GROUP ADMINISTRATOR MANUAL

Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

Health Advantage
An Independent Licensee of the Blue Cross and Blue Shield Association

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1.0 Introduction

Thank you for choosing Arkansas Blue Cross and Blue Shield or Health Advantage! Your employees rely on you to answer their questions about your group's health, dental and vision plans. This manual gives you the information to provide quick and accurate answers. Also, your group account representative, group service representative or your independent agent is always available to answer any questions you might have.

Please remember that this guide is not legally binding. If you find differences between the information in this guide and your Benefit Certificate, go with the specifics in your Benefit Certificate.

2.0 Contact Information

2.1 Who to Contact – Health and Pharmacy

Blueprint for Employers

Blueprint for Employers is an online, self-service tool for group administrators. Group administrators can register for online access to their plan information by visiting arkansasbluecross.com or healthadvantage-hmo.com and completing the registration process on the form from our website. Blueprint for Employers lets group administrators:

- View current/future list of enrolled employees and dependents
- View terminations within the last six months
- Order temporary ID cards and replacement cards
- Submit electronic changes and enrollments (if your group uses Blues Enroll, you will not be able to submit changes and enrollments via Blueprint for Employers)
- Track submitted enrollments as they move through the enrollment process
- Submit employee address changes
- Request a Certificate of Creditable Coverage (COCC)
- Register for eBill Manager and access eBill Manager
- Access forms (for groups that use paper processing)

Customer Accounts

To reach your customer accounts representative, please call the number on your bill, or email bccafinancial@arkbluecross.com (Arkansas Blue Cross) or hacafinancial@arkbluecross.com (Health Advantage). The group administrator may contact the customer accounts representative for questions or problems related to:

- Balances or adjustments on the billing statement
- Billing delays

Customer Service

To reach Customer Service, see section 2.4 or call the Customer Service number on the back of your insurance card. Our customer service department is available to help you and your employees:

- Answer questions about claims or benefits
- Order ID cards
- Change or assign a Primary Care Physician (PCP)
- Update other insurance information

Group Service

Please see section 2.5 and 2.6 for contact information. Your group service coordinator is a resource for the group administrator and can act as a liaison for service issues affecting your employees, such as:

- Change addresses (Note: for electronic groups, address changes must be made through the third party vendor such as Blues Enroll and cannot be made by group service – the employer or agent will facilitate these changes on behalf of the employee)
- Questions related to utilizing Blueprint for Employers
- Questions related to enrollment processing (e.g. new hires, qualifying events, open enrollment changes, State of Arkansas Continuation, COBRA enrollments/terms, exception requests, etc.)
- Escalated Blues Enroll or eEnrollment issues
- Eligibility and benefits questions for your plan
- Questions related to retro-terminations
- Escalated claims/benefit issues
- Updating your group's mailing address or group administrator contact information

Account Team

Your regional account representative or sales support team are available to:

- Answer general questions about the group contract
- Request benefit summaries
- Answer questions about renewal procedures and rates
- Answer questions about tax ID number changes, business name changes or buy-outs

My Blueprint

My Blueprint is an online, self-service center for your employees and their dependents. After coverage begins, employees can register for 24/7 access to their plan information by visiting arkansasbluecross.com or healthadvantage-hmo.com. On My Blueprint, members can:

- View a Personal Health Statement (PHS) for processed claims
- View amounts applied towards deductible and out-of-pocket accumulators
- Order ID Cards/access digital ID card
- Find a doctor or hospital
- Review benefits and estimate treatment costs
- Change or assign a Primary Care Physician (PCP)
- Order a Certificate of Creditable Coverage (COCC)

2.2 Who to Contact – Dental

Customer Service

Contact our Dental Customer Service at **888-223-4999** to:

- Answer questions about benefits
- Order ID cards
- Answer questions about claims
- Update other insurance information
- Make changes to an address

Account Team

Contact your regional account personnel if you:

- Have questions about the group contract
- Need marketing packets and extra employee applications
- Have questions about renewal procedures and rates

Group Service

Please see section 2.5 and 2.6 for contact information. Your group service coordinator is a resource for the group administrator and can act as a liaison for service issues affecting your employees, such as:

- Questions related to enrollment processing (e.g. new hires, qualifying events, open enrollment changes, COBRA enrollments/terms, exception requests, etc.)
- Escalated Blues Enroll or eEnrollment issues
- Eligibility and benefits questions for your plan
- Questions related to retro-terminations
- Escalated claims/benefit issues
- Incorrect address or group administrator contact information

Customer Accounts

To reach your customer accounts representative, please call the number on your bill or email bccafinancial@arkbluecross.com. The group administrator may contact the customer accounts representative for questions or problems related to:

- Balances or adjustments on the billing statement
- Billing delays

Claims

Contact Arkansas Blue Cross Dental Customer Service at **888-223-4999** for all claims questions. Phone lines are open 8 a.m. to 8 p.m. CST, Monday through Friday. You can also send a completed Dental Claim Form to:
Dental Claims Administrator
PO Box 69436
Harrisburg, PA 17106-9436

My Blueprint

Visit arkansasbluecross.com to register for My Blueprint. After their coverage begins, members can create a secure account for My Blueprint to:

- Check membership eligibility
- Read about their benefits
- Check the status of their claims
- Print a Personal Health Statement (PHS) on a paid claim
- Order a Certificate of Creditable Coverage (COCC) letter
- Request a member ID card
- View a digital copy of their member ID card

Additional Resources

Visit arkansasbluecross.com for information and forms on:

- Dental Xtra
- Dental Max Rollover

2.3 Who to Contact – Vision

Customer Service

Contact our Vision Customer Service at **800-877-7195** or sign in to your employer website if you need to:

- Verify your vision plan
- Answer questions about benefits
- Answer questions about claims

Group Service

Please see section 2.5 and 2.6 for contact information. Your group service coordinator is a resource for the group administrator and can act as a liaison for service issues affecting your employees, such as:

- Questions related to enrollment processing (e.g. new hires, qualifying events, open enrollment changes, COBRA enrollments/terms, exception requests, etc.)
- Escalated Blues Enroll or eEnrollment issues
- Eligibility and benefits questions for your plan
- Questions related to retro-terminations
- Escalated claims/benefit issues
- Update the employers address or group administrator contact information
- Need to make changes to an address (not applicable for third party vendor groups)
- Need to update other insurance information

Account Team

Contact your regional account personnel if you:

- Have general questions about the group contract
- Need market packets and extra employee applications
- Have questions about renewal procedures and rates

Customer Accounts

To reach your customer accounts representative, please call the number on your bill, or email bccafinancial@arkbluecross.com. The group administrator may contact the customer accounts representative for questions or problems related to:

- Balances or adjustments on the billing statement
- Billing delays

Claims

Contact VSP for all claims questions. You can also send a completed Vision Claim Form to:
VSP
PO Box 385018
Birmingham, AL 35238-5018

My Blueprint

Visit **arkansasbluecross.com** to register for My Blueprint. After their coverage begins, members can create a secure account for My Blueprint, where they can:

- Check membership eligibility
- Read about their benefits
- Check the status of their claims
- Print a Personal Health Statement (PHS) on a paid claim
- Order a Certificate of Creditable Coverage (COCC) letter
- Request a member ID card
- View a digital copy of their member ID card

2.4 Region Contact Information

Northwest Offices | Fayetteville/Rogers

516 E. Millsap Road
Suite 103
Fayetteville, AR 72703
Phone: 479-527-2310 | 1-888-847-1900
Fax: 479-527-2323
Customer Service: 1-800-817-7726
Email: customerservicenw@arkbluecross.com

West Central Office | Fort Smith

3501 Old Greenwood Road
Suite 5
Fort Smith, AR 72903
Phone: 479-648-1635 | 1-800-299-4060
Fax: 479-648-6322
Customer Service: 1-866-254-9117
Email: customerservicewc@arkbluecross.com

South Central Office | Hot Springs

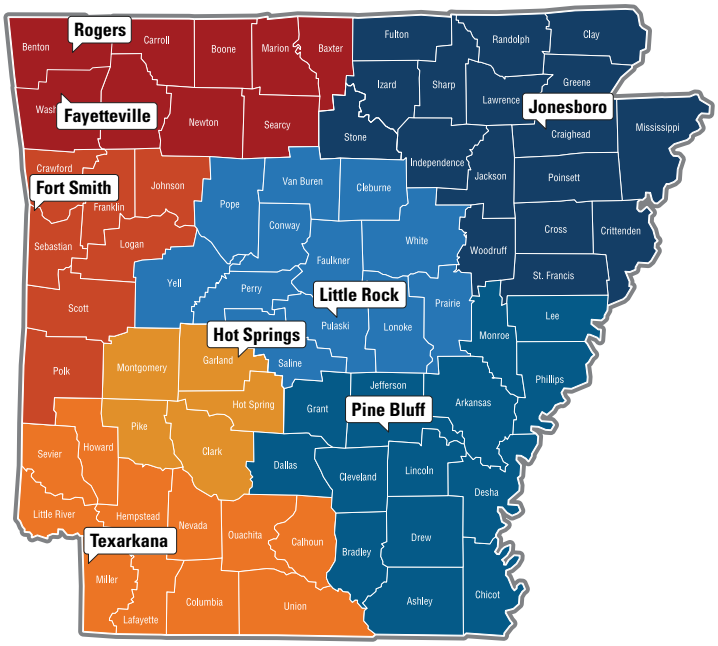
1635 Higdon Ferry Rd.Suite J
Hot Springs, AR 71913
Phone: 501-620-2620 | 1-800-588-5733
Fax: 501-620-2650
Customer Service: 1-800-588-5733
Email: hotspringscs@arkbluecross.com

