Request for Additional Information form will be faxed to the group showing the information that is missing. Examples are documentation to support a Special Enrollment Period such as verification of loss of eligibility, proof of incapacitated status, marriage license, divorce decree, petition for adoption, or court appointed guardianship papers.

**Late Enrollee:** A Late Enrollee is a subscriber or member that requests enrollment after the expiration of the Initial Enrollment Period, Open Enrollment Period, or Special Enrollment Period. Health Advantage does not accept Late Enrollees. Late Enrollees are deferred until the next open enrollment period. Members that meet definition of Special Enrollment Period are not considered Late Enrollees. Late enrollees must not be enrolled.

## 7.0 ENROLLMENT PROCESS FOR ADDING NEW SUBSCRIBERS AND FAMILY MEMBERS

### For Groups Submitting Electronic Enrollment:

Applications and changes in coverage must be communicated to Health Advantage in a timely manner in the required format. Health Advantage shall not be responsible for any applications or changes submitted in error or that are not in compliance with the provisions of the Group Contract and Evidence of Coverage. The process described below is for Groups that submit membership eligibility electronically.

Groups that provide membership eligibility electronically may include either of the following:

#### Electronic File:

1. Employees enroll on-line or complete an enrollment form. The group determines eligibility and the effective date and forwards the enrollment information directly to Health Advantage on a tape or electronic file. All changes in enrollment must be made by the group.

#### Third Party Vendor:

2. Employees enroll on-line or complete an enrollment form. The group forwards the information to a third party vendor to determine eligibility and effective date. The enrollment file is then submitted directly to Health Advantage on a tape or electronic file by the third party eligibility vendor. All changes in enrollment must be made by the group through the third party vendor.

Enrollment information is considered electronic if the information is received in any of the following:

1. Health Insurance Portability and Accountability Act (HIPAA) compliant ANSI 834, or 834 flat file placed on FTP site or location determined by Health Advantage.
2. Proprietary files or tape in the electronic format.
3. Excel spreadsheet or TEXT file emailed to Health Advantage (password protected).

#### Frequency of updates.

Updates may be an update or change file or a full file received on a daily, weekly, or biweekly basis depending on the size and turnover within a group. A full file match is performed at least quarterly following renewal.

**NOTE:** A file must be in the HIPAA compliant ANSI 834 or 834 flat file format in order for enrollment to be automated. Groups that are interested in having enrollment automated may contact Health Advantage for the file layout. At least 2 months should be allowed for testing prior to implementation.

## **For Groups Submitting Electronic Enrollment (continued):**

### **Subscriber Eligibility Determination**

A Subscriber must enroll within 31 days of:

- Initial Enrollment Period (date of full-time employment)
- Open Enrollment Period (determined by group or the one-month period before anniversary date)
- Special Enrollment Period. Date of Qualifying Event Period (loss of coverage, marriage, birth of child, adoption, or petition for adoption)

**Adding Group Subscribers/Members Via Electronic Enrollment** – The effective date must be in accordance with the Group Contract and Evidence of Coverage (see Section 8. 0, Coverage Effective Date Guidelines.)

**NOTE:** The group is not required to submit documentation to support enrollment; however, documents must be maintained by the group and made available to Health Advantage upon request. Examples of required documents include but are not limited to birth certificate, marriage license, divorce decree, petition for adoption, adoption papers, court appointed guardianship papers, verification of loss of eligibility (creditable coverage), proof of incapacitated status, verification of student status if verification is performed by group, and proof of prior insurance if group has pre-existing exclusion.

**NOTE:** A Late Enrollee is a Subscriber that requests enrollment after the expiration of the initial enrollment period, open enrollment period, or Special Enrollment Period. Health Advantage does not accept Late Enrollees. Late Enrollees are deferred until the next open enrollment period. Members that meet definition of Special Enrollment Period are not considered Late Enrollees.

**Qualifying Event** - When adding or terming a Subscriber/Member, the Qualifying Event must be indicated. This will let Health Advantage know if the Subscriber/Member meets criteria for a Special Enrollment Period. If Qualifying Event is loss of coverage, documentation of previous coverage must be attached.

**Incapacitated Dependents** - Proof of mental or physical incapacity and IQ Score must be received in order to continue coverage for dependents over the maximum dependent age that are medically certified as totally disabled and chiefly dependent on the Subscriber for financial support. New Subscribers requesting enrollment of an incapacitated dependent must provide proof that disability commenced before dependent reached the limiting age and child was continuously covered under a health benefit plan as a dependent of the Subscriber since before attaining the limiting age. Health Advantage's determination of eligibility shall be conclusive.

## **REQUIRED ENROLLMENT INFORMATION FOR ELECTRONIC GROUPS**

Membership enrollment files must be received by Health Advantage in HIPAA compliant format. The file must contain all required fields. The file layout and requirements can be obtained from Health Advantage.

