

Group Administrator Guide





Welcome to a special edition of our Group Administrator Guide.

In this edition, you will see a newly updated section on our Retroactive Policy. We have listened to your feedback and provided information on how to contact us and avoid having to submit retroactive activity requests.

You will also see a new section that highlights information on reporting requirements under the Affordable Care Act.

We hope this Guide is a useful tool that will assist us in partnering with you to provide the best possible service to our members.

Have a wonderful fall season,

A handwritten signature in black ink that reads "Maribeth P. Basile". The signature is written in a cursive, flowing style.

Maribeth Basile
Marketing Operations Analyst

Table of Contents

How to Contact Us.....	2
Sales	2
Customer Care.....	3
Help Us Help Your Members	3
First Call Resolution	4
Setting Up a Member Account Online.....	4
Monthly Health Summary Q&A.....	6
Membership Enrollment Options.....	7
Electronic.....	7
Web	8
Paper.....	9
Enrollment and Billing Support Form	10
Cancellation Requests.....	12
Billing and Payment Information	13
Eligibility	15
Group Eligibility.....	15
Eligible Subscribers.....	16
Eligible Dependents.....	17
Spouse.....	18
Other Adult Dependents of the Subscriber.....	22
Enrollment.....	25
Probationary Period	26
How Do I Enroll, Change or Terminate Employees/Dependents?.....	28
Primary Care Physician (PCP) Enrollment Requirements	29
Enrollment Transactions, Add, Change and Terminate.....	29
Enrollment Opportunities	31
Initial Enrollment Period.....	31
Special Enrollment Period	31
Annual Open Enrollment Period Information.....	32
Group Level Activity	33
Medicare.....	34
Continuation of Coverage	35
Retroactive Policy	43
Reporting Requirements.....	43
Health Insurance Portability and Accountability Act of 1996 and Privacy (HIPAA).....	47
Protected Health Diagnosis	48
Frequently Asked Questions.....	48

How to Contact Us

Reason for Call	Who to Call
Commercial Large Group (50 or more eligible subscribers) Benefits, Setup, Updates, Cancellations, Billing, Member Enrollment or Member Cancellations	Call your Account Service Consultant
Commercial Small Group (Less than 50 eligible subscribers) Benefits, Setup, Updates, Cancellations, Billing, Member Enrollment or Member Cancellations	Call the small group inquiry line at 1-844-843-5256
Medicare Billing, Member Enrollment or Member Cancellations	Call the Medicare Membership Department at 1-877-240-1320
Web Password Resets or Technical Issues	Call our Web Help Desk at 1-800-278-1247 (Monday - Friday, 9 a.m. to 4:30 p.m. EST)
Member Claims, Benefits or Authorizations for Medical, Dental or Pharmacy Plans	Members should call the number on their Member ID Cards

Before you call:

Due to Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, there are restrictions regarding the disclosure of health information to a third party without a Release of Information form on file with us. Account Service Consultant and Small Group Inquiry line phone numbers are for group administrators only. Each time a Group Administrator contacts their Account Service Consultant or the Small Group Inquiry line, we require the following:

- ▶ Group Number (if not available, group address is required)
- ▶ Group Name
- ▶ Contact Name

Our mailing address: Excellus BlueCross BlueShield
P.O. Box 22999
Rochester, NY 14692

Our Billing/Payment Address:

Please refer to the address on your invoice.

Our email address :

ExcellusBCBS.com - follow instructions on the website for secure email process.

Customer Care

Questions specific to an individual employee's claims or benefits should be directed to our Customer Care department using the telephone number listed on the employee's identification card.

Hours of Operation:

Monday - Thursday 8 a.m. - 8 p.m., Friday 9 a.m. - 8 p.m.,

Help Us Help Your Members

We are always happy to speak with our members and look forward to assisting them and answering their questions. For their convenience, please remind your members of the online options available to them.

When your members do call Customer Care, please remind them to:

- Call the number listed on their identification card. Please note only some customer care numbers are open till 8 P.M.
- Have their identification card with them
- Have any bills or correspondence they are questioning with them
- Make sure they and everyone covered under their policy has completed an [AUTHORIZATION TO SHARE MY PROTECTED HEALTH INFORMATION FORM](#)

To comply with federal Health Insurance Portability and Accountability Act (HIPAA) regulations, health plans must obtain a member's permission to share that member's protected health information with any other person. There are limited exceptions to this rule. Until a child reaches age 18, parents may access most of their child's health information without first obtaining the child's permission. However, regardless of the child's age, parents generally do not have access to diagnosis, treatment or payment information for sexually transmitted diseases, abortion, and drug and alcohol abuse, unless the child specifically authorizes the release of such information.