Southwest Office | Texarkana

1710 Arkansas Boulevard
Texarkana, AR 71854
Phone: 870-773-2584 | 1-800-470-9621
Fax: 870-779-9138
Customer Service: 1-800-470-9621

Southeast Office | Pine Bluff

509 Mallard Loop Drive
Pine Bluff, AR 71603
Phone: 870-536-1223
Fax: 870-543-2915
Sales: 1-800-330-3072
Customer Service: 1-800-236-0369
Email: pbcs@arkbluecross.com



Northeast Office | Jonesboro

2110 Fair Park Blvd, Suite I
Jonesboro, AR 72401
Phone: 870-935-4871 | 1-800-299-4124
Fax: 870-974-5713
Sales: 1-800-619-7690
Customer Service: 1-800-299-4124
Email: neregionscs@arkbluecross.com

Central Offices | Little Rock

320 W. Capitol, Suite 900
Little Rock, AR 72201
Sales: 501-379-4600 | 1-800-605-8301
Marketing Fax: 501-379-4659
Customer Service: 1-800-238-8379

2.5 Large Group Account Management, Fully Insured

Karen Woodward

Account Manager
krwoodward@arkbluecross.com
479-527-2343

Karen Chism
Market Service Representative
kechism@arkbluecross.com
479-527-2313

Brittany Rogers
Group Service Coordinator
bfrogers@arkbluecross.com
870-974-5704

David Needham

Account Manager
dwneedham@arkbluecross.com
479-648-6324

Art Rideout
Market Service Representative
aerideout@arkbluecross.com
479-648-6336

Ariel Bowers
Group Service Coordinator
ambowers@arkbluecross.com
479-648-6360

Kayla Propps

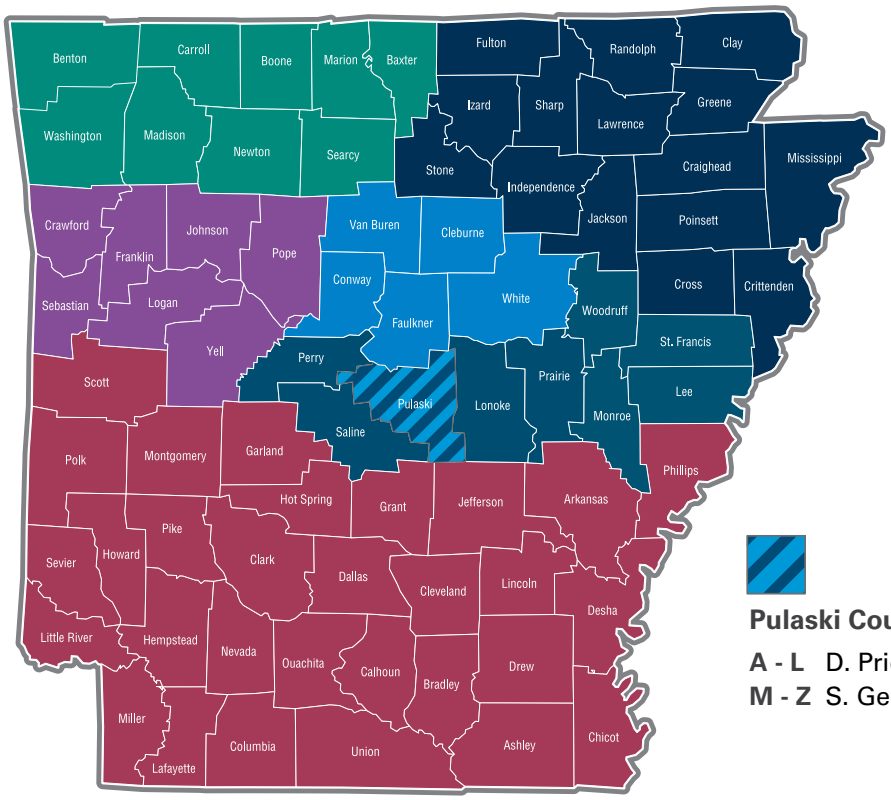
Account Manager
kkpropps@arkbluecross.com
870-779-9141

Patty Harris
Market Service Representative
puharris@arkbluecross.com
501-620-2631

Amanda Rowlett
Group Service Coordinator
anrowlett@arkbluecross.com
870-974-5703

Lynette VanDyke

Manager, Large Group Account Management
mlvandyke@arkbluecross.com
501-378-2349



Pulaski County
A - L D. Price
M - Z S. George

Tim McCall

Account Manager
mtmccall@arkbluecross.com
870-974-5764

Judi Andrews
Market Service Representative
jaandrews@arkbluecross.com
870-897-0252

Russell Waters
Group Service Coordinator
arwaters@arkbluecross.com
870-779-9115

Sonya George

Account Manager
scgeorge@arkbluecross.com
501-378-2426

Janette Spicer
Market Service Representative
jmspicer@arkbluecross.com
870-543-2925

Kizzy Collins
Group Service Coordinator
kscollins@arkbluecross.com
479-527-2353

Dustin Price

Account Manager
dsprice@arkbluecross.com
870-974-5762

Corrie Nelson
Market Service Representative
chnelson@arkbluecross.com
870-543-2942

Candiss Caldwell
Group Service Coordinator
cjcaldwell@arkbluecross.com
870-543-2947

2.6 Small Group Account Management

Chad Dodson
Manager, Small Group Sales
Phone: 870-779-9114 | Cell: 903-277-5525
mcdodson@arkbluecross.com

Allen Glenn

Agent /Broker Representative
asglenn@arkbluecross.com
Office: 479-648-6342
Cell: 479-650-6299

Tonya Moore
Market Service Representative
trmoore@arkbluecross.com
Office: 479-648-6325

Michelle Parsley
Small Group Sales Support
mcparsley@arkbluecross.com
Office: 479-527-2339

Nicole Bader
Group Service Coordinator
smallgroupservice@arkbluecross.com
Office: 479-648-6313

Paper Application and Change Form Submissions

groupchanges@arkbluecross.com

Service Inquiries

smallgroupservice@arkbluecross.com

John Kimbrough

Agent/Broker Representative
jwkimbrough@arkbluecross.com
Office: 501-378-2335
Cell: 501-580-3471

Larayna Gilmore
Market Service Representative
lcgilmore@arkbluecross.com
Office: 501-378-2337

Tara Kogel
Market Service Representative
tmkogel@arkbluecross.com
Office: 501-378-2396

Christy Holt
Small Group Sales Support
caholt@arkbluecross.com
Office: 870-974-5722

Reggie Brown
Group Service Coordinator
smallgroupservice@arkbluecross.com
Office: 501-399-3979

Judy Stephens

Agent/Broker Representative
jlstephens@arkbluecross.com
Phone: 870-543-2903
Cell: 870-489-1700

Larayna Gilmore
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lcgilmore@arkbluecross.com
Office: 501-378-2337

Christy Holt
Small Group Sales Support
caholt@arkbluecross.com
Office: 870-974-5722

Shelby Robbins
Small Group Sales Support
smrobbins@arkbluecross.com
Office: 870-779-9118

Ashley White
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smallgroupservice@arkbluecross.com
Office: 501-399-3991

Shan Serrano

Agent/Broker Representative
swserrano@arkbluecross.com
Office: 870-779-9148
Cell: 501-786-1714

Tara Kogel
Market Service Representative
tmkogel@arkbluecross.com
Office: 501-378-2396

Shelby Robbins
Small Group Sales Support
smrobbins@arkbluecross.com
Office: 870-779-9118

Terrie Steege
Group Service Coordinator
smallgroupservice@arkbluecross.com
Office: 501-620-2609

3.0 Group Administrator Enrollment Responsibilities

As group administrator, you are responsible for the following functions:

Enrollment

Refer to sections 4.0 or 5.0 for more information.

- Schedule enrollment/open enrollment meetings
- Distribute marketing materials to help employees make informed choices of coverage
- Monitor member enrollment and accuracy of completed member applications
- Submit applications for eligible newly hired employees
- Submit changes for existing members
- Audit billing statements to ensure accuracy of member additions and terminations.
- Provide required legal documentation for addition of newly eligible members

Required Legal Documentation

Refer to sections 3.1 and 3.2 for information.

Terminations

Refer to sections 4.5 or 5.0 for more information.

- Submit terminations in a 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 group (please see section 13.0 for instructions regarding COBRA notifications
- Provide 120-day Arkansas State Continuation Coverage when applicable (groups under 20) and return form within ten days of termination of employment, membership coverage or loss of dependency status (please see section 13.0 for additional information)

ID Cards and Benefit Materials

Refer to section 9.0 for more information.

- Update member addresses regularly to ensure members receive benefit materials
  - Subscribers will receive a new member packet with benefit materials to their home address
  - An ID card will be mailed separately
- Distribute member materials that are returned for incorrect addresses

The Evergreen Renewal Process

To simplify your group's annual renewal, Arkansas Blue Cross and Health Advantage uses an "evergreen" renewal process. Simply stated, if your group wants to keep their current benefits – and agrees to the new rates for the new policy year – your health, dental and vision plans will renew automatically.

Arkansas Blue Cross considers your first premium payment on the new plan year as confirmation of the group's intention to continue with their same benefits in the new policy year. The auto-renewal process ensures that your group's coverage will continue without interruption while keeping the same benefits as the previous year, or the closest possible alternative. Occasionally, Arkansas Blue Cross may require a signature as part of the renewal; you will be contacted in those situations.

Arkansas Blue Cross will keep you informed of the upcoming renewal. You or your appointed agent of record will receive notice approximately 84, 45 and 30 days before your group's anniversary date letting you know the status of your renewal process.

Arkansas Blue Cross must receive payment for the new plan year to continue coverage. If payment is not received, Arkansas Blue Cross will interpret non-payment as the group's intention to cancel coverage.