### **Required Enrollment Information – NEW SUBSCRIBER**

1. Group/Division number/Department number
2. Subscriber name (first, middle, last)
3. Effective date
4. Date of Full-time Employment
5. Subscriber Address
6. Home and Work phone number
7. Social Security number (SSN)
8. Gender
9. Date of birth
10. County Code
11. Benefit Status Code (Active, COBRA, Retired)
12. PCP with FIVE DIGIT PCP NUMBER from Health Advantage Provider Directory (PCP selection is not required for Open Access Plans).
13. Other Health Insurance or Medicare information for coordination of benefits (COB). Must have effective date of other insurance.
14. Prior Coverage or Creditable Coverage information if the group has Pre-existing Condition Limitation Period: Prior coverage must include the effective date and termination date.
15. Life Beneficiary information for Groups with Life Insurance that is billed by Health Advantage. Beneficiary information: last name, first name, middle initial, date of birth and relationship to employee.
16. COBRA information. COBRA effective date and end date

## Required Enrollment Information – NEW DEPENDENT

1. Dependent name (first, middle, last)
2. Effective date
3. Social Security number (Preferred)
4. Gender
5. Date of birth
6. PCP with FIVE DIGIT PCP NUMBER from Health Advantage Provider Directory (PCP selection is not required for Open Access Plans).
7. Other Health Insurance or Medicare information for coordination of benefits (COB). Must have effective date and termination date of other insurance.
8. Prior Coverage or Creditable Coverage information if the group has Pre-existing Exclusion. Prior coverage must include the effective date and termination date.
9. Relationship code (spouse, child, student, stepchild, incapacitated dependent)

**EMERGENCY UPDATES.** It is considered an emergency situation if an eligible member is at a health care provider's office, hospital, or pharmacy to receive services, but has not yet been enrolled. Emergency additions and changes may be faxed to 501-301-6869 or emailed to Account Representative. The Group Administrator should contact the account representative or someone in Customer Accounts that the update is being sent.

**EXCEPTIONS:** When information is provided that is incomplete or that is not consistent with the Group Contract and Evidence of Coverage, an error report is printed and the group or the eligibility vendor is contacted to verify the information or correct discrepancies.

## 8.0 COVERAGE EFFECTIVE DATE GUIDELINES

Member	Qualifying Event	Effective Date	Remarks
Spouse	Marriage	First of month after date of marriage	Application must be submitted within 31 days of marriage
Spouse	Loss of Other Coverage	First of month after loss of coverage/day after loss of coverage	Application must be submitted within 31 days of loss of coverage
Natural Child of Employee	Loss of Other Coverage	First of month after loss of coverage	Application must be submitted within 31 days of loss of coverage
Newborn Child	Birth of Child	Date of Birth	Enrolled within 90 days of Date of Birth
Adopted Child - Newborn	Petition for Adoption	Date of Birth	Enrolled within 60 days of Date of Birth
Adopted Child - Not a Newborn	Petition for Adoption	Date Placed for Adoption or Date of Petition for Adoption	Enrolled within 60 days of placement or filing of Petition for Adoption
Court Ordered Coverage for Child	Court Order	First of the Month after application received	Custodial parent or child support agency can submit copy of Court Order
Grandchild/ Other	Court appointed Guardianship or Legal Custody	First of the month after receipt of application (date of birth if newborn)	Enrolled within 31 days of Qualifying Event (90 days for newborn); Proof of Custody or Guardianship required
Stepchild	Loss of Other Coverage, marriage (addition or family members)	First of the month after receipt or date spouse eligible.	Enroll within 31 days of Qualifying Event.
Current Member - Mentally or Physically Incapacitate	Dependent maximum age per group contract	Maximum age of group contract	To prevent any break in coverage, should be enrolled as incapacitated dependent within 31 days
New Member Mentally or Physically Incapacitated Dependent	Dependent was covered on previous group health plan	Date Subscriber is effective for new group	Proof of incapacity, IQ score before dependent reaches maximum age of group contract and Creditable Coverage

## 9.0 COMPLETION OF EMPLOYEE APPLICATION FOR PAPER GROUPS

### SMALL GROUP

#### Completion of Small Group Employee Application – Groups with 2 – 100 Employees

<b>TOP PORTION</b>	<ol style="list-style-type: none"> <li>1. Group Number – 10-digit number (if existing group).</li> <li>2. I.D. Number – Leave blank if New Enrollee (new hire).</li> <li>3. Indicate New Enrollee or Add Family Member (complete all that apply).</li> <li>4. Date of Full-time Employment or COBRA Effective Date and reason.</li> </ol>
<b>SECTION 1</b>	<b>EMPLOYEE INFORMATION</b>
	<ol style="list-style-type: none"> <li>1. Subscriber name</li> <li>2. Address</li> <li>3. Home <b>and</b> Work phone number</li> <li>4. Employer and Job Title</li> </ol>
<b>SECTION 2</b>	<b>MEMBER INFORMATION</b>
	<ol style="list-style-type: none"> <li>1. Subscriber and dependents Social Security number (MUST BE LEGIBLE)</li> <li>2. Date of birth for each Member</li> <li>3. PCP with FIVE DIGIT PCP NUMBER from Health Advantage Provider Directory for each Member (no specialists). PCP selection is not required for Open Access Plans.</li> <li>4. Whether child is natural, stepchild or other (grandchild requires custody).</li> </ol>
<b>SECTION 3</b>	<b>WAIVER OF ENROLLMENT/SPECIAL ENROLLMENT RIGHTS</b>
	Complete if waiving coverage for Subscriber or any Member of the family. List Members being waived, and complete other insurance information.
<b>SECTION 4</b>	<b>OTHER MEDICAL INSURANCE</b>
	This Section must be completed if any Member will have Medicare or other health insurance in addition to Health Advantage while covered under Health Advantage. Must have effective date of other insurance.
<b>SECTION 5</b>	<b>LIFE INSURANCE – (Groups that have Life billed with health)</b>
	Beneficiary First Name, Middle Initial, Last Name, date of birth and relationship to the employee must be completed. This must be completed for employees for groups with 2-50 employees when premium for Life Insurance is billed with health premium by Health Advantage.
<b>SECTION 6</b>	<b>CREDITABLE COVERAGE INFORMATION (Groups with Pre-ex only)</b>
	This section must be completed for new employees of groups that have an Open Access Plan. Failure to complete this section will result in assignment of a 12-month preexisting condition exclusion period.
<b>SECTION 7</b>	<b>MEDICAL QUESTIONNAIRE</b>
	This section must be Completed for all small group business. Application includes instructions sheet.
<b>SECTION 8</b>	<b>UNDERSTANDINGS, REPRESENTATIONS AND AGREEMENTS (SIGNATURES) - Group signature not required for new groups</b>
	Signature of Applicant (Subscriber/Contract Holder) required. Group Representative signature required for new hires and additions only.

