

Health Advantage



An Independent Licensee of the Blue Cross and Blue Shield Association

GROUP ADMINISTRATOR GUIDELINES

FOR EMPLOYER GROUPS THAT SUBMIT ELECTRONIC ELIGIBILITY

issued by
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**GROUP ADMINISTRATOR GUIDELINES
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1.0 INTRODUCTION

Group Administrator Guidelines for groups that submit electronic eligibility

These Group Administrator Guidelines are for use by Employer Groups that enroll on-line or that provide electronic eligibility to Health Advantage directly or through a third party eligibility vendor. These guidelines are not intended for Groups that submit paper enrollment applications. 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 intended to provide administrative 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.
 - Attachment A – Appeals and Complaints
 - Attachment B - Schedule of Benefits (Covered services, limitations, and exclusions)
 - Attachment C - Benefit Summary - specifies benefit maximums, deductibles, copayments and/or coinsurance amounts, and out-of-pocket maximums for Schedule of Benefits
 - Amendments, if any
3. **Benefit Riders (if applicable)**
 - Managed Pharmacy Benefit Rider - contains benefits, limitations, and exclusions for prescription medication coverage
 - Mental Health/Substance Abuse Rider, Air Ambulance Rider, or TMJ Rider (if applicable) – Specific Riders replace benefits in the Evidence of Coverage
4. **Health Advantage Frequently Asked Questions (FAQ).** This is a composite of frequently asked questions on health plan information, claims, appeals, and eligibility. The FAQs for each plan type are available on the web site.
5. **Preventive Health Guidelines** - Recommended preventive health care for Members. Also available on the website.
6. **Coordination of Benefits (COB) Questionnaire.** Members must provide Health Advantage with Medicare and other insurance information and changes to the information for proper payment of claims. COB Questionnaire available on the web site.
7. **Any other group information**

The Group Administrator Guidelines manual and all Health Advantage forms can be printed from web site HealthAdvantage-hmo.com

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 - 1-800-330-3072

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

Customer Service. Group Administrators or Members should call a Customer Service Representative (CSR) for the following:

- Verification of health plan or pharmacy eligibility
- Benefit questions
- Order ID cards
- Claims questions
- Update other insurance information if this information is collected by Health Advantage
- Primary Care Physician (PCP) selection and changes if Health Advantage is responsible for collecting PCP information. If PCP information is submitted electronically, all changes must be made through the group.

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
- Renewal procedures and rates

Customer Accounts - (FAX 501-301-6869). 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 Customer Accounts for the following:

- Eligibility issues or 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*. 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.

Group Administrator Guidelines (electronic eligibility)

January 2007

(All forms available at *HealthAdvantage-hmo.com*)

3.0 GROUP ADMINISTRATOR RESPONSIBILITIES

Enrollment

- Schedule enrollment/open enrollment meetings
- Distribute Marketing materials so employees can make informed choice of health care coverage
- Verify accuracy of member enrollment information
- Enter enrollment information on-line or submit enrollment to eligibility vendor
- Maintain copies of required eligibility documentation on file. Documentation must be made available to Health Advantage upon request.

Required Eligibility Documentation

- Adding newborn – Birth Certificate
- Adding spouse - Marriage Certificate; Certificate of Coverage if for loss of coverage
- Court ordered coverage – Qualified Medical Child Support Order or divorce decree
- Adopted child - petition for adoption or adoption papers
- Grandchild - proof of court appointed custody/guardianship with date filed with court
- Stepchild - verification that child is living in the same household as Subscriber in parent-child relationship
- Termination of spouse - divorce decree, legal separation papers or signature of spouse if termination is in anticipation of divorce and there is not a legal separation
- Disabled Dependent - proof of mental or physical incapacity (Forms Section) must be submitted to Health Advantage for determination
- Student verification information – if student verification is performed by the group

Terminations

- Enter or submit terminations in timely manner
- 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 the group

Group Billing/Premium Collection

- Remit premium by first of the month for month that coverage is in effect
- Submit premium backup (listing for whom and how premium should be applied)
- Complete Health Advantage Adjustment Form for monthly billing and submit with premium check and premium backup (if group is not self-billed)

ID Cards and Benefit Materials

- Ensure members receive Benefit Materials - Subscribers will receive packet with Benefit Materials and ID Card (Dependents receive ID Card only if added later)
- Distribute Member materials that are returned for bad addresses (Return Mail)

Miscellaneous

- Submit changes in ownership, account executive, or contact person
- Post notices for employees of proposed changes in health care coverage as required by law