If you have any questions about the evergreen renewal process, your sales representative or agent will be able to assist in the process.

Miscellaneous

- Notify your local regional office regarding changes in business ownership, group administrator, billing name or address (see section 2.5 and 2.6)
- Post notices for employees of proposed changes in coverage as required by law

Family Medical Leave Act and Military Leave

Refer to section 15.0 for more information.

- Groups with 50 or more employees on every working day during 20 or more calendar workweeks in the current or preceding calendar year are subject to the Family and Medical Leave Act (FMLA)
- 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 18 months

3.1 Coverage Effective Date Guidelines

Qualifying Event	Member	Effective Date	Requirements
Marriage	Spouse and/or stepchildren	First of month after date of marriage	Enrollment Application must be submitted within 30 days of marriage; need copy of marriage certificate
Loss of minimum essential coverage/ loss of Advanced Premium Tax Credit (APTC)	Employee, spouse, natural children, stepchildren	First of month after loss of coverage/loss of APTC	Enrollment Application must be submitted within 30 days of loss of coverage; need copy of certificate of credible coverage (proof of paternity or maternity may be requested)
Loss of Medicaid coverage due to involuntary reason	Employee, spouse, natural children, stepchildren	First of month after loss of coverage	Enrollment Application must be submitted within 60 days of loss of coverage; need copy of certificate of credible coverage
Birth of child	Newborn child	Date of birth	Newborn Enrollment Request must be submitted within 90 days of date of birth (proof of paternity or maternity may be requested)
Birth of child	Employee (if initially waived coverage), and spouse (if applicable)	First of month prior to date of birth of newborn child	Enrollment Application must be submitted within 90 days of date of birth and newborn must also be enrolled (proof of paternity or maternity may be requested)
Petition for adoption	Adopted child – newborn	Date of birth	Enrollment Application must be submitted within 60 days of date of birth; need copy of legal adoption paperwork
Petition for adoption	Adopted child – not a newborn	Date placed for adoption or date of petition for adoption filed	Enrollment Application must be submitted within 60 days of placement or filing of petition for adoption; need copy of legal adoption paperwork
Court order	Court ordered coverage for child	First of month after receipt of completed enrollment request	Enrollment Application must be submitted as soon as the group is notified of the court order; need copy of court order or National Medical Support Notice (the employee must be enrolled for the child to be eligible)
Court appointed permanent guardianship or legal custody	Grandchild/other	First of the month after receipt of application (date of birth if newborn)	Enrollment Application must be submitted within 30 days of qualifying event (90 days for newborn); proof of custody or permanent guardianship required (temporary custody not eligible to enroll); foster children are not eligible

Qualifying Event	Member	Effective Date	Requirements
Dependent reaches age 26 or dependent maximum age per group contract	Current member – mentally or physically incapacitated dependent	First of the month after dependent reaches age 26 (or maximum dependent age)	To prevent any break in coverage, dependent should be enrolled as incapacitated dependent within 30 days (Proof of Incapacity of a Dependent Form is in **Forms section** of our website)
Dependent over age 26 and is covered on existing group plan	New member mentally or physically incapacitated dependent	Date member is effective for new group	Need proof of incapacity before age 26 (Proof of Incapacity of a Dependent Form is in **Forms section** of our website)
Return from active military duty	Reinstatement military personnel	Date returned to work	Enrollment Application must be submitted within 90 days of returning to work; need copy of returning member's orders ending active duty or other proof of active duty end date
Employee moves from PT status to FT status	Employee and eligible dependents	First of month upon satisfaction of waiting period	Enrollment Application must be submitted within 30 days of the eligible effective date; need supporting documentation (if applicable); FT date of hire is used to calculate effective date
New Hire (FT Employee)	Employee and eligible spouse and/or dependents	First of month upon satisfaction of the new hire waiting period	Enrollment Application must be submitted within 30 days of the eligible effective date; need supporting documentation (if applicable)
Open Enrollment	Employee and eligible spouse and/or dependents	First of month of a group's anniversary	Enrollment Application must be received by the last business day of the month prior to a group's anniversary date; need supporting documentation (if applicable)

Note: A late enrollee is an employee, spouse and/or dependent that requests enrollment after the expiration of their initial enrollment period or after the eligibility period for a qualifying event. Late enrollees will be deferred until the next open enrollment period.

Note: Please refer to **section 4.6** for information regarding submission of this documentation.

3.2 Life Events Checklist

Qualifying Event	Member	Effective Date	Requirements
Death of Dependent	Deceased dependent or spouse	Coverage ends as of the date of death	Must provide date of death and process the cancellation within 60 days of death; plan may require copy of death certificate
Death of Employee	Employee and all other dependents	Coverage continues through the end of the month in which death occurs	Must provide date of death and process the cancellation within 60 days of death; plan may require copy of death certificate
Divorce	Any dependents but not the employee	Coverage continues through the end of the month in which divorce occurs	Must provide date divorce was finalized and process the cancellation within 60 days of the divorce; plan may require a copy of divorce decree
Financial Hardship	Employee and/or any dependents	Coverage continues through the end of the month in which plan processes the cancellation	Must process as soon as possible for member since the cancellation date will be based upon the date processed (if submitting via paper, use the change form); both the member's and group administrator's signatures are required
Legal Separation	Any dependents but not the employee	Coverage continues through the end of the month in which legal separation occurs	Must provide legal date of separation and process the cancellation within 60 days; plan may require copy of Legal Separation documents
Loss of Dependent Child Status	Dependent no longer eligible	Coverage continues through the end of the month in which loss of dependent status occurs	Must process the cancellation within 60 days from loss of dependent status; *for group contracts that allow coverage for dependents up to age 26, the plan will automatically terminate coverage at the end of the month of the 26th birthday*
Loss of Network (employee moves in or out-of-area)	Employee or any dependent	Coverage continues through the end of the month in which loss of network occurs	Must process the cancellation within 60 days of the loss of network/move; If submitting via paper, provide a change form signed by the employee and the group administrator, along with a written explanation from the group administrator explaining the reason for termination
Marriage	Employee or any dependent	Coverage continues through the end of the month in which marriage occurs	Must provide date of marriage and process the cancellation within 30 days of the date of marriage; If submitting via paper, provide a change form signed by the employee and the group administrator; plan may require a copy of marriage certificate

Qualifying Event	Member	Effective Date	Requirements
Military Leave	Employee or any dependent	Coverage continues through the end of the month in which leave starts	Must provide date of military leave and process the cancellation within 60 days of the leave; plan may require a copy of the Service Member's Orders
Now Eligible for Other Coverage	Employee or any dependent	Coverage continues through the end of the month prior to when other coverage takes effect	Must process the cancellation within 60 days of date other coverage takes effect; if submitting via paper, use the change form (requesting termination) and include both the employee and the group administrator signature
Reduction of Hours	Employee and all other dependents	Coverage continues through the end of the month in which reduction of hours occurs	Must process the cancellation within 60 days of employee's loss of full time employment status; if submitting via paper, use the change form and include both the employee and the group administrator signature
Subscriber Request Cancellation	Employee or any dependent	Coverage continues through the end of the month in which the cancellation is processed	Must process as soon as possible for member since the cancellation date will be based upon the date processed; if submitting via paper, use the change form and include both the employee and the group administrator signature

Note: Please refer to **section 4.6** for information regarding submission of this documentation.

4.0 Enrollment Changes (Non-Electronic Groups)

A group is considered non-electronic if it does not use BluesEnroll or another third party vendor to submit electronic enrollment.

4.1 Blueprint for Employers

Blueprint for Employers is your secure, self-service website that features the information you need to make administration of your benefits easier than ever. If you designated a web admin contact on your group application or Blueprint for Employers registration form, we will send them an email with a link to set up their Blueprint for Employers account, and a guide on how to use the system.

The chief web admin can:

- View all enrolled employees and dependents
- View employee coverage that has been canceled
- See employees with future effective dates
- Print temporary ID cards
- Order replacement ID cards
- Complete electronic application and change forms
- Track an application addition

Registration is easy:

Step 1: Visit Blueprint for Employers
Step 2: Select "Register"
Step 3: Click on the "registration form" link
Step 4: Email the completed form to bpesupport@arkbluecross.com, or fax it to **501-378-2953**

Your group must be active in our system to begin using Blueprint for Employers.

4.2 Enrollment Process for Adding New Subscribers and Dependents

Adding Subscribers and Dependents via Paper Enrollment Form

For subscribers, the entire application must be completed according to instructions, with all sections of the application completed. The full-time date of hire and group number(s) should always be noted on the top of the application.

Adding Dependents

The reason for adding a dependent to an existing policy/contract must be indicated, and the effective date should always be noted on the top of the application. This information lets Arkansas Blue Cross/Health Advantage know what coverage effective date is desired. The group administrator will be contacted if the requested effective date cannot be administered.

Reinstatement of Previously Covered Member

The Application for Reinstatement needs to be received within 30 days of the policy termination date. 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 the subscriber/dependent is eligible for continuous coverage, there can be no break in coverage and reduction of premium. All premiums must be submitted with the next bill to provide continuous coverage.

General Recommendations for Completion of Paper Employee Applications

New hires should complete an application when initially employed to avoid delays in coverage. If there is a waiting period, the application will be coded and held for processing one month prior to effective date.