*There is a separate Employee Application for Large Groups (101+ Employees)*

## COMPLETION OF EMPLOYEE APPLICATION FOR PAPER GROUPS

### LARGE GROUP

#### Completion of Large Groups Employee Application—Groups with 101 + Employees

<b>TOP PORTION</b>	<ol style="list-style-type: none"> <li>1. Group/Division Number – 10-digit number (if existing group).</li> <li>2. I.D. Number – Leave blank if New Enrollee (new hire).</li> <li>3. Indicate New Enrollee or Add Family Member (complete all that apply).</li> <li>4. Date of Full-time Employment or COBRA Effective Date and reason.</li> </ol>
<b>SECTION 1</b>	<b>EMPLOYEE INFORMATION</b>
	<ol style="list-style-type: none"> <li>1. Subscriber name</li> <li>2. Address</li> <li>3. Home and Work phone number</li> <li>4. Employer and Job Title</li> </ol>
<b>SECTION 2</b>	<b>MEMBER INFORMATION</b>
	<ol style="list-style-type: none"> <li>1. Subscriber and dependents Social Security number (MUST BE LEGIBLE)</li> <li>2. Date of birth for each Member</li> <li>3. PCP with FIVE DIGIT PCP NUMBER from Health Advantage Provider Directory for each Member (no specialists). PCP selection is not required for Open Access Plans.</li> <li>4. Whether child is natural, stepchild or other (grandchild requires custody).</li> <li>5. Name and location of school for each student that is student age or reaching maximum dependent age according to group contract.</li> </ol>
<b>SECTION 3</b>	<b>OTHER MEDICAL INSURANCE</b>
	This Section must be completed if any Member will have Medicare or other health insurance in addition to Health Advantage while covered under Health Advantage. Must have effective date of other insurance.
<b>SECTION 4</b>	<b>WAIVER OF ENROLLMENT/SPECIAL ENROLLMENT RIGHTS</b>
	Complete if waiving coverage for Subscriber or any Member of the family. List Members being waived, and complete other insurance information.
<b>SECTION 5</b>	<b>CREDITABLE COVERAGE INFORMATION</b>
	This section must be completed for new employees ONLY for groups that have an Open Access Plan WITH a preexisting exclusion.
<b>SECTION 6</b>	<b>LIFE INSURANCE</b>
	Completed only for employees of groups 51-100 employees that have the life insurance premium billed with health premium by Health Advantage. Beneficiary First Name, Middle Initial, Last Name, date of birth and relationship to the employee must be completed.
<b>SECTION 7</b>	<b>SIGNATURES - Group signature not required for new groups</b>
	Signature of Applicant (Subscriber/Contract Holder) required. Group Representative signature required for new hires and additions only.
<b>Separate Form</b>	<b>MEDICAL QUESTIONNAIRE FOR LATE ENROLLEES</b>
	This form is not required for Health Advantage. Late Enrollees are deferred until the next open enrollment period.

*There is a separate Employee Application for Small Groups (2-100 Employees)*

NOTE: Most current Large Group Employee Application at [HealthAdvantage-hmo.com](http://HealthAdvantage-hmo.com)

## 10.0 IDENTIFICATION CARDS AND MEMBER MATERIALS

1. Identification (ID) Cards are printed for each Member of the family and mailed directly to the Subscriber's address.
2. ID cards generally print the business day after a Member is entered or a change is made in the system. A new ID Card prints each time the Member has a change in any of the information that appears on the ID Card.
3. ID Cards for new Subscribers and their dependents are verified by checking:
  - ID Card for each Member of the family
  - Legibility
  - Member Identification (ID) Number
  - Correct Copayment or Coinsurance amounts
  - Group/division Number
  - Date of Birth
  - Primary Care Physician information
  - Address, City, State and Zip Code
4. New Subscriber ID Cards are mailed in an envelope clearly marked "MEMBERSHIP CARD ENCLOSED" in red letters. In addition, a separate mailing is sent in a large envelope clearly marked "Membership Materials" which includes:
  - Welcome Letter
  - Evidence of Coverage Amendments, if any
  - Managed Pharmacy Rider (if applicable)
  - Other Riders according to the contract
  - Any other information determined by the contract
5. ID Cards printed as a result of a change in the Member record are mailed directly to Member in a window envelope clearly marked "MEMBERSHIP CARD ENCLOSED."
6. Members may request replacement of lost ID Cards by calling Health Advantage Customer Service or logging onto the Health Advantage web site. (Log-in ID and Password required)

**NOTE:** Members should ensure that all Providers have a copy of the current and correct ID Card and submit claims according to the information on the Member's ID Card. The Member name and date of birth on the claim must match the Health Advantage information.