4.0 PREMIUM COLLECTION PROCEDURES

Billing Procedures

1. New groups are billed after all members are active on the system.
2. Renewal groups are billed after the group is renewed and when new members (open enrollment additions) have been loaded.
3. All Commercial Groups are billed monthly. Group billing is run automatically between the 12th and 18th of each month depending on when the weekend falls. Member changes received by the 10th of the month will be reflected on the next month's bill.
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 month for 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. Premium must be remitted by first of the month for month that coverage is in effect. The following procedures are recommended:

Premium payment by check:

1. Make check payable to "Health Advantage Membership."
2. Include group/division number or group name on check.
3. Make check for amount billed, plus or minus adjustments.
4. Submit Premium to: Health Advantage Membership/Accounting, P.O. Box 8069, Little Rock, AR, 72203-8069.

By Wire Transfer:

1. Notify Health Advantage by email or letter of date wire transfer will be made.
2. Wire transfer must be made to "Health Advantage."

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 15 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 paid to date will pend.
 - Pharmacy claims are flagged when the group is identified as delinquent.
 - Flags are released when payment is received.
2. When grace period (31 days) is 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 premium 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 will be cancelled on the paid to date for non-payment of premium.

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 Health Insurance Portability and Accountability Act (HIPAA) 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 software works in conjunction with Blues Enroll 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 Blues Enroll message center alerting you to make the adjustments on the Blues Enroll 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 Blues Enroll 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.

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 and Outpatient)
 - Home Health Care following catastrophic accidents
 - Home IV Antibiotics or other Drug Therapy
 - Pain Management
 - Premature Infant Care
 - 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.

HealthConnect Blue

Health Connect 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* 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 ELECTRONIC ELIGIBILITY

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:

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.
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 (or printed report) by the third party eligibility vendor. All changes in enrollment must be made by the group through the third party.

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. Proprietary files printed to paper and forwarded to Health Advantage.
4. 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 annually 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.

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

Reinstatement of Previously Covered Members. The effective date must be in accordance with Group Contract and Evidence of Coverage. If a member is eligible for continuous coverage and did not have a qualifying event for reinstatement, there can be no break in coverage and reduction of premium. All premium must be submitted with next bill to provide continuous coverage.

Dependent students must request reinstatement within 31 days of the beginning of the current semester, or must be deferred until the next semester or the next open enrollment. When a dependent is reinstated as a student, the effective date is the first of the month the current semester begins.

Qualifying Event. To add a Subscriber or a Member to the plan after the initial enrollment period or open enrollment period has expired, there must be a Qualifying Event. Documentation of qualifying event must be maintained by the group and be available upon request by Health Advantage.

Incapacitated Dependents. Proof of mental or physical incapacity must be received by Health Advantage in order to enroll or 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. (Proof of Incapacity Form in Forms Section and at *HealthAdvantage-hmo.com*). If a dependent is enrolled by the group as an incapacitated dependent, and subsequently fails to provide proof of incapacity, or does not meet criteria for incapacity, coverage will be rescinded.

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.

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.

7.0 REQUIRED ENROLLMENT INFORMATION

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 Exclusion. 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

SSN Requirement. Effective September 2004, the Subscriber SSN will no longer be used as the Member ID number on Health Advantage members. All Member ID numbers will be converted to a non-Social Security number that will appear on the Member ID Card and billing. ID numbers will be system generated. The Subscriber SSN is a required field on all files and will be used for matching a member's record on the membership system.

Required Enrollment Information – NEW DEPENDENT

1. Dependent name (first, middle, last)
2. Effective date
3. Social Security number
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)
10. Students: name and location of school for each student - when annual student verification is performed by Health Advantage.

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 Customer Accounts. 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 discrepancy.

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.