- Section 2 – Please use legal name for enrollment purposes
- Section 9 – Signature Dates should be within 60 days of eligibility date
- Applications or copies must be legible to avoid keying errors
- See chart on **section 3.1** and **3.2** for legal documentation requirements
- An Incapacity Form (Subscriber and Physician) showing proof of mental or physical incapacity and IQ score must be submitted for dependents older than the maximum dependent age, according to the group contract, for the member to be enrolled as an incapacitated dependent (Proof of Incapacity of a Dependent Form can be found in the **Forms section** of our website)
- Do not reduce font size when faxing the application

Applications and changes should always include:

- Reason for addition/change
- Group number
- Name and SSN of subscriber and each dependent
- Effective date of enrollment or change according to the Evidence of Coverage/Group Benefit Certificate
- Employee address

If an employee application is received with incomplete or missing required support documentation, a Request for Additional Information will be faxed, mailed or emailed to the group about the missing information. Each request

will have a deadline date to return the requested info to **groupchanges@arkbluecross.com** (or fax to 501-301-1956). Examples of such information include verification of loss of eligibility, proof of incapacitated status, marriage license, divorce decree, petition for adoption or court-appointed guardianship papers. Supporting documentation can be emailed to your local regional office (see **section 4.6**).

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 qualifying event. Late enrollees are deferred until the next open enrollment period. Members that meet the definition of special enrollment period are not considered late enrollees.

Helpful Links

ABCBS/HA Employee Application
Employee Application (Spanish)
Other forms
Blueprint for Employers

4.3 Employee Application Completion Guide

Top Section	✓ Employer/Tax ID ✓ Medical, dental and vision group number (if existing group) ✓ ID number (leave blank if new enrollee or new hire) ✓ Date of full-time employment or COBRA effective date and reason
Section 1	✓ Check all applicable boxes ✓ Check all applicable boxes and list date of qualifying event ✓ Attach supporting documentation for qualifying event (see section 3 for details on qualifying events)
Section 2	✓ Select covered members and dependents ✓ Subscriber and dependents' Social Security numbers (must be eligible) ✓ Indicate relationship of children (natural, step or adopted) ✓ Use legal name for enrollment ✓ Sex and birth date for each member Indicate type of coverage desired for each person ("E" for enrollment, "W" for waiver)Ten-digit NPI number for PCP (if required)
Section 3	✓ Marital status
Section 4	✓ Address ✓ Phone number ✓ Email address
Section 5	✓ Job title ✓ Hours worked weekly ✓ Salaried, hourly or other
Section 6	✓ Complete if waiving medical coverage for any member of the family
Section 7	✓ Previous insurance carrier information ✓ Must have name of other insurance, member ID and effective/end date (if applicable) ✓ Family members covered by previous carrier(s) ✓ Must be completed in FULL if a member will have Medicare or other health insurance in addition to Arkansas Blue Cross/Health Advantage while covered under your group's plan ✓ Must be completed in FULL if a member is enrolling due to loss of minimum essential coverage
Section 8	✓ Life insurance for groups with embedded life ✓ Beneficiary first name, middle initial, last name, date of birth and relationship to the enrollee ✓ This section must be completed when paying for life insurance and health premiums
Section 9	✓ Employee signature **and date** ✓ Group representative signature **and date** ✓ Note: signature dates must be within 60 days of eligible effective date

4.4 Member Record Changes

Arkansas Blue Cross and Health Advantage strive to maintain accurate records for groups and members. In order to pay a claim, the member ID number, name and date of birth in our membership system must match the information on the claim from the provider. The plan must be informed of changes as soon as they occur in order to provide the best service.

Addition of Subscriber or Member

Complete an employee application to add a subscriber or member.

Address Changes

We must have the member's correct mailing address to send ID cards, benefit materials, member newsletters, personal health statements (PHS), referral letters (if applicable) and any other correspondence.

Each time a member calls customer service or a change is submitted, the address is verified and updated as needed. If the address is incorrect, members should contact their employer's group administrator to update their address. Group administrators are responsible for communicating changes to the plan. For groups using the paper enrollment process, a completed change form will be required (change forms can be emailed to groupchanges@arkbluecross.com or fax to 501-301-1956). When mail is returned with a forwarding address, the address is updated. Return mail with an incorrect address is forwarded to the group administrator for verification. It is the group administrators responsibility to communicate any address updates to the health plan.

Primary Care Physician Change

In some cases, in order for medical services to be covered and claims to be paid correctly, members must have a PCP assigned. Members should select a PCP when enrolling and again if their PCP leaves the network. PCP changes can be made by submitting the change on My Blueprint, or by calling the customer service number on the member's ID card and providing the physician's name, office location and ten-digit NPI.

Date of Birth

All ID cards contain the member's date of birth. Members with an incorrect date of birth on the ID card must inform the employer/group's plan. The date of birth on provider claims must match the date of birth in the membership system. If a member's date of birth is incorrect, please email your local group service team with the correct date, and they will assist you with updating the member's record. Regional contact info can be found in section 2.5 and 2.6.

Required Information for All Changes

- Reason for change
- Group number
- Subscriber's name and SSN or member ID number
- Effective date of change according to Evidence of Coverage/Group Benefit Certificate
- Address (if changed since enrollment)

Change in Subscriber Premium Rate

The addition or termination of a dependent can change the premium rate for a subscriber. If this occurs before the next monthly billing, the correct premium should be remitted with the monthly premium and an explanation written on the Explanation of Payment form. Please note that the Explanation of Payment form enclosed with an invoice serves only as an explanation of your payment remittance. To change or cancel an employee's coverage, you must submit the appropriate change or enrollment request to **groupchanges@arkbluecross.com**.

4.5 Termination of Coverage

It is the group administrator's responsibility to notify Arkansas Blue Cross or Health Advantage of subscriber and member terminations and date of termination as soon as possible. Termination requests received by the tenth of the month should appear on the following month's premium bill. Be sure to audit your billing statements to verify that member additions and terminations are correct.

Subscriber/member terminations must be submitted with other eligibility changes in Blues Enroll, Blueprint for Employers or other electronic vendor, or through the paper change form process.

Retroactive Terminations

Arkansas Blue Cross or Health Advantage will 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.

Qualifying Events for Loss of Eligibility (examples):

- Dependent
  - Spouse: divorce (or legal separation)
  - Joins military
- Eligible for coverage through own employer (for certain plans)
- Subscriber death
  - Provide date of death
  - All contracts are termed at the end of the month
  - Dependents are eligible for continuation of coverage
- Dependent death
  - Provide date of death
  - Dependent contract termed at the end of the month
- See section 3.2 for additional information

Note: When a subscriber/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 by calling customer service at the number on the back of the member ID card, or by calling the local **regional customer service office**.

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 account representative. All members of a group terminate on the same date that the group is terminated. Arkansas Blue Cross/Health Advantage may also terminate the group contract if the group does not uphold the terms of the contract. It is the group's responsibility to notify all members when the group contract is terminated. The member is responsible for all claims paid after the paid-to date.

4.6 Submission of Paper Applications and Change Forms

Email completed change forms to **groupchanges@arkbluecross.com**, or fax paper change forms to 501-301-1956.

These contacts are good for all health, pharmacy, dental and vision, with the exception of dental and vision school group business which is located in **section 7.2**. For faster processing, these forms can be submitted online through Blueprint for Employers. See **section 4.1** for more information.

4.7 Spreadsheet Enrollment

The following information is good for all health, pharmacy, dental and vision, with the exception of dental and vision school group business which is located in **section 7.1**. Please contact your account team in your regional office to request the spreadsheet template and instructions. Refer to **section 2.5 and 2.6** for the appropriate regional contact information.

OPEN ENROLLMENT ONLY: Spreadsheet enrollment is now available for fully insured employer groups with 50+ eligible employees. This option should only be used once — during open enrollment — and should not be used for ongoing maintenance.

NOTE: Full spreadsheets for initial enrollment or changes-only is acceptable for renewals. The spreadsheet may be used to add or drop dependents, choose a different medical plan, apply for a new plan or waive or decline coverage.

Spreadsheet enrollment will allow for a faster enrollment process and updates to membership systems and less manual intervention that will, in turn, decrease errors. Employers are required to maintain all legal documentation and employee enrollment forms.

This option should not be utilized if the group is using another electronic platform — BluesEnroll, Payson, ADP — for their enrollment.

4.8 Renewal

The Evergreen Renewal Process

To simplify your group's annual renewal, Arkansas Blue Cross and Health Advantage uses an "evergreen" renewal process. Simply stated, if your group wants to keep their current benefits – and agrees to the new rates for the new policy year – your health, dental and vision plans will renew automatically.

Arkansas Blue Cross considers your first premium payment on the new plan year as confirmation of the group's intention to continue with their same benefits in the new policy year. The auto-renewal process ensures that your group's coverage will continue without interruption while keeping the same benefits as the previous year, or the closest possible alternative. Occasionally, Arkansas Blue Cross may require a signature as part of the renewal; you will be contacted in those situations.

Arkansas Blue Cross will keep you informed of the upcoming renewal. You or your appointed agent of record will receive notice approximately 84, 45 and 30 days before your group's anniversary date letting you know the status of your renewal process.

Arkansas Blue Cross must receive payment for the new plan year to continue coverage. If payment is not received, Arkansas Blue Cross will interpret non-payment as the group's intention to cancel coverage.

If you have any questions about the evergreen renewal process, your sales representative or agent will be able to assist in the process.

5.0 Electronic Groups

Enrollment information is considered electronic if the information is received as a Health Insurance Portability and Accountability Act (HIPAA) compliant ANSI 834. This includes groups using BluesEnroll or Marketplace via BenefitFocus and groups using payroll or other benefit systems. This section does not include Blueprint for Employers or Total Enrollment Solutions (TES), which can be used at no cost to your group. For more information on electronic options, contact your account representative or agent.

Enrollment

Applications and changes in coverage must be transmitted in a timely manner in the required format. Arkansas Blue Cross and 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/Group Benefit Certificate. The process described below is for groups that submit membership eligibility electronically.

Third-Party Vendor (Groups with 100+ employees enrolled)

Employer groups are responsible for applying all eligibility rules, in the system they choose, for electronic enrollment. All enrollment changes made by the group will be made through the third-party vendor.