The necessary forms can be completed online – or we can fax or mail copies to you.

When your members submit information/correspondence to Customer Care, please remind them of the following:

- Complete all pertinent forms – do not leave anything blank
- Ensure that their member ID number is on the correspondence
- Include a contact phone number we can use to reach them if needed

Important information about the subscriber's address:

Many communications are sent directly to our subscriber population, some of which include:

- New member packets
- Monthly Health Summaries
- Identification cards
- Certificates of coverage

Please make sure that we are always provided with the employee's most current, correct and full address to ensure receipt of this important information.

To update or change their address, subscribers can contact Customer Care by calling the number on their identification card, or you can contact the Enrollment Processing Inquiry Unit.

We also accept paper requests from groups and brokers to change a subscriber's address.

Please complete one of our approved applications and mail it to us at P.O. Box 22999, Rochester, NY 14692.

Address updates can also be sent to us via the Secure Email Process, noted on page 10.

First-Call Resolution

First-call resolution is our goal. We are committed to resolving your inquiry during your initial call. We have established a number of initiatives and have empowered our Customer Care Advocates to do more than ever before. We will make calls on the member's behalf when necessary, set realistic expectations and follow-up in a timely manner. We are working hard to lessen the amount of work you have to do in order to resolve your issues.

Feedback can be provided through our phone surveys. We appreciate any and all comments.

Setting Up a Member Account Online

Setting up an account for members and those on their policy is easy... all they need is their ID number.

When members visit our website – ExcellusBCBS.com – they can select "Register now!" and follow instructions to get set up.

There are a variety of options and services available for members online – listed below are some of them:

View Benefits & Claims

- View benefits, copays and deductibles
- Review claim history
- Check the status of referrals and authorizations
- Obtain a copy of the monthly health statement

Print Forms

- ▶ Claim forms
- ▶ HealthyRewards reimbursement forms (if applicable)
- ▶ Advance care planning
- ▶ Managing your privacy
- ▶ Membership and enrollment forms

Make Changes

- ▶ Change and find primary care physician
- ▶ Change address
- ▶ Find a doctor using our online directory
- ▶ Request (and print) a new ID card
- ▶ Get information on health care reform
- ▶ Find ways to save money on prescriptions
- ▶ Learn more about member Blue 365 discounts, including LASIK vision correction, glasses, massage therapy
- ▶ Contact Customer Care – via email or through a live chat

For members age 18 years and older who wish to have Protected Health Information (PHI) disclosed to someone other than themselves (including disclosure to parents), we recommend that they complete an authorization form for the disclosure of PHI. The completed form will allow us to disclose information to the person(s) named on the authorization and will eliminate delays in answering their questions should they need to contact us. On the member home page, from the quick links available, a member can select “Manage your Privacy” to access the form(s).

Did You Know?

If you set up online accounts for your employees, be aware that you may be putting yourself at risk for unauthorized access to employees’ protected health information, such as claims information.

We recommend that you avoid setting up online accounts on behalf of your employees. If employees need assistance setting up their online accounts, please instruct them to call our Web Help Desk at 1-800-278-1247.

Our Web Help Desk hours are: Monday through Friday, 9 a.m. to 4:30 p.m. EST.

Monthly Health Summary Q&A

When will members receive a Monthly Health Summary?

The Monthly Health Summary will be sent to the subscriber's mailing address when one or more members on the contract have claim activity during the previous month.

Is the Monthly Health Summary compliant with New York state regulations regarding timeframes for communicating claim results for members?

Yes, the Monthly Health Summary is compliant with NYS Department of Financial Services rules for communicating claims activity/status to members within a certain timeframe.

Will protected health diagnosis information be on the Health Summaries?

Claims for protected diagnoses will appear on the Monthly Health Summary as a generic service (e.g. "office visit") – details of protected diagnoses will not be displayed.

Why are we putting protected health diagnosis information on the Health Summaries?

Generic information about protected diagnoses is provided on the Monthly Health Summary in order to satisfy state and federal regulations for communicating with subscribers about their claims activity.

We must notify contract holders of any usage against their contract. This includes claims for protected diagnoses. Instead of removing the contract holder from the notification process, we are protecting the patient by only supplying generic information.