8.0 COVERAGE EFFECTIVE DATE GUIDELINES

Member	Qualifying Event	Effective Date	Remarks
Spouse	Marriage	First of month after date of marriage	Application must be made 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 made within 31 days of loss coverage
Natural Child of Employee	Loss of Other Coverage	First of month after loss of coverage	Application must be made 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	Adoption or Petition for Adoption	Date of Birth	Enrolled within 60 days of Date of Birth
Adopted Child - Not a Newborn	Adoption or 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	Qualified Medical Child Support Order or divorce decree.	First of the Month after application received by group	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	Enrolled within 31 days of Qualifying Event; Stepchild must live in the same household as Subscriber
Current Member - Mentally or Physically Incapacitated Dependent	Dependent reaches age 19 or dependent maximum age per group contract	First of the month after dependent reaches age 19 (or maximum dependent age)	To prevent any break in coverage, must be enrolled as incapacitated dependent within 31 days (Proof of Incapacity of Dependent Form in Forms Section)
New Member Mentally or Physically Incapacitated Dependent	Dependent over age 19 and was covered on previous group health plan	Date Subscriber is effective for new group	Proof of incapacity before age 19 (or maximum dependent age) and Creditable Coverage since age 19 must be received by Health Advantage
Student	Reaches maximum dependent age per group contract	First day following loss of coverage as dependent	Within 31 days of Qualifying Event (reaches maximum dependent age)
Reinstatement of Student Status	Becomes full-time student at accredited school	First of the month that semester begins	Apply within 31 days of Qualifying Event – beginning of current semester.

9.0 MEMBER RECORD CHANGES

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 submitted by the health care provider. Health Advantage must receive changes as soon as they occur in order to provide the best service possible.

Social Security Number (SSN)

Effective September 2004, the employee's Social Security number (SSN) will no longer be used as the Member ID number. All subscribers will be assigned a non-Social Security number that will appear on Member ID cards. ID Numbers will be system generated.

Social Security numbers will still be required on all new members and will be used internally for proper coordination of benefits and claims processing. For members loaded without a SSN, i.e. newborns, a letter, "Request for Member SSN," is generated and sent to the Subscriber to provide this information (included in the Forms Section and at *HealthAdvantage-hmo.com*) The Member must contact the group to provide or correct a SSN.

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*) and submit to the group to have address updated.

Primary Care Physician Change

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.

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. Once enrolled, PCP selections and changes are made by contacting the Customer Service at the number listed 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.

If the group requires the Member to make PCP selections on-line or to submit PCP changes through the group, the Member must contact the group to select or change a PCP. Only emergency changes can be made through Customer Service. The preferred method is for

PCP information to be collected and submitted on new members only. (See Primary Care Physician Selection Procedures, Section 11.0)

Date of Birth Corrections

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.

Name changes

Name changes must be submitted as a member record change. The member must notify the group of a name change.

Change in Dependent Student Status (See also Dependent Student Procedures).

In order for a dependent student to be eligible for coverage, he/she must be a full-time student at an accredited college, university or vocational training school, financially dependent on the Subscriber, and under maximum age specified in the Group Application.

If Health Advantage is responsible for verification of student status, the member will be sent a Student Verification Letter annually (Forms Section). The Group Administrator may request a change in student status by completing the Student Verification Letter in the Forms Section. The Student Verification Letter can be used to:

- Terminate a student
- Reverify annual eligibility
- Reinstate a previously covered dependent as a student

NOTE: When a student termination request is submitted, the Group Administrator must notify the student of their continuation rights. When a student is termed by Health Advantage for non-response of student eligibility, a Certificate of Creditable Coverage letter is sent to the Member and a termination notice is sent to the Group Administrator. The Group Administrator must notify the dependent student of their continuation rights and make any necessary premium rate adjustment for Subscriber.

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.

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. The only exception to this is for new groups which can be overnighted directly to the Group Administrator or picked up by the Marketing Representative and delivered directly to the Group Administrator.
2. ID cards generally print the business day after a member is enrolled 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
 - Member Identification (ID) Number
 - Correct Copayment or Coinsurance amounts
 - Group/division Number
4. New Subscriber ID Cards are mailed in a large envelope clearly marked "MEMBERSHIP CARD ENCLOSED" in red letters with a Member Packet which includes:
 - Welcome Letter
 - Evidence of Coverage
 - Attachment A – Appeals and Complaints
 - Attachment B - Schedule of Benefits
 - Attachment C - Benefit Summary
 - Amendments, if any
 - Managed Pharmacy Rider (if applicable)
 - Other Riders according to the contract
 - Health Advantage Frequently Asked Questions
 - Preventive Health Guidelines
 - Coordination of Benefits (COB) Questionnaire
 - 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 the 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 in the Health Advantage Provider Directory at *HealthAdvantage-hmo.com* and listed as a PCP accepting new Members.
2. If the group does not provide the Primary Care Physician (PCP), the Member is enrolled and the ID card is 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 (Forms Section). 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. If PCP information is not provided on enrollment and Health Advantage is responsible for assisting with PCP selection and changes, the Member must contact Customer Service at the number listed on the Member's ID Card to select or change a PCP. The Member must provide the physician's name, office location and PCP 5-digit code.
5. If the group is responsible for submitting PCP information and changes, the Member must notify the Group of the PCP selection or change. The Member will not be allowed to make PCP changes through Customer Service, except for emergencies.
6. Once the PCP information is received by Health Advantage, a new ID Card is mailed within 1-2 business 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" or Network name (dual network) printed on the ID card and will not be sent a PCP Selection Letter.