Note: A file must be in the HIPAA-compliant ANSI 834 format in order for enrollment to be automated. Allow at least two to three months for testing prior to implementation.

Frequency of Updates

Updates may occur in a change file or full file received on a daily, weekly or biweekly basis depending on the size and turnover within a group. .

Eligibility Determination

The effective date must be in accordance with the group contract and Evidence of Coverage/Group Benefit Certificate (As outlined in section 3.1, 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 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.

Emergency Updates

An emergency situation is when an eligible member is at a provider's office, hospital or pharmacy to receive services, but has not yet been enrolled. Please contact the group service team in your regional office on how to make an emergency update. Regional contact information can be found in section 2.5 and 2.6.

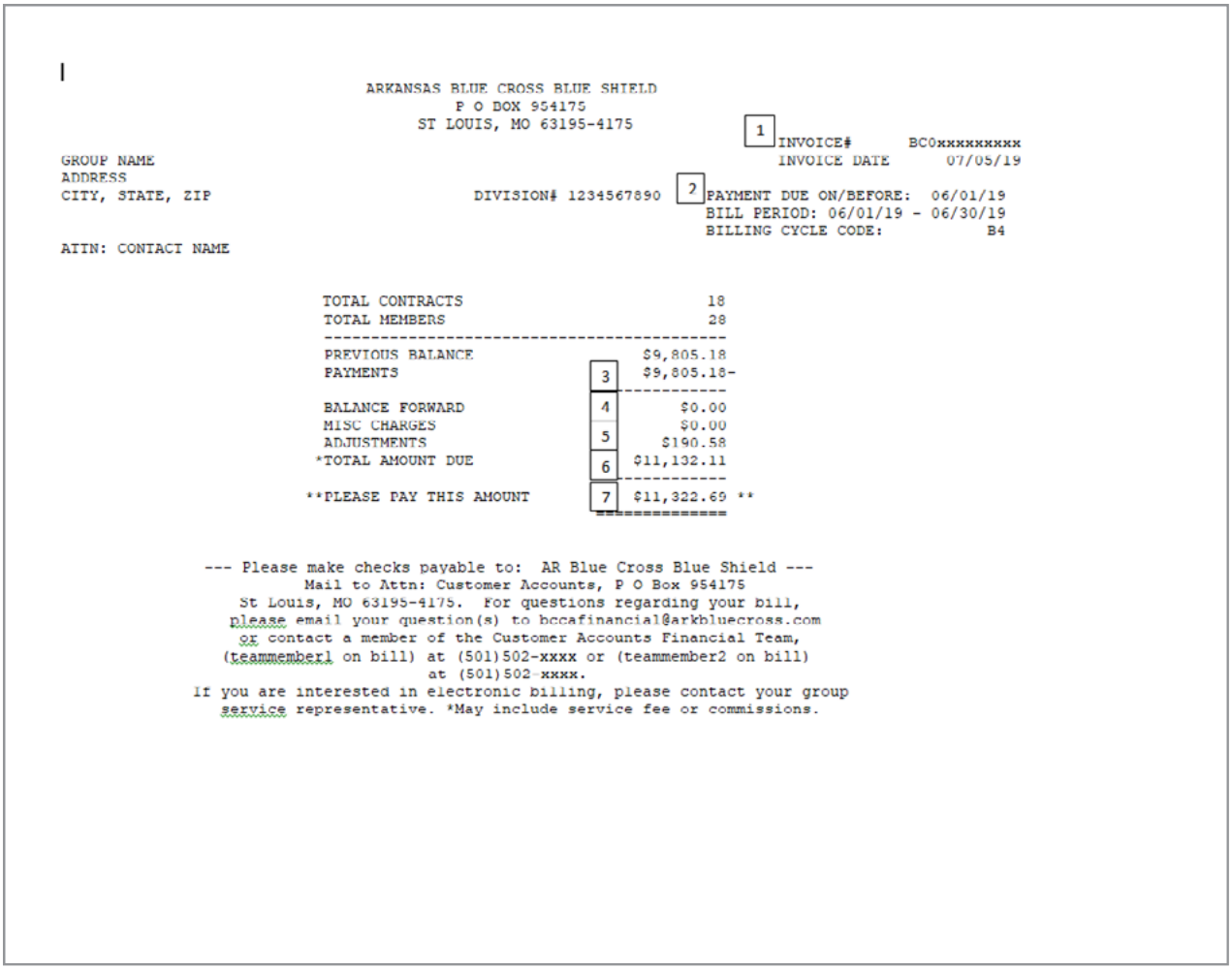
For more information on school groups see section 7.1.

6.0 Premium Billing and Payments

6.1 Paper Bills

How to Read Your Bill

Here is an example of how your bill will look:



```
                          ARKANSAS BLUE CROSS BLUE SHIELD
                                  P O BOX 954175
                               ST LOUIS, MO 63195-4175

                                                                  [1] INVOICE#        BC0xxxxxxxxx
                                                                      INVOICE DATE        07/05/19
GROUP NAME
ADDRESS
CITY, STATE, ZIP                          DIVISION# 1234567890  [2] PAYMENT DUE ON/BEFORE:  06/01/19
                                                                  BILL PERIOD: 06/01/19 - 06/30/19
                                                                  BILLING CYCLE CODE:            B4
ATTN: CONTACT NAME


                                TOTAL CONTRACTS                          18
                                TOTAL MEMBERS                            28
                                ------------------------------------------
                                PREVIOUS BALANCE                   $9,805.18
                                PAYMENTS                       [3] $9,805.18-
                                                                   ----------
                                BALANCE FORWARD                [4]      $0.00
                                MISC CHARGES                       $0.00
                                ADJUSTMENTS                    [5]    $190.58
                               *TOTAL AMOUNT DUE               [6] $11,132.11
                                                                   ----------
                              **PLEASE PAY THIS AMOUNT         [7] $11,322.69 **
                                                                   ==========


      --- Please make checks payable to:  AR Blue Cross Blue Shield ---
                Mail to Attn: Customer Accounts, P O Box 954175
          St Louis, MO 63195-4175.  For questions regarding your bill,
        please email your question(s) to bccafinancial@arkbluecross.com
          or contact a member of the Customer Accounts Financial Team,
        (teammember1 on bill) at (501)502-xxxx or (teammember2 on bill)
                              at (501)502-xxxx.
    If you are interested in electronic billing, please contact your group
       service representative. *May include service fee or commissions.
```

Dental and Vision payments need to be mailed the address below:

Arkansas Blue Cross and Blue Shield
Payment Processing Center
PO Box 957483
St. Louis, MO 63195

How to Read Your Bill

1. **Invoice Date –** If any changes to the group were processed after the invoice 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. 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 seven days, pharmacy claims will be placed on hold and the group will be subject to cancellation.

3. **Payments –** Any payments made after your previous bill and before this **invoice date**.

4. **Balance Forward –** Any leftover balance after all payments were received prior to this **invoice date**. If the prior month's premiums have been paid after this invoice **date, subtract** the amount paid from the **balance forward**. If the remaining amount is not zero, then it should be deducted from or added to 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 must be added or subtracted accordingly. Refer to the bill's adjustment page for details.

6. **Current Premiums –** This amount is the 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 review numbers one through six before paying this amount. This amount often includes premiums already paid or premiums for members that are terminated but have not yet shown on adjustment page. All eligibility changes must be submitted with Blues Enroll, Blueprint for Employers or other electronic vendor, or through the paper change form process.

   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, do not pay or deduct these amounts. The adjustment may be delayed until the next billing cycle due to the date that the change was made in our system and the invoice date. You can expect the adjustment to show up on the next billing cycle. If these items have been on the bill multiple times, contact us to verify that the member has been added or terminated.

Billing Procedures

- New groups are billed after all members are active and/or entered into the system
- Renewal groups are billed after the group has renewed or when new members (open enrollment additions) have been entered into the system, based on which comes later
- All groups are billed monthly

Be sure to audit your billing statements to verify that member additions and terminations are correct. If you have any questions about your bill, call the number listed on your billing statement, or submit an email to bccafinancial@arkbluecross.com (Arkansas Blue Cross) or hacafinancial@arkbluecross.com (Health Advantage).

Premium Collection

- Premium is always due on the first of the contract month in which coverage is provided
  - Failure to pay premium by the due date will result in claims being held for any month that premium is not paid
- Groups have a 30-day grace period to submit premium
- 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 the method of payment. The following procedures are recommended:

Premium Payment by Check

- Always include the appropriate page(s) of your bill for each invoice number to ensure accurate posting of premium
- Submit premium for amount billed, plus or minus adjustments
- Send premium to the address listed on your bill
- If needed, complete **Explanation of Payment form** and submit with payment
- The Explanation of Payment form cannot be used to terminate or add members to your group's plan.

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 (credit or debit) will appear on the next monthly billing
5. Repeated unresolved discrepancies or failure to pay premium will result in cancellation of coverage back to the paid-to date. The member is responsible for all 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 and Pharmacy claims for dates of service after the paid-to date may be pended or denied
   - Claims holds are released when payment is received
2. When grace period 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 with a letter of cancellation
   - Pharmacy is notified that the 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 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 that are due but unpaid at the time of termination
   - Ineligible to reapply for group coverage for a period of six months from the date of termination

Premium Checks with Insufficient Funds

If a check is returned due to insufficient funds, the group will be assessed a $50 charge. Medical, dental, vision and pharmacy payment 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 that requires premium payments by cashier's check, which must be received prior to the due date to continue coverage.