Essentially, we are trying to balance two legislative regulatory requirements — one which advises that we must protect patients' health information and a second which advises that we must communicate with the contract holder.

By displaying protected health diagnosis related claims on the Monthly Health Summaries, are we out of compliance with NYS regulations?

No – Claims for protected diagnoses will appear on the Monthly Health Summary as a generic service (e.g. "office visit") – details of protected diagnoses will not be displayed. So, we remain in compliance with NYS and federal laws and regulations regarding protected health diagnoses.

A claim was paid but according to the code in the comments the benefit is exhausted, however, the member insists they have not used that particular benefit this year and the claim is indicating that it is paid. So, why is the code in the comments section?

The code shows that the benefit is now exhausted with the claim that has processed and paid.

Benefits for In - Network Services	
Benefit Period	January 1, 2013 - October 31, 2013
Copayments and Coinsurance	
Office Visit - PCP	\$15.00
Office Visit - Specialist	\$25.00
Copayment	0%
Deductible	
Individual	Not Applicable
Family	Not Applicable
Cost of Protected Maximum	
Individual	Not Applicable
Family	Not Applicable

Mammograms Save Lives	
• A mammogram is an X-ray of the breast to find small tumors that you or your doctor are unable to feel	
• Mammograms are important because the earlier breast cancer is found, the more successfully it can be treated	
• Recommendations differ; talk to your doctor about when you should have a mammogram	
• It's important to share any family medical history of cancer with your doctor.	

Have You Had Your Flu Shot?	
• People 65 years of age and older	
• Children under 5 years of age	
• Pregnant women	
• People with chronic medical conditions	

A member is in a High Deductible Health Plan (HDHP) and wants to know why his/her prescription drug claims don't show on the Monthly Health Summary.

Even though prescription drug claims do not appear on the medical Monthly Health Summary at this time, they are being calculated into the members' deductible and out-of-pocket maximum information that is shown on the cover page.

Members who have prescription drug coverage that has a deductible and/or coinsurance benefit design will receive a monthly My Rx Statement in addition to the Monthly Health Summary.

What column should a member be looking at and comparing to the bill they receive from their provider's office in order to make sure they are being billed the correct amount?

There is a section on the Monthly Health Summary titled Member Responsibility. This section consists of Deductible, Coinsurance, Copay and Non Covered expenses. The provider can bill the amounts listed in these columns. If members have any questions or concerns regarding how a claim processed, or believe the Member Responsibility is not correct, they can contact our Customer Care department at the phone number listed on the back of their ID card.

Membership Enrollment Options

We offer a variety of enrollment options, including Web, electronic and paper. Select the option that meets your business needs.

Electronic Enrollment

Electronic enrollment is a method of electronically submitting enrollment files and exchanging data that is compliant with the Health Insurance Portability and Accountability Act.

If your group size is 100 or more members, and you are currently submitting paper enrollment forms, please contact us at Electronic.Enrollment@Excellus.com for more information on this option.

Benefits of Electronic Enrollment

- ▶ Enjoy faster service
- ▶ Enrollment is submitted via a secure server
- ▶ Enrollment is submitted on one file rather than multiple paper applications or web transactions
- ▶ Decrease in manual interventions for additions, terminations or changes to current enrollment

Please Note

Valid Social Security numbers must be sent for subscribers. It is also strongly recommended that valid Social Security numbers are sent for dependents. We are required to ask for enrolled subscriber and dependent Social Security

numbers in order to meet our reporting obligations under the Affordable Care Act. If a valid Social Security number cannot be sent for a dependent, then it must be omitted. Do not send invalid Social Security numbers as they will impact eligibility.

Web Enrollment

Web enrollment is available to all employer groups. This type of enrollment has two options:

1) Full Access Option: this option allows you to enter all employee applications and make updates to a member's coverage on our website.

▶ **Please note:** For cancelling members with ID numbers that are nine characters long, with an alpha character in the middle, use the first day of the month as the cancel date.

Another feature is that your employees may submit their own updates and enrollment requests. If you choose this option, we will notify you whenever you have an employee enrollment and change request pending for approval or denial.

2) View Only Access: this option allows you to view a real-time member roster and print/order ID cards.