## 11.0 PRIMARY CARE PHYSICIAN SELECTION PROCEDURES

### HMO and Point of Service Plans - Selection of Primary Care Physician (PCP) required

1. At the time of enrollment, a Primary Care Physician (PCP) must be selected for each member of the family. The PCP must be a physician listed in the Health Advantage Provider Directory at [HealthAdvantage-hmo.com](http://HealthAdvantage-hmo.com) as a PCP and accepting Members.
2. If a Member application is received that requires a Primary Care Physician (PCP), and one is not selected, the Member is enrolled and the ID card will be issued. The ID Card will print showing "Member awaiting PCP" on the space provided for the Primary Care Physician.
3. ID Cards showing "Member awaiting PCP" are sent to Members along with a PCP Selection Letter. This will allow the Member to have an ID card if they need to seek urgent medical treatment. Members must select a PCP before receiving routine and specialty care.
4. The PCP Selection Letter instructs the Member to call Customer Service to choose a PCP, or if unable to call, complete and return the PCP Selection Letter. Members are encouraged to call Customer Service to select a PCP. Customer Service will enter the request on-line. On-line requests are processed the following business day and the Member should have their new ID Card in 5 - 7 days.

### Open Access POS Plans - PCP Selection Optional

Although not required, each Member of the family is encouraged to select a Primary Care Physician (PCP) when enrolling in the health plan for urgent care needs and proper coordination of all care. If an HMO or POS group renews with an Open Access Plan and Members have a PCP assigned, no change will be made without the Member's request. New Members on an Open Access Plan that do not select a PCP will have "PCP Selection Optional" printed on the ID card and will not be sent a PCP Selection Letter.

### PCP Termination

When a PCP leaves the Health Advantage Network, he/she may request that their Members be transferred to another PCP. If the PCP does not request that Members be transferred to another PCP, they will be assigned to a default provider number and receive an ID Card showing "Member awaiting PCP." The Member will be notified by letter by Health Advantage to select another PCP.

***Members may check PCP information at [HealthAdvantage-hmo.com](http://HealthAdvantage-hmo.com)  
Login ID and Password required for My BluePrint***

## 12.0 MEMBER RECORD CHANGES

### Completion of Employee Application for Small Group and Large Group

Every effort is made by Health Advantage to maintain accurate records on all groups and Members. In order to have a claim paid, the member ID#, Name and Date of Birth on the Health Advantage Membership system must match the information on the claim from the health care provider. Health Advantage must be informed of changes as soon as they occur in order to provide the best service possible.

#### Addition of Subscriber or Member

Addition of a Subscriber or Member requires an Employee Application (enrollment application) to be completed. Any change in the status of a Member record may be made on the Change Request Form.

#### Address Changes

In order for Members to receive ID Cards, Benefit Materials, Member Newsletters, Explanation of Benefits (EOB) statements, Referral letters (if applicable), and any other correspondence sent by Health Advantage, the address must be correct.

Each time a Member calls Customer Service or a change is submitted, the address is verified and updated if there is a new address. When mail is returned with an expired forwarding address, the address is updated. A Member may contact Customer Service to request address change or to correct an address that contains an error or complete the Address Change Form.

#### For Electronic Groups:

#### Address Changes

In order for members to receive ID Cards, Benefit Materials, Member Newsletters, Explanation of Benefits (EOB) statements, Referral letters (if applicable), and any other correspondence sent by Health Advantage, the address must be correct.

Address changes must be made through the group. Each time a Member requests any type of change, the address should be verified. When mail is returned to Health Advantage with an expired forwarding address, the new address will be forwarded to the group to update on the eligibility report. Members may contact Customer Service to request a correction to an address that contains an error. Members may complete the Address Change Form (Forms Section or at [HealthAdvantage-hmo.com](http://HealthAdvantage-hmo.com)) and submit to the group to have address updated.

## **Primary Care Physician Change**

### ***For Paper Groups:***

In order for medical services to be covered and claims to be paid correctly, HMO and POS Members must have a Primary Care Physician (PCP) assigned (PCP selection is optional for Open Access POS Plans). Members must select a PCP when enrolling and when their PCP leaves the Health Advantage Network. PCP changes can be made by contacting the Customer Service number on the Member's ID Card and providing the physicians name, office location and the 5-digit provider code. All PCP changes are effective on the first of the month following request.

### **For Electronic Groups:**

If Health Advantage is responsible for assisting the Members with PCP selections and changes, the PCP 5-digit number is sent on new members only.

## **Date of Birth**

### **For Paper Groups:**

All Member ID Cards contain the date of birth. Members with an incorrect date of birth on the ID card must inform Health Advantage Customer Service. The date of birth on Provider claims must match the date of birth in the Health Advantage Membership system.

### **For Electronic Groups:**

Date of birth corrections must be submitted as a member record change. All Member ID Cards contain the date of birth. The date of birth on Provider claims must match the date of birth in the Health Advantage Membership system. Members with an incorrect date of birth on the ID card must notify the group to submit the correct date of birth.

## **Required Information for All Changes**

- Reason for change
- Group number
- Name and SSN of Subscriber
- Effective date of change according to Evidence of Coverage
- Address if changed since enrollment
- Assigned group account representative name (if known)

**NOTE:** For any addition that does not follow a rule in the Evidence of Coverage, attach a letter explaining the reason for change so that eligibility and effective date can be verified.

## **Change in Subscriber Premium Rate**

The addition or termination of a dependent can change the premium rate for the Subscriber. If this occurs before the next monthly billing, the correct premium should be remitted with the monthly premium with an explanation on the Billing Adjustment Form.

## 13.0 OTHER INSURANCE INFORMATION (COORDINATION OF BENEFITS)

### Coordination of Benefits

Coordination of benefits ("COB") applies when a Member has coverage under more than one Health Benefit Plan. Health Advantage coordinates benefits to prevent duplicate payments on claims. If any member has Medicare or other insurance coverage that provides benefits for hospital, medical, or other expenses, benefit payments may be subject to coordination of benefits. Health Advantage has the right to coordinate benefits. It is the Member's responsibility to inform Health Advantage of other insurance or Medicare even if Health Advantage is not the primary carrier. The member may also be required to provide Health Advantage with copy of the primary carrier's Explanation of Benefits and all itemized bills if Health Advantage is the secondary carrier. The rules establishing the order of benefit determination are described in the Evidence of Coverage.