Reinstatement Procedures

1. A group that is cancelled for non-payment of premium may be eligible for reinstatement. The cancelled group must submit an Application for Reinstatement and two cashier's checks:
   - For premium due at the time of cancellation and current month premium
   - For a non-refundable $350 reinstatement fee
2. The underwriting department reviews the reinstatement application and makes a decision
3. If a group is denied reinstatement, the group is not eligible for another group contract for six months from the date of termination

eBilling

eBill Manager is an online invoice presentation, adjustment and payment system that allows you to receive and pay health, dental and vision plan invoices electronically. eBill Manager provides:

- Secure invoice delivery
- Ability to make adjustments to the invoice
- Online payment capabilities
- Consolidated invoices (health, dental, vision, embedded life)
- Access to invoice history (up to 18 months)
- Downloading invoices into Excel or PDF
- Ability to construct reports from invoices due to the electronic delivery of invoices

eBill Manager allows invoices to be created two weeks later than traditional paper invoices for more timely and accurate transactions. Group administrators can still request traditional invoices generated on the 14th of the month.

In addition, eBill Manager allows adjustments to invoices for cancellations or coverage reductions. Online instructions explain how to remove employees no longer enrolled or to adjust coverage level. The payment due will also be appropriately adjusted.

Electronic premium payments are available for small groups (two to 50) that are not enrolled in eBill Manager.

Note: These cancellations or reductions in coverage must also be applied as soon as possible through the electronic enrollment system or via a normal enrollment method in order for payments to be reconciled.

Membership additions to your group's plan must be made through an electronic enrollment system or a normal enrollment method and will be added to the next invoice. Arrears will be billed if applicable.

To access eBill Manager or for assistance in using this product, contact your group service coordinator. See section 2.5 and 2.6 for contact information.

For additional help with eBill Manager, visit benefitfocusmedia.com/content/benefitfocus/ebilling-training-videos.

7.0 Dental and Vision – School Groups Only

This section provides information pertaining to school groups to answer questions group administrators may have about their dental or vision insurance. .

7.1 School Group Enrollment and Maintenance

Spreadsheet Enrollment

Spreadsheet enrollment is available for school group employer groups. This expedites the processes for enrolling, renewing and updating your group membership, ensuring faster results with fewer errors. Employers are still required to maintain all legal documentation and employee enrollment forms.

Do not use spreadsheet enrollment if your group uses ADP, BluesEnroll or another electronic platform for enrollment.

Ongoing Spreadsheet Maintenance

Ongoing spreadsheet maintenance is a tool that lets you create and pre-populate your group's current enrollment into a spreadsheet that can be downloaded and edited. You can modify the spreadsheet for changes during open enrollment, adding or dropping employees and their dependents, then submit it to Arkansas Blue Cross to update your eligibility system. You can also reconcile your own enrollment system at your convenience, both before and after open enrollment.

The Evergreen Renewal Process

To simplify your group's annual renewal, Arkansas Blue Cross and Health Advantage uses an "evergreen" renewal process. Simply stated, if your group wants to keep their current benefits – and agrees to the new rates for the new policy year – your health, dental and vision plans will renew automatically.

Arkansas Blue Cross considers your first premium payment on the new plan year as confirmation of the group's intention to continue with their same benefits in the new policy year. The auto-renewal process ensures that your group's coverage will continue without interruption while keeping the same benefits as the previous year, or the closest possible alternative. Occasionally, Arkansas Blue Cross may require a signature as part of the renewal; you will be contacted in those situations.

Arkansas Blue Cross will keep you informed of the upcoming renewal. You or your appointed agent of record will receive notice approximately 84, 45 and 30 days before your group's anniversary date letting you know the status of your renewal process.

Arkansas Blue Cross must receive payment for the new plan year to continue coverage. If payment is not received, Arkansas Blue Cross will interpret non-payment as the group's intention to cancel coverage.

If you have any questions about the evergreen renewal process, your sales representative or agent will be able to assist in the process.

Annual Spreadsheet Renewal

You can send in your group's spreadsheet when you need to renew your group's coverage. Each listed member of your group must be assigned the appropriate group and division or package number.

Do not submit the spreadsheet until the account structures have been established.

Once the account structures have been set, you or your group's agent must populate the spreadsheet with each member you want to include in your group's plan.

Note: If there is a record on the spreadsheet containing an enrollee that has been cancelled, do not delete the record on the spreadsheet. Our automated system will process the cancelled record electronically.

BluesEnroll Enrollment

BluesEnroll is an online self-service tool that gives group administrators access to a comprehensive suite of management resources to streamline the enrollment process.

Ongoing BluesEnroll Maintenance

BluesEnroll ongoing maintenance lets you manage daily tasks, communicate with employees and enforce complex business rules. This allows you to generate detailed reports on demand, and view benefit changes as they are updated.

Annual BluesEnroll Renewal

For groups on BluesEnroll, the eEnrollment and Billing team can help you coordinate and customize your group's plan during annual renewal. The eEnrollment and Billing team can help add another product type to your group's plan, or even change your plan offerings entirely.

D834 Enrollment

D834 enrollment must be completed via spreadsheet format. In order to implement, testing must be completed with group payroll vendors.

Ongoing D834 Maintenance

During the D834 implementation process, you can maintain enrollment via BluesEnroll, Blueprint for Employers, and spreadsheet.

Annual D834 Renewal

Open enrollment files should be submitted separately from normal, weekly files. Groups already set up for D834 integration must submit separate files to add another product type, which must be coordinated through the eEnrollment and Billing team.

Electronic Enrollment Process

	Initial Enrollment	Interim Maintenance	Long-term Maintenance
	Onboarding of new groups	**Use as stepping stone to longer term option**	**Ongoing maintenance**
Paper applications	N/A	N/A	N/A
Spreadsheet (pre-defined template) Weekly changes-only file Weekly full file	 ✓ ✓	 ✓ ✓	
Blueprint for Employers	✓	✓	✓
BluesEnroll	✓	✓	✓
Marketplace	✓		✓
834			✓

7.2 Submission of Paper Applications and Change Forms

Jordan Deramus – Internal Service Group Representative ancillary@arkbluecross.com **Fax: 501-378-5802**

7.3 Quick Reference Guide

For more information on Dental and Visions not specific to school groups, see the reference guide below:

8.0 Case Management

Case Management Program

Our case management program features an interdisciplinary team that works toward improving members' lives through information, education, and assistance to members and their families. Case Management focuses on a holistic approach, with nurse case managers at the center of the model. Recognizing that social, economic, and financial factors play a role in a member's health, the aim of the program is not only to work with a member's physician to manage and help coordinate care, but also to provide resources to members, help choose cost-effective treatment alternatives, and assist the member in navigating a complex healthcare system.

Early identification of an illness or injury is vital information for case managers, and the employer is often the first to know that a member is receiving treatment for a serious illness or injury. A group administrator or the employee's supervisor should contact the group's assigned group service coordinator to explain the member's health situation. Regional contact information can be found in **section 2.5 and 2.6**.

Examples of situations in which case management may assist in conservation of limited benefits include, but are not limited to:

Special Delivery

The Special Delivery program is a prenatal care program dedicated to the good health of all mothers and their babies and is designed to help an expectant mother have a healthy baby. The goal of the program is the prevention and management of high-risk pregnancies through education, early detection, and treatment. The Special Delivery program encourages the mother-to-be to actively participate in obtaining comprehensive prenatal care. Expectant mothers – regardless of their pregnancy-risk status – may obtain information or enroll in the Special Delivery program by calling **1-800-225-1891** ext. **20225**.

Health & Wellness (for participating groups)

Our Health & Wellness program is a complimentary health information service designed for members who have questions about their everyday health or 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 healthcare when they see their physician. The program is available 24/7 at **1-800-318-2384** or through My Blueprint. The Health & Wellness program can help identify candidates for the case management program.

9.0 Identification Cards and Member Materials

- Identification (ID) cards are printed and mailed directly to the subscriber's address
- A new ID card prints each time the member has a change in any of the information that appears on the ID card

ID cards are mailed in an envelope clearly marked "MEMBERSHIP CARD ENCLOSED." In addition, a separate mailing is sent in a large envelope clearly marked "MEMBERSHIP MATERIALS."

Members may request replacement of lost ID cards by calling their **local regional customer service office** or logging into My Blueprint.

Members can also access their electronic ID cards from My Blueprint.

To register for My Blueprint, go to: **arkansasbluecross.com** or **healthadvantage-hmo-com**.

Select "Sign In" in the upper right-hand corner, then select "Register" and follow the instructions. You will need to enter your member ID number or Social Security number, name and date of birth as it appears on your member ID card. You will create your own **username** and **password** which will allow you immediate access to all the features of My Blueprint. You, your covered spouse and covered dependents can register for My Blueprint.

We're Mobile!

With My Blueprint Mobile, members can view electronic ID cards, estimate treatment costs and access many more My Blueprint features.

Note: Members should ensure that 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's name and date of birth on the claim must match the most current information on file.

10.0 Primary Care Physician Procedures

For some Health Advantage Plans, a Primary Care Physician (PCP) must be selected for each member of the family at the time of enrollment. The provider must be listed as a PCP currently accepting new members in the Health Advantage Provider Directory at healthadvantage-hmo.com. If a member application requires a PCP and if one is not selected, the member is enrolled and the ID card will still be issued. "Member awaiting PCP Assignment" is written in the space for the PCP's name. For HMO Plans, members must select a PCP before receiving routine or specialty care.

Primary Care Physician Change or Termination

A PCP who leaves the Health Advantage network may request that their members transfer to another PCP. If the PCP does not make such a request, the member will be assigned a default provider number and receive an ID card showing "Member awaiting PCP Assignment." The member will receive a letter requesting them to select a new PCP. See below for more information on how to select a PCP and how to make changes to an existing designation.

Selecting a Primary Care Physician

Members can select a PCP using the "Find Care" link on our website and following the prompts. The provider selected must be listed as a PCP currently accepting new members.