Benefits of web enrollment

- ▶ Enjoy faster service
- ▶ Receive immediate confirmation that request is received
- ▶ View real-time member roster 24/7 (sort by subgroup, name, age, date of birth, active/terminated status)
- ▶ Convert roster to a Microsoft Excel spreadsheet to make reconciliation of invoices easier
- ▶ View and update a member's policy (change member address and/or phone)
- ▶ Print/order ID cards

Social Security Inclusion

▶ We are required to ask for a Social Security number in order to meet our reporting obligations under the Affordable Care Act. Also, it is strongly recommended that valid Social Security numbers are sent for all dependents.

To add or activate a new group number, or remove an old group number from your web account, an existing user can:

▶ Log on our website ExcellusBCBS.com, and follow the link for Employer, and go to the Quick Links section under the "Enroll and Update" tab

To learn more about this convenient method of enrollment, simply go to our website at ExcellusBCBS.com, follow the link for "Employer" and select "Register." Then complete the Group Web Access Request Form. Upon approval, we will send you an email with a username and password. Once you receive this, you may complete the registration process online.

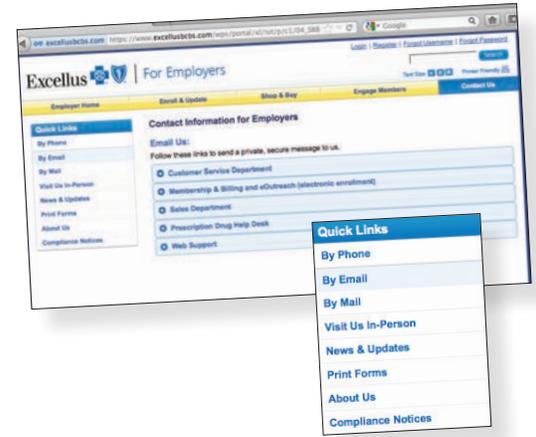
If you are a Broker interested in web enrollment, please contact BrokerContractsExcellus@Excellus.com.

Paper Enrollment

Paper enrollment is our traditional method of enrolling new members and making changes to a member's coverage. Our goal is to work with you to ensure that all required fields on the application are complete and accurate. This will reduce the number of applications returned to you for additional information/clarification and will speed up the process to enroll members.

Below are a few reminders to assist in the enrollment process:

✓	Always use blue or black ink on the applications.
✓	If highlighting, only use yellow.
✓	Write legibly.
✓	Complete all areas of the application.
✓	Always provide an employee's hire date.
✓	Include all signatures.
✓	Check appropriate coverage boxes.
✓	We are required to ask for a valid Social Security number in order to meet our reporting obligations under the Affordable Care Act. Also, it is strongly recommended that valid Social Security numbers are sent for all dependents.
✓	Ensure a complete and legible subscriber address is included.
✓	Applications that have missing or illegible information may not be processed. If this is the case, we will notify the group with a letter.
✓	Activity must be submitted as it occurs to ensure timely enrollment or cancellation. Please do not send activity with your premium payment.
✓	Mail the completed application to: Excellus BlueCross BlueShield, P.O. Box 22999, Rochester, NY 14692, or visit our website to scan a secure request to us.
✓	Regarding cancellation dates: <ul style="list-style-type: none"> ▶ For cancelling members with ID numbers that begin with a "2" and do not contain an alpha character, use the last day of the month as the cancel date. ▶ For cancelling members with ID numbers that are nine characters long, with an alpha character in the middle, use the first day of the month.
✓	Use only acceptable enrollment forms, which are available to print from the website at: ExcellusBCBS.com/Employer . Click on Print Forms at the bottom of the employer/benefit administrator's home page. If you submit an alternate group enrollment form, the form may not be processed.



Enrollment and Billing Support Form

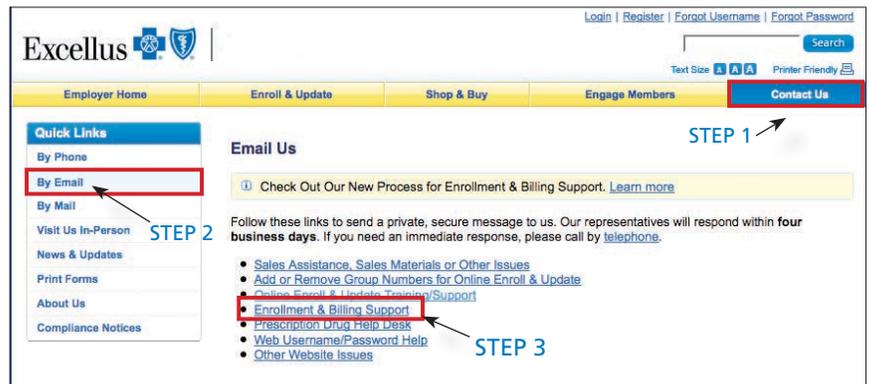
Why use this form?