### Other Insurance information

There is a separate section on the Employee Application (enrollment application) for other insurance information. This section must be completed at the time of enrollment for each Member of the family that will be continuing other health insurance or Medicare at the same time they have coverage with Health Advantage.

### Changes to Other Insurance Information

For prompt payment of claims, other health insurance information must be kept current. Changes in other insurance are considered a change in Member information. Members may update other insurance information by calling Customer Service, submitting the change in writing, or completing the COB Questionnaire and mailing it to:

Claims COB Department  
Health Advantage  
P.O. 8069  
Little Rock, AR 72203-8069

*The Coordination of Benefits (COB) Questionnaire is available at [HealthAdvantage-hmo.com](http://HealthAdvantage-hmo.com)*

## 14.0 OUT OF SERVICE AREA COVERAGE -- BLUECARD PROGRAM

### Members Traveling Outside the Service Area

Health Advantage Members have access to the BlueCard Program for Emergency and Urgent care when traveling outside the service area (State of Arkansas but within the United States). Services must be received from a Blue Cross and/or Blue Shield provider listed in the BlueCard Traditional Network. Claims are billed with the XCH prefix and Member's ID number through the Local health plan and routed electronically to Health Advantage. Medical Services other than Emergency Care or Urgent Care through the BlueCard Program must first be authorized by the Member's Primary Care Physician or approved by Health Advantage to be covered at the In-Network benefit level.

### Members Living Outside the Service Area for more than 90 days

Health Advantage Members that live, work, or attend school outside the Service Area (State of Arkansas but within the United States) for more than 90 days may be eligible for a special Out of Area Classification. If approved by Health Advantage, the Member uses his/her Health Advantage ID Card to access services covered by Health Advantage on the Member's Group Health Plan. Services are covered at the In-Network benefit level when provided by a Blue Cross and/or Blue Shield provider participating in the BlueCard Traditional Network. Claims are billed with the XCH prefix and Member's ID number through the Local health plan and routed electronically to Health Advantage. If approved for payment, the Member's out-of-pocket expenses are limited to the Member's In-Network Deductible, Copayment and/or Coinsurance. The Member is responsible for the difference between the billed charge and allowed charges for services provided by non-participating BlueCard providers.

### Members eligible for the Out of Area Classification are:

- Dependent Students attending school Outside the State of Arkansas but within the United States for at least 90 consecutive days. Renewal is required annually.
- Dependent Spouses and Children living Outside the State of Arkansas for at least 90 consecutive days. Renewal is required annually.
- Active full-time employees of an Arkansas Employer Group that live outside the State of Arkansas for more than 90 days. The Group Administrator must approve applications for active employees. Annual renewal is not required.

The Subscriber must complete the appropriate application to request the Out of Area Classification. The completed application may be attached to the Employee Application on enrollment, faxed to 501-301-6869, or mailed to: Health Advantage Membership, P.O. Box 8069, Little Rock, AR 72203-8069. If approved, ID card(s) and benefit materials are mailed to the address provided. A copy of the application is mailed to the Subscriber.

Additional BlueCard Program information and Out of Area Applications can be obtained at [HealthAdvantage-hmo.com](http://HealthAdvantage-hmo.com). To locate the nearest participating BlueCard Traditional Network provider, Members may go to [www.bcbs.com](http://www.bcbs.com) or call 1-800-810-2583 (BLUE).

**NOTE:** *All Covered Services are subject to the Health Advantage Allowable Charge. When the Blue Card program is not utilized, Members are responsible for the amount charged in excess of the Allowable Charge billed by Out-of-Network providers.*

## 15.0 TERMINATION OF COVERAGE

### Subscriber/Member Terminations

#### For Electronic Groups:

It is the responsibility of the Group Administrator to make the change or notify the eligibility vendor when a Subscriber's or Member's coverage is to be terminated. Termination requests received by Health Advantage by the 10th of the month should be reflected on the following month's premium billing.

For groups that use third party eligibility vendors, terminations may also be faxed to Health Advantage at the time the information is provided to the third party using the Change Form (Forms Section). The effective date of termination must be completed.

If a termed Subscriber/Member is still on the monthly bill and premium is not being submitted to Health Advantage for the member, proof of termination request to Health Advantage or third party must accompany the premium payment.

Retroactive Terminations. Health Advantage shall refund premium payments applicable to periods after the effective date of termination, provided the Group can demonstrate the Member made **no** contribution to such premium payments. Retroactive termination requests may not exceed 60 days from the last day of the month preceding the month of the request.

#### For Paper Groups:

It is the responsibility of the Group Administrator to notify Health Advantage of Subscriber and Member terminations and date of termination as soon as possible. Termination requests received by the 10th of the month should be on the following month's premium bill.

Terminations may be requested by using the Change Form (Forms Section) and faxing to 501-301-6869. The effective date of termination must be completed.

If a termed Subscriber/Member is still on the monthly bill, the termination may be submitted with the monthly group bill by including the Member name, contract number and termination date on the Monthly Billing Adjustment Form.

Retroactive Terminations. Health Advantage shall refund premium payments applicable to periods after the effective date of termination, provided the Group can demonstrate the Member made **no** contribution to such premium payments. Retroactive termination requests may not exceed 60 days from the last day of the month preceding the month of the request.

## Qualifying Events for Loss of Eligibility

- Spouse – divorce (or legal separation)
- Dependent
  - Joins military
  - Eligible for coverage through own employer (for certain plans)
- Death (Subscriber); include date of death (Employee only contract is termed on date of death, Employee/spouse or Employee family contracts are termed at the end of the month). For the death of Subscriber, dependents are eligible for continuation of coverage.