Changing a Primary Care Designation

Members may verify their PCP information and make PCP changes from the My Blueprint portal at healthadvantage-hmo.com. See section 2.1 for more information on My Blueprint.

Members can also make PCP changes by calling the customer service phone number on the back of their member ID card or contacting their local regional customer service office. Members must provide the physician's name, office location and ten-digit NPI.

Alternatively, members can fill a PCP Selection Letter, and fax or mail it to the address listed on the form.

11.0 Other Insurance Information

Coordination of Benefits

Coordination of benefits (COB) applies when a member has coverage with more than one benefit plan. Arkansas Blue Cross and Health Advantage coordinate 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. Your group's plan has the right to coordinate benefits. It is the member's responsibility to inform the plan of other insurance or Medicare even if Arkansas Blue Cross or Health Advantage is not the primary carrier. The member may also be required to provide a copy of the primary carrier's Explanation of Benefits or Personal Health Statement and all itemized bills if Arkansas Blue Cross or Health Advantage is the secondary carrier. The rules establishing the order of benefit determination are described in the Evidence of Coverage/Group Benefit Certificate.

Other Insurance Information

A separate section on the employee application (enrollment application) requires other insurance information. This section must be completed at the time of enrollment for each family member who will continue coverage with other health, dental or vision insurance or Medicare while receiving additional coverage with Arkansas Blue Cross or Health Advantage.

Changes to Other Insurance Information

For prompt payment of claims, other insurance information must remain current. Changes in other insurance are considered a change in member information. Members may update other insurance information by calling the customer service number on the back of their ID card, or by calling their local **regional customer service department**. Alternatively, they may submit the change in writing by completing the COB questionnaire and mailing it to:

Arkansas Blue Cross and Blue Shield
Attn: COB Department
P.O. Box 2181
Little Rock, AR 72203

Health Advantage
Attn: COB Department
P.O. Box 8069
Little Rock, AR 72203-8069

The coordination of benefits (COB) questionnaire is available at **healthadvantage-hmo.com** or **arkansasbluecross.com**.

12.0 Out-of-State Coverage – BlueCard® Program

Members Traveling Out-of-State

Arkansas Blue Cross and Health Advantage members have access to the BlueCard program for emergency and urgent care when traveling outside the service area (outside Arkansas, but within the United States). Services must be received from a Blue Cross and Blue Shield provider listed in the BlueCard Traditional Network. Claims are billed with the applicable prefix (example: XCH, TYZ, XCW, BTU or HBS). This will change the Traditional network to the PPO network on any prefix besides the XCH. Medical services other than emergency care or urgent care through the BlueCard program must first be authorized by the member's PCP and approved by Arkansas Blue Cross or Health Advantage to be covered at the in-network benefit level.

Employees Living Outside of Service Area (more than 90 days)

Health Advantage allows a special out-of-area classification for employees who live outside Arkansas, but within the United States, for more than 90 days. The member uses his/her 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 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 charge for services provided by non-participating BlueCard providers.

Dependents Eligible for the Out-of-Area Classification

Health Advantage Members only

- Dependent spouses, and children living outside of Arkansas for at least 90 days (annual renewal required)

The member must complete the appropriate application to request the out-of-area classification for their dependent. Once completed, it should be attached to the employee application at enrollment and 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.

BlueCard Program

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, go to arkansasbluecross.com or call **1-800-810-2583 (BLUE)**. The link to the out of area classification form is also available online

Note: All covered services are subject to the Arkansas Blue Cross and Blue Shield/Health Advantage allowable charge. When the BlueCard program is not utilized, members are responsible for the amount charged in excess of the allowable charge billed by out-of-network providers.

Note: Please contact the provider locator number on back of the member ID card or log on to **BCBS.com**.

13.0 State of Arkansas Continuation and COBRA

State of Arkansas Continuation

Group medical coverage may be continued for 120 days, or through the date the member or the group pays the premium, or the date the member becomes eligible under a similar group health or Medicare plan, whichever is sooner. Employees of groups that are not subject to COBRA may be eligible to elect the 120-day state of Arkansas continuation of coverage.

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 health plan for at least three consecutive months prior to employment termination or change in dependency status. In order to be eligible for The State of Arkansas Continuation Law, the member may not be eligible for any other group health plan. An election for continuation of coverage must be made by notifying the group and Arkansas Blue Cross or Health Advantage through a submission of a completed State of Arkansas Continuation of Coverage Election Form within ten days of loss of coverage. For additional information about The State of Arkansas Continuation Law, contact your Regional Office (refer to section 2.6 for regional contact information).

COBRA Continuation

COBRA applies to every employer (except employers classified as "church groups") who maintains a group health plan and who employs 20 or more employees on 50 percent of its typical business days during the preceding calendar year (or as further defined under the 2001 Final **COBRA** Regulations). Qualified Beneficiaries whose coverage ends due to a qualifying event may elect **COBRA** coverage.

- A Qualifying Event occurs when any of the following cause a loss of coverage of a Qualified Beneficiary under your group's plan:
  - Termination for any reason other than gross misconduct (layoff, resignation, retirement, etc.)
  - Reduction of hours worked by employee
  - Death of the employee
  - Divorce or legal separation
  - Dependent child ceasing to meet eligibility requirements
  - Dependent coverage is listed because the active employee (or **COBRA** continuant) becomes entitled to Medicare
  - Retiree or retiree's spouse or child loses coverage within one year before or after the commencement of proceedings under Title 11 (bankruptcy) United States Code of the sponsoring employer
- A Qualified Beneficiary is any employee, spouse or dependent child who was covered on the day before the Qualifying Event, who would otherwise lose coverage under the plan because of the Qualifying Event. This definition includes a child born to or placed for adoption with a covered employee during the period of **COBRA** coverage.
- The employer or the plan administrator must notify every employee and every covered spouse of all of their rights under **COBRA** when they first become covered under the group health, dental or vision plan. Separate notices must be sent if separate residences are maintained. This applies to all current and future employees and covered spouses.

- Each time a Qualifying Event occurs, the employer must notify, within 14 days of the notification to the Plan Administrator, each Qualified Beneficiary of his/her continuation rights, benefits and premium rates for the plan(s) in which they are eligible.
- Qualified Beneficiaries are allowed to buy continuation coverage retroactive to the benefit termination date. They are entitled to make this election within 60 days of the date of the notification of their rights or the date that benefits would terminate, whichever is later. If they decline, they may change their minds and elect, if they are still within the 60-day election period.
- When a Qualifying Event causes loss of coverage, the employer must allow continued coverage under the group health, dental or vision plan for up to 18 months in the case of termination or reduction of hours, or up to 36 months for a dependent Qualifying Event. A second Qualifying Event for a dependent occurring during the 18-month coverage period of the first Qualifying Event expands the original period to 36 months.
- A Qualified Beneficiary's continuation period must be extended from 18 months to 29 months if the Social Security Administration determines that the Qualified Beneficiary was totally disabled under Title II or XVI of the Social Security Act on the day of the Qualifying Event, or within the first 60 days of COBRA coverage. Additionally, if the Qualified Beneficiary sends a copy of the determination notices to HealthEquity/WageWorks (if used) or the Employer before the end of the initial 18-month period and within 60 days of the date of the notice, coverage must be extended from 18 months to 29 months. The same holds true for any member of the Qualified Beneficiary's family.
- Because the law is complex and judicial decisions about compliance can occur at any time, a complete description of legal requirements is precluded. Consult an attorney if needed.

COBRA Administration

Groups that are subject to COBRA may use HealthEquity/WageWorks, a national COBRA compliance administrator contracted by Arkansas Blue Cross and Health Advantage, another third-party COBRA compliance administrator or administer COBRA through the group.

Most groups contract with HealthEquity/WageWorks. Its services include:

- COBRA premium billing
- Eligibility adjudication
- Premium collection
- Continuing COBRA transactions processing
- Documentation retention
- Supplying forms for use in administering COBRA

Go to **wageworks.com** or call **888-678-4872** for more information about HealthEquity/WageWorks.

Groups That Choose HealthEquity/WageWorks for COBRA Administration – New Qualifying Event

If a group chooses HealthEquity/WageWorks for its COBRA Administration, it should follow these steps in case of a new qualifying event for an employee:

1. Employer contacts Arkansas Blue Cross and Blue Shield/Health Advantage to terminate coverage by sending HealthEquity/WageWorks information about the Qualifying Event online or by mail within 30 days of the event.
2. HealthEquity/WageWorks sends notice of the Qualifying Event to the Qualified Beneficiaries, who are offered the same coverage that was lost because of the event.
3. If election is made within 60 days but without payment, HealthEquity/WageWorks sends an invoice with a 45-day grace period from the date of election.
4. If election is made with payment, HealthEquity/WageWorks will notify the employer through its weekly eligibility report email. The employer can email the eligibility report to Arkansas Blue Cross Customer Accounts Division or Health Advantage Customer Accounts Division at **bccaenrollment@arkbluecross.com** or **hacaenrollment@arkbluecross.com**, respectively. The employer can also fax the eligibility report to 501-378-3248 (Arkansas Blue Cross) or 501-301-6869 (Health Advantage) to reinstate the participant.
5. If groups process changes through Blues Enroll, or another electronic platform, they must process COBRA reinstatements via their electronic platform.
6. If no election is made within 60 days, the case is dropped.
7. Later, invoices are mailed to participants around the 12th of each month.

Canceled Records

If participant is canceled for non-payment, HealthEquity/WageWorks will notify the employer through its weekly eligibility report email. **It is the employer's responsibility** to email the eligibility report to Arkansas Blue Cross Customer Accounts Division or Health Advantage Customer Accounts Division at **bccaenrollment@arkbluecross.com** or **hacaenrollment@arkbluecross.com**, respectively. The employer can also fax the eligibility report to 501-378-3248 (Arkansas Blue Cross) or 501-301-6869 (Health Advantage) to terminate coverage. If groups process changes through Blues Enroll, or another electronic platform, they must process COBRA terminations via their electronic platform.