The purpose of this web based form is to streamline all of your Membership and Billing inquiries and requests. By submitting your inquiries and requests via this form, they are securely transmitted directly to the request management system that is utilized to assign and process requests within our Membership and Billing department. Requests submitted via this online tool can be easily tracked, assigned and managed through completion. The process is simple; this document outlines how to use the form and what to expect once you submit an inquiry to Membership and Billing.

- ▶ Please note: You must have an active web account to use this feature.

Accessing the form

Employer Home Page	Broker Home Page
<ul style="list-style-type: none">• From the Employer home page of our website, click 'Contact Us' from the upper right hand corner• Click 'By Email' from the options on the left• Click 'Enrollment and Billing Support'	<ul style="list-style-type: none">• From the Broker home page of our website, click 'Contact Us' from the upper right hand corner• Click 'By Email' from the options on the left• Click 'Enrollment and Billing Support'



Using the Form

The fields of the form are self-explanatory. To ensure your inquiry is routed appropriately, please review the below descriptions for the 'Reason for Inquiry' field:

- ▶ **Billing** – Use to request copies of invoices.
- ▶ **E-File** – Only groups that have been pre-approved for our e-File enrollment may use this option.
- ▶ **ID Card Request/Research** – Use to submit a request for a new set of ID cards or when requesting a mass reissue of ID cards for an entire group.

- ▶ **Reconciliation** – Use to request a research posting of funds or to request a reconciliation worksheet of payment activity.
- ▶ **Subscriber/Member** – Use for member activity, new enrollments (single or multiple enrollments), member additions to existing contracts, membership changes, terminations, general questions and research. All appropriate paperwork must accompany the request and required fields must be completed.

Tracking System and Notifications

You will be notified when your inquiry is received, assigned and completed.

- ▶ **Inquiry Received:** As soon as your inquiry is submitted, you will receive a pop up message indicating that your inquiry was received. This is a system generated generic message; there are no timeframes or specific information noted.
- ▶ **Tracking Number:** When your inquiry has been assigned internally, you will receive an automated email from the system which will include a tracking number. The tracking number can be referred to with any questions related to the inquiry. This tracking number will take up to 1 business day to be received.
- ▶ **Complete:** This email will advise that the inquiry was completed. The tracking number and resolution to the inquiry will be provided in this email. If for some reason the request was not completed as requested, please reach out to your dedicated support with the tracking number.
- ▶ **Closed – No Action Taken:** if your inquiry does not contain the necessary information to complete, it will be closed without any action taken. A detailed description of the reason for closing out the inquiry will be provided in this email. A subsequent request will need to be filled out with the necessary information if this is asked for in the closure notification. If questions about it exist, utilize the tracking number when contacting your dedicated support.

Additional Information Regarding Future Enhancements:

Please note that the following enhancements are in process; we are unsure of the exact timeframe that they will be in production at this time.

- ▶ Currently, the email you receive with your tracking number does not contain specific information about the inquiry. An effort is underway to have this information pulled into the email.
 - ▶ Based on the type of inquiry, the automated email sent to you could contain the group name, group number, broker name, subscriber name, subscriber ID#, and the membership inquiry number
- ▶ A Print Friendly button will be added on the input and confirmation screens.
- ▶ Examples of each reason option will be displayed to be sure you selected the right reason for your inquiry. This will help to ensure the inquiry is routed to the appropriate area for resolution

Cancellation Requests

Easy Options For Cancellations

Visit our website at ExcellusBCBS.com/Employer and go to the “Contact Us” section. Follow our secure email instructions to send your cancellation request electronically. (Note: if using the secure email option, please keep a copy of this request for your records.)

Visit the “Enroll and Update” tab to view “Online Enrollment & Account Maintenance” options.

For paper cancel submissions:

- ▶ Visit ExcellusBCBS.com/Employer and select the “print forms” option. Select from one of the approved application request forms, and complete the following sections of the form for a subscriber cancellation:
- ▶ Subscriber information
- ▶ Group/Employer information
- ▶ Subscriber/Employee status
- ▶ Cancellation information

For termination of a dependent, please complete the following sections of the approved application form:

- ▶ Subscriber information
- ▶ Group/Employer information
- ▶ Subscriber/Employee status
- ▶ Cancellation information (check the dependent information portion of this section)
- ▶ Dependent information (list the dependent that is cancelling off the policy)

The Group Representative signature must accompany this form.