**NOTE:** Terminations are at the end of the month except when specified otherwise. When a Subscriber or Member is terminated, a Certificate of Creditable Coverage is printed and sent to the Subscriber. A Certificate of Creditable Coverage may be requested at any time at [HealthAdvantage-hmo.com](http://HealthAdvantage-hmo.com) or by calling Customer Service.

### Termination of Group Coverage

The Group Contract may be terminated by the Employer on any paid to date. The request to terminate group coverage must be submitted to the Marketing Representative. All Members of a group terminate on the same date the group is terminated. The Group Contract may also be terminated by Health Advantage if the terms of the contract are not upheld by the group. **It is the Group's responsibility to notify all Members when the group contract is terminated.** The Member is responsible for all medical and pharmacy claims paid after the "paid to" date.

## 16.0 CONTINUATION PRIVILEGES, COBRA AND CONVERSION

### Continuation of Coverage (120-day Arkansas State continuation)

1. Coverage may be continued for 120 days, or through the date the Member or the Group pays the premium, or Member becomes eligible under a similar group health plan or Medicare, whichever is sooner. Employees of groups that are not subject to COBRA may elect this 120-day Arkansas State continuation of coverage.
2. A Member whose employment terminates or dependency status changes has the right to elect continuation of coverage under Arkansas Law. To be eligible, the Member must have been continuously covered under the Plan for at least 3 consecutive months prior to employment termination or change in dependency status, not be eligible for any other group health plan, and make the election by notifying the Group and Health Advantage in writing within 10 days of loss of eligibility.
3. A Member may elect a Conversion Plan instead of continuation of coverage, or have the option of a Conversion Plan at the end of the 120-day continuation period.

### COBRA Continuation

1. Section 10001 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) applies to Groups with 20 or more employees on 50 percent of its typical business days during the preceding calendar year. Subscribers and Dependents whose coverage ends due to a Qualifying Event may elect COBRA coverage.
2. Qualifying Events include termination of a Subscriber's employment (other than by reason of the Subscriber's gross misconduct), reduction of hours of employment, divorce or legal separation from spouse, Subscriber becomes eligible for Medicare, or a dependent loses eligibility as a dependent.
3. The Group Administrator must notify Subscriber and any dependents notice of COBRA rights by first class mail within 14 days of Qualifying Event. The Member must elect COBRA within 60 days of the date of Qualifying Event or date of notification, whichever is later.
4. Once in effect, COBRA coverage may continue as long as the group contract remains in force and Member pays required premium, ending at the end of the maximum period of:
  - Subscriber's death - 36 months for dependents
  - Termination of a Subscriber's employment (other than for gross misconduct) or reduction in hours of employment - 18 months for employee and dependents; or 29 months if Subscriber is disabled at time of or within 60 days of termination of employment or reduction in hours
  - Subscriber becomes eligible for Medicare – maximum of 18 months for dependents
  - Subscriber divorces or becomes legally separated from spouse - 36 months for spouse
  - Dependent loses eligibility - 36 months
  - Member becomes eligible under any other group health plan -date of coverage
  - Subscriber/Member becomes entitled to Medicare - date entitled to Medicare

## **COBRA Administration**

Groups that are subject to COBRA may use Ceridian Benefits Services, Inc. a national COBRA Compliance Administrator contracted by Health Advantage, another third party COBRA Compliance Administrator, or administer COBRA through the group. Most groups contract with Ceridian Benefits Services, Inc. Services provided by Ceridian:

- Billing of COBRA premium;
- Adjudication of eligibility;
- Premium collection;
- Processing of ongoing COBRA transactions on behalf of the group;
- Retention of documentation; and
- Supplying forms for use in administering COBRA.

For more information on Ceridian Benefits Services, Inc., go to [ceridian-benefits.com](http://ceridian-benefits.com) or call 1-800-790-9057.

### **Groups That Use Ceridian Benefits Services, Inc.**

1. The Group notifies Health Advantage to terminate coverage.
2. Ceridian sends the top 3 copies for the COBRA Notification form and Rate Sheet to employee within 14 days of Qualifying Event. Employee will no longer be eligible for life insurance.
3. The Ceridian Copy of the COBRA Notification form is sent directly to Ceridian at the time the other copies of COBRA Notification form and Rate Sheet are sent to the employee.
4. Employee/Dependent(s) has 60 days to elect COBRA coverage.
5. If the Employee/Dependent(s) elect COBRA coverage, Ceridian bills him/her for all premiums to pay through current month. The Employee/Dependent(s) has 45 days to return full payment to Ceridian.
6. Once Ceridian receives payment, it is forwarded to the Group with the Employer Copy (Participant Update). The Group faxes the form to Health Advantage Customer Accounts Division, fax number 501-301-6869 promptly.
7. Ceridian bills the continuant monthly and remits payment to the Group. The Group is responsible for payment of premium to Health Advantage.
8. The Group must notify Health Advantage of any changes in status.

### **Groups subject to COBRA but do not use a COBRA Compliance Administrator**

1. The Group notifies Health Advantage to terminate coverage.
2. The Group notifies Employee/Dependent(s) within 14 days of Qualifying Event.
3. Employee/Dependent(s) has 60 days to elect COBRA coverage from the date coverage ends or the date of the notification, whichever is later.
4. If elected, the Group sends in Employee Application or change form with COBRA effective date for Member to be reinstated on COBRA continuation without a break in coverage.

5. The Group collects all premiums to pay through current month and forwards to Health Advantage.
6. The Group must notify Health Advantage of any changes in status.
7. Please refer to the Department of Labor Wages and Hour Division's website for Up-to-date COBRA Information.