Ongoing Administration

- Invoices are mailed to participants around the 12th of each month
- Standard reports are emailed to the designated group contact(s) on a weekly basis
- Monthly reports are provided within the first ten business days of each month following activity
- These reports include new events, terminations, changes in status, address changes, etc.
- Monthly premium statements are sent explaining payments to HealthEquity/WageWorks, minus the two percent administration fee
- These statements include the date when premiums were collected, name, participant identification, amount and paid-through date

For additional assistance related to questions about COBRA terminations or additions, please email your group's assigned group service coordinator. Regional contact information can be found in **section 2.5 and 2.6**.

Groups That Do Not Use COBRA Compliance Administrator

1. The employer notifies Arkansas Blue Cross and Blue Shield/Health Advantage to terminate coverage
2. The employer sends the Qualifying Event Notice to the Qualified Beneficiary or Beneficiaries
3. The Qualified Beneficiary or Beneficiaries have up to 60 days from the date of the notice, or the date coverage ends, whichever is later, to elect **COBRA** coverage, and 45 days to pay after the date of election
4. If **COBRA** is elected and payment is made on a timely basis, the employer submits an employee application or **COBRA** notification from their third party **COBRA** vendor, indicating the **COBRA** effective date and termination span for the member to be reinstated through **COBRA** without a break in coverage
5. The group collects all premiums to pay through the current month and sends them to Arkansas Blue Cross/ Health Advantage
6. The group must notify Arkansas Blue Cross/Health Advantage of any changes in status
7. If you need assistance with a **COBRA** question, please contact your legal counsel in **COBRA** law
8. For assistance related to how to notify The Health Plan about a COBRA termination or addition, please contact your **Group Service Coordinator**

14.0 How to File a Claim for Covered Services

Reimbursement of Payment for Covered Services Received in Service Area

If a member makes a payment other than required copayments/coinsurance for services covered by your group's plan, a claim for reimbursement may be made. The member needs to submit a copy of the receipt for payment of services received and a copy of the bill to Arkansas Blue Cross/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:

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

Health Advantage
Attn: Claims
P.O. Box 8069
Little Rock, AR 72203-8069

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

Members should fill out our claim forms (available at arkansasbluecross.com and healthadvantage-hmo.com) and attach a copy of the receipt and the bill and submit them to us.

Filing a Claim for Covered Services Received Outside of Service Area

Claims for medical services received through the BlueCard program are filed with the local Blue Cross and Blue Shield plan. The alpha prefix and the member's ID number must be included and routed electronically by the provider to Arkansas Blue Cross/Health Advantage.

If a member receives services from a non-participating BlueCard provider in an out-of-service area, the member can submit a **HCFA Standard Form 1500 Claim Form** or a copy of the bill for services received with a request for payment to Arkansas Blue Cross/Health Advantage. The request must include the member's ID number, name, date of birth and the group name or number. It must be submitted within 180 days of the date on which the expenses were first incurred. It must be sent postage paid and addressed to:

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

Health Advantage
Attn: Claims
P.O. Box 8069
Little Rock, AR 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 the 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 Arkansas Blue Cross/Health Advantage allowable charges, and to the terms, conditions, limitations and exclusions of the member's Evidence of Coverage/Group Benefit Certificate.
Medications from out-of-network pharmacies are not covered except for emergencies.

15.0 The Family and Medical Leave Act and Military Leave

Family and Medical Leave Act of 1993

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

Family Leave

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

- 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
- 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
- Worked at a location where at least 50 employees are employed within 75 miles

If an employee takes family leave under the act, the employer must keep paying the employee's 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.

Members 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 the member's re-employment. Arkansas Blue Cross/Health Advantage may require a copy of the returning member's orders terminating the active duty.

16.0 Total Enrollment Solution (TES)

The following information is good for all small group metallic health, dental and vision plans, with the exception of dental and vision school group business.

Arkansas Blue Cross and Health Advantage are focused on a better enrollment process for our small group customers. By moving to a convenient online solution for small groups, we are streamlining benefits to a simple online review and enrollment so you can focus less on paper applications and more on the things that matter most — your business.

The quoting and new group enrollment process, as well as the renewal process, is still driven by the agent who enters the group's employee census data and finds health, dental, vision and life plans that work best for the group.

Register for TES

For security purposes the agent will send the PIN in a separate email. You will need to re-register each renewal year.

You will receive an email from TES with a link to the homepage.

Step 1: Are you a first timer? Select the "Register" button
(Already registered for TES? Simply sign in with your username and password ... not your Tax ID number or PIN)

Step 2: Enter your group's Tax ID number and PIN

Step 3: Select "Continue" to register as a TES user

Step 4: Already registered? Log in with your username and password (not your Tax ID number or PIN)

Create Username and Password

Step 1: Choose a username, password and security question

Step 2: Agree to the terms and conditions

Step 3: Select "Continue"

Review Your Information

Step 1: Review employer information, census data and plan details

Step 2: Contact the agent to make any changes

Step 3: Print out or save rate information for your records and select "Continue"

Legal Disclaimer

We need to know if your group is commonly owned, and you agree to protect employees' health information.

Step 1: Read the legal disclaimers

Step 2: Check the applicable boxes and select "Continue"

Digital Signature

The group's decision-maker digitally signs the applications.

Step 1: Click the "Sign" button
Step 2: Review the application
Step 3: Check boxes to agree to the terms of coverage
Step 4: Enter name as shown on the contract and confirm electronic signature
Step 5: Select "Submit"
Step 6: Once all applications have a green checkmark, select "Continue"
Step 7: Print or save a copy of your signed application contract for your records

Choose Payment Method (for new product enrollment only)

Step 1: Select payment method (credit card or electronic bank draft). If the total premium is greater than $60,000 for any product, there will be no credit card option; you will need to select electronic bank draft.
Step 2: Select "Continue" (payment must be made by the last day of the month prior to effective date)

Payment

Step 1: Provide payment information and billing address
Step 2: Enter contact information
Step 3: Select "Continue" (payment is not charged until confirmation on the next screen)
Step 4: Review the details
Step 5: Select the "Submit Payment" button

Groups that purchase health and either dental or vision will pay once, but it will show up as separate charges on the credit card or bank draft.

Note: Once the first payment is processed in TES, you will be done with that system and can begin using Blueprint for Employers.

The Double Check

Arkansas Blue Cross may review a group's contract and documentation once they finish TES online enrollment to ensure that we have received all necessary information for successful enrollment, such as:

- The group's most current **State Wage & Quarterly Report**
- A minimum of two full-time employees must enroll
- No more than 50% of employees reside in the same household
- 75% of all eligible employees must enroll in the insurance plan
- Proof of your company's physical address

Here is How it Works!

Some documentation is necessary for coverage. We will send an email to the group administrator explaining the review, and later to let them know whether or not they passed. Here are some of the emails we may send:

"Heads Up!" Email

The group administrator will receive a courtesy "heads-up" email if the group is one selected for the review.
Who gets it? Everyone under review.

"Congratulations, You Passed!" Email

If the auditor finds everything in order, we will send a follow-up email saying the group passed the review.
Who gets it? Employer groups that pass the review.

"Sorry, We Are Missing Things" Email

If the auditor finds that we are missing a few things from the group's documentation, we will send a second letter letting the group know what we are missing and give them seven to ten-days to send us what we need.
Who gets it? Employer groups that owe us additional documentation or details.

"Unfortunately, We Have to Terminate the Coverage" Email

If we still do not receive the documentation we are looking for after we ask, the group's coverage can be terminated. We will encourage groups to re-enroll with the proper documentation the next month.
Who gets it? Employer groups that do not include the necessary documents for a TES enrollment.

"One of Your Employees Does Not Qualify" Email

Individuals can be terminated if they do not qualify for coverage. We will send a letter to the group administrator letting him or her know. Who gets it? Employer groups that had an employee who did not qualify for coverage.

17.0 Definition of Terms

Child – A subscriber's natural child, legally adopted child or stepchild. Child also means a child who has been placed with the subscriber for adoption, or 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 permanent guardianship.

Dependent – Any member of a subscriber's family who meets the eligibility requirements and is enrolled in the group and for whom the group's plan has received premium.

Full-Time Employee – A permanent employee working at least 30 hours a week and 48 weeks a year.

Incapacitated Dependent – Any member who 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.

Late Enrollee – Any employee or dependent who requests enrollment in the group's plan after the expiration of the initial enrollment period or open enrollment period and who is not eligible for a qualifying event. Members who meet the criteria for the qualifying event are not considered late enrollees. Late enrollees are deferred until the next open enrollment period.

Member – A person covered by the group's health, dental or vision plan whether it is the subscriber and/or dependents.

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 may enroll in the group's 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.

Qualifying Event – An event that allows a subscriber or dependent to be eligible for health, dental or vision coverage under the group's plan.

Spouse – An individual who is the husband or wife of a subscriber from a marriage that is legally recognized in a jurisdiction within the United States of America.

Stepchild – A natural or adopted child of the spouse of a subscriber.

Subscriber – 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/she meets the above conditions.

Subscriber Number/Contract Number – The member ID number automatically assigned upon coverage. Numbers have an 01 extension after the ID number for a member and dependents are assigned 02, 03, etc.

Important Information

Group Number	Region
Renewal Date	Open Enrollment Month

Contacts

Agent/Broker

Name	Phone	Email

Group Service Coordinator

Name	Phone	Email

Account Team

Name	Phone	Email

COBRA Vendor

Name	Phone	Email