PCP Termination

When a PCP leaves the Health Advantage Network, a default provider number is assigned and the member will receive an ID Card showing "Member awaiting PCP." The Member will be notified by letter by Health Advantage to select another PCP.

NOTE: The preferred method for PCP selection and changes is for the PCP information to be collected and submitted by the group on new members only. When PCP changes are made through Customer Service, PCP availability can be verified since some PCPs may not accept new members, or may have age restrictions.

*Members may check PCP information at HealthAdvantage-hmo.com
Login ID and Password required*

12.0 DEPENDENT STUDENT PROCEDURES

Dependent Students

A student is defined as a dependent that is a full-time student at an accredited college, university or vocational training school, under the maximum student age specified in the Group Application, and who is financially dependent on the Subscriber.

Student Verification – when performed by Health Advantage

1. When a dependent reaches the maximum dependent age (usually 19), a Student Verification Letter prints on the first business day of the month before the dependent reaches maximum age. The letter must be returned with the school information in order to continue coverage as a dependent student. A second letter prints the following month if the Member record is not updated. If there is no response within 60 days from the date of the first letter, the member is termed at the end of the birth month or according to the group's dependent age policy.
2. For verification purposes, college semesters normally begin in January and August. Students remain eligible while in high school and the summer following graduation if they are planning to attend college the following semester. Students graduating from college are terminated at end of month of graduation.
3. Annual Student Verification. Health Advantage verifies student status annually. Up to two letters are sent for annual reverification. If there is no response within 60 days of the date of the first letter, the member is termed at the end of the month and the group and the member are notified by letter.
4. The Subscriber is responsible for notifying Health Advantage of a change in student status of a dependent. When students are termed due to loss of eligibility, they are entitled to continuation of coverage according to the Evidence of Coverage.

Student Verification – when performed by the group or a third party

If a group requires that student verification not be sent to the Subscriber, then the dependent age policy will apply through the maximum student age. These dependents will not be identified in the Health Advantage membership system as a student, but will retain the class code for dependents until they reach the maximum student age according to the group contract. It is the groups responsibility to notify Health Advantage when the dependent is no longer a student.

Reinstatement of Student Status

The request must be made in writing within 31 days of Qualifying Event with coverage effective date indicated. The Qualifying Event date is the first of the month of the semester that the member becomes a full-time student. The effective date of reinstatement for dependent students is the first of the month the semester begins. If the request for reinstatement is not submitted within 31 days of beginning of semester, the student is considered a Late Enrollee and is deferred until the next semester or the next open enrollment.

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 and Medicare Information

If the group provides other insurance and Medicare information for coordination of benefits, changes to other insurance or Medicare information should be submitted through the group. However, information may be requested by Health Advantage when needed to process a claim correctly.

If the group does not provide other insurance information or Medicare information on enrollment, the COB Questionnaire included in the new member packet may be completed and returned to Health Advantage. It is the member's responsibility to inform Health Advantage of other insurance or Medicare coverage and all changes to other insurance information.

Changes to Other Insurance Information

For prompt payment of claims, other health insurance information must be kept current. Health Advantage includes a Coordination of Benefits (COB) Questionnaire in all new member packets. This form should be completed and forwarded to Health Advantage anytime there is a change in Medicare or other insurance information. Changes in other insurance are considered a change in member information. To add or change other insurance or Medicare information, Members may call 1-800-969-3983, submit the information in writing, or complete the COB Questionnaire and mail to:

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

The Coordination of Benefits (COB) Questionnaire is included in the Forms Section and available at 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). 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) 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 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 consecutive days. The Group Administrator must approve applications for active employees. Annual renewal is not required.

The Subscriber must complete the appropriate application (Forms Section) to request the Out of Area Classification. The completed application must be submitted to Health Advantage. It may be 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 member at the out-of-state 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*. To locate the nearest participating BlueCard Traditional Network provider, Members may go to *www.bcbs.com* or call 1-800-810-2583 (BLUE).