### **Conversion Plan Option – available only to members of fully insured groups**

1. If a Subscriber ceases to be eligible for coverage on the Employer Group Health Plan and is not eligible for coverage under any other group health plan or Medicare coverage, the Subscriber may apply on his or her behalf and on behalf of his or her enrolled Dependent(s) for a Health Advantage Conversion Plan. Application must be made to Health Advantage within 31 days of loss of group coverage.
2. The Conversion Plan will be administered by Health Advantage at the conversion rates in effect at the time of the conversion. Health Advantage may change the conversion rates with 30 days notice to Members. The Conversion Plan is age/sex rated with four rate categories. The rates will change on January 1, after one full year of conversion coverage and annually thereafter for the next three years.
3. The benefits in the Conversion Plan may not match the benefits in the group health plan. No Prescription Medication Benefits are available on the Conversion Plan.
4. The effective date of the Conversion Plan is the first day following loss of coverage under the group health plan. The Conversion plan is renewed each January 1 which means that the contract year will be January 1 through December 31 for all subsequent years that the coverage is in effect. The Member is required to sign a new contract for each January 1, to continue coverage for another year.
5. The Member can be cancelled on "paid to" date for non-payment of premium if premium is 30 days late. The Member is responsible for all claims incurred after the "paid to" date.
6. The Member may request termination of the Conversion Plan at any time, but must give Health Advantage written notice at least 30 days before the termination is to be effective.
7. When the Member becomes eligible for any other group coverage or Medicare, the Member must notify Health Advantage in writing at least 30 days before loss of eligibility on the Conversion Plan.
8. The Conversion Plan can be elected instead of the Continuation (120 days), at the end of the Continuation period, or at the end of the COBRA maximum period.

## 17.0 HOW TO FILE A CLAIM FOR COVERED SERVICES

### Reimbursement of payment for Covered Services received in the Service Area

If a Member makes payment, other than required Copayments/Coinsurance, for services covered by Health Advantage, a claim for reimbursement may be made by the Member by submitting a copy of receipt for payment for services received and a copy of the bill to Health Advantage. The request must include the member's ID number and group name or number, and be made within 180 days from the date on which expenses were first incurred. The request for reimbursement must be sent postage paid and addressed to:

Health Advantage Claims  
Post Office Box 8069  
Little Rock, Arkansas 72203-8069

The Member is responsible for the difference between billed charges and allowed charges for services provided by non-participating providers.

### Filing a Claim for Covered Services received outside of the Service Area

Claims for medical services received through the BlueCard program are filed with the local Blue Cross and/or Blue Shield plan with the XCH prefix and Member's ID number and routed electronically to Health Advantage.

For Out of Service Area services that are not received from a BlueCard participating provider, the member may submit a HCFA Standard Form 1500, Claim Form, or a copy of the bill for services received with a request for payment to Health Advantage. The request must include the member's identification (ID) number, name and date of birth, and the group name or number, and be submitted within 180 days from the date on which expenses were first incurred. It must be sent postage paid and addressed to:

Health Advantage Claims  
Post Office Box 8069  
Little Rock, Arkansas 72203-8069

The Member is responsible for the difference between billed charges and allowed charges for services provided by non-participating providers.

### Pharmacy Services

For Reimbursement for pharmacy charges, the member may submit the Prescription Claim Form with copy of receipt, member ID, and group name or number to:

**Caremark Claims Department**  
**P O BOX 52136**  
**Phoenix, AZ 85072-2136**

**NOTE:** *All Covered Services are subject to the Health Advantage Allowable Charges, and to the terms, conditions, limitations and exclusions of the Member's Evidence of Coverage. Medications from Out-of-Network Pharmacies are not covered except for emergencies.*

## 18.0 RETURNED MAIL PROCEDURES/ADDRESS CHANGES

1. In order for the Member to receive materials at their home address, Health Advantage must have a current address. When a Member moves and does not inform Health Advantage of the address change, all correspondence that is sent to the Member is returned to Health Advantage until the address is updated on the Member's record in the membership system. Correspondence that is returned:
  - Member packets with ID Cards
  - ID Cards in window envelopes
  - Member packets without ID Cards
  - Denial letters
  - Explanation of Benefits (EOB statements)
  - Referral letters
  - Pharmacy Updates
  - Member Newsletters
2. If the mail is returned and the forwarding address is on the envelope, the Member's record in the membership system is updated and the correspondence is remailed.
3. When there is no forwarding address or the forwarding address has expired, the mail is sent to group administrator for distribution to the member and to update the employee's address.
4. To request an address change, the Group Administrator or the Member may call Customer Service at 1-800-843-1329, or complete the address change at [HealthAdvantage-hmo.com](http://HealthAdvantage-hmo.com). The Address Change Form may be faxed to 501-301-6869 or mailed to Health Advantage, P.O. Box 8069, Little Rock, AR 72203-8069.

## 19.0 THE FAMILY AND MEDICAL LEAVE ACT/MILITARY LEAVE Family and

### Medical Leave Act of 1993

Groups with 50 or more employees for each working day during each of 20 or more calendar work weeks in the current or preceding calendar year are subject to The Family and Medical Leave Act (FMLA).

### Family Leave

If subject to this Act, an employee must be granted up to 12 weeks unpaid leave for the following reasons:

- for the birth or placement of a child for adoption;
- 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. It is suggested that the employer continue to pay the employee's portion of the premium, if any, during the leave to ensure that the employee's coverage continues unabated during the leave, and keep the employer in compliance with the requirement that the coverage resumes unchanged when the employee returns from the leave. If the employee's coverage were to lapse due to non-payment of premium during the leave, he or she would have to reapply for coverage. The employee can be provided with a COBRA Notification at the end of the 12 weeks if not returning to work.