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

Out of Area applications must be submitted directly to Health Advantage

15.0 TERMINATION OF COVERAGE

Subscriber/Member Terminations

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 will make the final decision on all retroactive termination requests. Premium should be submitted and accompanied with a request for termination and explanation or reason it is retroactive for consideration by Health Advantage. 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

- Subscriber terminates employment
- Spouse – divorce (or legal separation), or becomes eligible for group plan through own employer
- Dependent Child/Dependent Student:
 - Becomes covered by other parent
 - Marries or joins the military
 - Reduces hours or quits school (may be eligible for continuation of coverage)
 - Eligible for coverage through own employer
- Subscriber/spouse - becomes eligible for Medicare
- Death (Subscriber or Member); 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 (sample included in Forms Section) is printed and sent to the Subscriber. A Certificate of Creditable Coverage may be requested at any time at *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, or the group no longer meets minimum participation requirements. 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 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 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 1001 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 child 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 child 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. (CobraServ) 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.

Groups that Use Ceridian Benefits Services, Inc.

1. The Group notifies Health Advantage or third party to terminate coverage.
2. Employer sends the top 3 copies for the COBRA Notification form and Rate Sheet to employee within 14 days of Qualifying Event.
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 premium 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.
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 or third party 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 notifies Health Advantage or third party of COBRA effective date for Member to be reinstated on COBRA continuation without a break in coverage.

Group Administrator Guidelines (electronic eligibility)

January 2007

(All forms available at HealthAdvantage-hmo.com)

5. The Group collects all premium to pay through current month and forwards to Health Advantage.
6. The Group must notify Health Advantage of any changes in status.

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 eligibility.
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 Direct Member Reimbursement Form (included in Forms Section) with copy of receipt, member ID, and group name or number to:

Ark BCBS, Dept #276
Argus Health Systems, Inc.
P.O. Box 416019
Kansas City, MO 64141

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.*

Group Administrator Guidelines (electronic eligibility)

January 2007

(All forms available at HealthAdvantage-hmo.com)

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 update the address, 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 information is remailed and the envelope is forwarded to the group to enter address change.
3. When there is no forwarding address or the forwarding address has expired, the Member mail is sent to the Group Administrator for distribution to the member and to update the employee's address.
4. Address changes must be submitted through the group. Members may complete the Address Change Form in the Forms Section or at *HealthAdvantage-hmo.com* and submit to the Group Administrator to update address.

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.

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

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.

20.0 DEFINITION OF TERMS

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

Subscriber. The employee of the group that is the policyholder or the contract holder for himself/herself and members of the family.

Subscriber number/Contract Number. Effective September 2004, the contract or member identification (ID) number will be a non-Social Security 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. Members on a policy or contract that are dependents of the Subscriber.

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 provided: such Child lives with the Subscriber in a parent-Child relationship; and the Subscriber has a legal right to claim and does claim such Child as a dependent on the Subscriber's federal income tax return.

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 (usually 19) 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 order to provide coverage for incapacitated dependents. Health Advantage's determination of eligibility shall be conclusive. (The Proof of Incapacity of Dependent Form in Forms Section)

Qualifying Event. Any event or happening that allows a Subscriber or Dependent 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
- Child loses coverage under other parents plan
- Dependent reaches maximum age
- Student reaches maximum age
- Dependent/student marries or 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
- Dependent becomes full-time student

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.

21.0 HEALTH ADVANTAGE FORMS INDEX

1. Change Request Form.
This form may be used to update information such as PCP information, other insurance information, Life Beneficiary information, or any other information that is not submitted with eligibility information electronically. Any member information that is collected and submitted by the group must be updated through the group and sent to Health Advantage electronically.
2. Newborn Enrollment Request.
This form may be used to collect newborn enrollment information from members. It may also be provided to the member before the baby is born to be completed and returned to the group with the newborn enrollment information since the employee may not be returning to work for several weeks.
3. Proof of Incapacity Questionnaire (2 pages). Completed forms must be submitted to Health Advantage for determination of incapacity.
4. Primary Care Physician Selection Letter
5. Request for Member SSN Letter
6. Dependent Student Verification Letter.
7. Coordination of Benefits (COB) Questionnaire (2 pages)
8. Out of Area Application for Dependents. This form is submitted directly to Health Advantage Membership, P.O. Box 8069, Little Rock, AR 72203-8069.
9. Out of Area Application for Active Employees. This form is must be signed by the Group Administrator and submitted to Health Advantage Membership, P.O. Box 8069, Little Rock, AR 72203-8069.
10. Health Benefits Certificate of Coverage Letter (Sample)
11. Address Change Form
12. Billing Adjustment Form
13. Prescription Claim Reimbursement Form (2 pages)