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 circumstances beyond the employee's control.

**Military Leave:** If a Subscriber is called to active duty in the armed services of the United States of America for a period of more than 30 days, the Subscriber (and any covered dependents) may elect to continue coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) or COBRA for a period of 18 months. When the Subscriber is called to active duty for more than 30 days, the dependents are eligible for Tricare benefits, effective immediately with no premium payment required. The web site is: <http://www.tricare.osd.mil/supplementalinsurance/>

Member's returning from active military service (and any previously covered dependents) may enroll in the Plan within 90 days of his or her return to employment. The effective date of coverage is the date of Member's re-employment. Health Advantage may require a copy of the returning Member's orders terminating the active duty.

### Group Administrator Guidelines

September 2011

(All forms available at [HealthAdvantage-hmo.com](http://HealthAdvantage-hmo.com))

## 20.0 DEFINITION OF TERMS

For the purpose of this manual, the following operational definitions are provided:

**Subscriber** - means a person who is directly employed by the Employer for Full-Time Employment. This person must reside in the United States and be paid for full-time work in the conduct of the Employer's regular business. No director or officer of the Employer shall be considered a Subscriber unless he meets the above conditions.

**Subscriber number/Contract Number** - The contract number (member ID number) will be automatically assigned. The employee/subscriber will have an extension of 01 following the ID number and the dependents will have 02, 03, etc.

**Dependent** - means any member of a Subscriber's family who meets the eligibility requirements of Health Advantage, who is enrolled in the Group, and for whom Health Advantage has received premium.

**Member** - This term is used when referring to a person covered by Health Advantage for health care benefits whether it is the Subscriber and/or Dependents.

**Child** - A Subscriber's natural Child, legally adopted Child or Stepchild. "Child" also means a Child that has been placed with the Subscriber for adoption. "Child" also means a Child for whom the Subscriber must provide medical Child support pursuant to a court order or a Child for whom the Subscriber has been court appointed the guardian.

**Stepchild** - A natural or adopted Child of the Spouse of the Subscriber.

**Incapacitated Dependent.** An incapacitated dependent is a member that is over the maximum dependent age according to the group contract, and medically certified as totally disabled and chiefly dependent on the Subscriber for financial support. If an incapacitated dependent is over the limiting age at the time enrollment is requested, the incapacity must have commenced before the limiting age (and the dependent must have been continuously covered as a dependent of the Subscriber since attaining the limiting age. Proof of mental or physical incapacity must be received by Health Advantage in the form of an IQ Score in order to provide coverage for incapacitated dependents. Health Advantage's determination of eligibility shall be conclusive.

**Qualifying Event-** An event that allows a Subscriber or Dependent to be eligible for health care coverage under a group health plan:

- Loss of eligibility from another group health plan due to termination of employment
- Loss of coverage under another group health plan (group cancelled coverage)
- Loss of coverage under spouse's group plan
- Loss of coverage due to divorce or legal separation
- Dependent loses coverage under other parents plan
- Dependent reaches maximum age

- Dependent joins the military
- Subscriber called to active duty for more than 30 days or returning from active duty military

#### Adding and/or Reinstatement of Members

- Marriage
- Birth or adoption of a Child
- Court Ordered coverage of child

**Special Enrollment Period** - A Special Enrollment Period is the 31-day period during which time an employee or employee's dependent may enroll in the Plan, after his or her initial Eligibility period or Open Enrollment Period and not be a Late Enrollee. Special Enrollment Periods occur in two instances:

1. **AFTER THE TERMINATION OF ANOTHER HEALTH PLAN:** A Special Enrollment Period occurs (1) after an employee's or dependent's coverage under another health plan terminated as a result of loss of eligibility, or (2) after the employer providing such other health plan terminated its contributions. In order for the Special Enrollment Period to apply, the employee must have stated in writing, at the time coverage under the Plan was first offered, that the employee or dependent(s) were declining coverage because of coverage under such other health plan.
2. **AFTER THE ADDITION OF A DEPENDENT:** A Special Enrollment Period occurs for an employee, employee's spouse or employee's new dependent child (1) after the employee marries, (2) after an employee's child is born, or (3) after an employee adopts a child or has a child placed with the employee for adoption.

**Late Enrollee** - A Late Enrollee is any employee or dependent who requests enrollment in the Group's health benefit plan after the expiration of the Initial Enrollment Period or Open Enrollment Period and who is not eligible for a Special Enrollment Period. Members that meet the definition of Special Enrollment Period are not considered Late Enrollees. Late Enrollees are deferred until the next open enrollment period.

**Open Enrollment Period** - The Open Enrollment Period occurs annually, during the month designated by the Employer and set forth in the Group Contract when employees who are eligible for coverage may enroll in the Plan. 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 Contract, enrollments and coverage changes made during the Open Enrollment Period become effective on the anniversary date of the Group Contract.

**Preexisting exclusion period** - (This applies only to groups with Pre-existing) New hires and add-ons are subject to a 12-month pre-existing condition exclusion period. A pre-existing condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on (1) the Member's effective date or (2) the first day of the Waiting Period, whichever applies. This 12-month pre-existing exclusion period can be reduced or eliminated by providing Creditable Coverage information from previous health insurance prior to the hire date (new hires) or the effective date (additions, including Open Enrollment additions) providing there is not more than a 63-day break in coverage.

#### Group Administrator Guidelines

September 2011

(All forms available at [HealthAdvantage-hmo.com](http://HealthAdvantage-hmo.com))