Please note: In order to streamline the process and eliminate numerous paper forms, we no longer accept any forms that were formerly used for individual or multiple subscriber/member cancellation requests.

Once the form is completed, it can be mailed to Excellus BlueCross BlueShield, P.O.Box 22999, Rochester, NY 14692, or be sent using the Secure Email Process noted above.

Regarding cancellation dates:

For cancelling members with ID numbers that begin with a “2” and do not contain an alpha character, use the last day of the month as the cancel date.

For cancelling members with ID numbers that are nine characters long, with an alpha character in the middle, use the first day of the month.

Group Eligibility

New York state law has limitations regarding which types of employer groups qualify for group health insurance coverage. These requirements vary by type of entity (e.g., employer). In addition, we have certain underwriting guidelines, as permitted by law, that govern whether a group may be accepted for coverage or may maintain coverage. We illustrate some of these general guidelines below:

- ▶ The group must have a worksite in our service area
- ▶ The group must meet the definition of an insurable group, or have an exception from the NYS Department of Financial Services
- ▶ A small group must be community rated. A large group may be experience rated. Definitions of these terms are below:

Group Size

- ▶ Sole Proprietors and Partnerships with only owners and spouse enrolled:
 - ▶ Prior to January 1, 2014, enrollment in the group coverage was permitted
 - ▶ Beginning with renewals on January 1, 2014, if a sole proprietor or partnership covers only the owner(s) and spouse(s), group rates are no longer applicable. These former groups will be reclassified as individuals.
- ▶ A small group is defined as one to 50 eligible employees
- ▶ A large group is defined as 51 or more eligible employees

Notes:

1. In accordance with Affordable Care Act (ACA), for 2014, sole proprietors who only enroll themselves and/or spouse and partners who enroll only themselves and/or spouses must be reclassified as individuals, even if the business has employees who are not eligible for coverage.
2. In accordance with ACA, NYS will change its method of determining group size to one that is consistent with federal law. Group size will be based on employees, rather than eligible employees and a small group will be redefined as one with 100 or fewer employees. This change is to take place in 2016.

Community Rating

The premium for all persons covered by a policy or contract are the same, without regard to age, sex, health status, occupation or any other demographic factors. The rates may vary by geographic location.

Experience Rating

The premium for the policy selected by the group is determined at least in part by the group's claims experience and/or demographics.

If you have further questions regarding our underwriting guidelines or these terms, please contact your Broker or Account Manager.

Eligible Subscribers

The subscriber is the person to whom the policy is issued. In order to enroll in our insurance programs, subscribers must meet the criteria outlined in this section. Except as otherwise specified, we rely on you for verification of subscriber eligibility. We may request information to support enrollment of a subscriber at any time, however, so please maintain these records as long as the individual remains enrolled in our coverage, regardless of how many years he or she remains enrolled. Once the individual terminates coverage, you must retain these records for 10 years. Please note this 10-year requirement applies for paper, web and electronically-submitted requests.

Eligible subscribers must be citizens of the United States, permanent residents or non-immigrants whose authorization status permits employment. Products that require a gatekeeper in the form of a primary care physician (e.g., HMO, POS) or certain products with limited networks require that the subscriber live, work or reside in the service area of our plan. A few gatekeeper products allow the subscriber to live in a contiguous country.

If you have questions about the type of product purchased by your group, please contact your Account Manager or Broker.



Active Employees

Full-time employees work 30 or more hours per week. You may determine the number of hours required for your employees between 30 to 40 hours. For example, you may establish the threshold as 35 hours per week. You may also make separate determinations for different classifications, such as salaried employees must work 40 hours per week, and hourly employees must work 30 hours per week.

Part-time Employees

Part-time employees for a small group or a sole proprietor must work 20 hours or more per week in order to qualify for health coverage. Large employers may include employees who work 17.5 hours or more per week.

Retired Employees

Retirees are eligible for coverage if your group includes retiree coverage as an employee benefit. The retiree, and all eligible dependents, must be enrolled in Excellus BCBS's products immediately prior to retirement. They must also maintain coverage continuously throughout retirement. Spouse and/or dependents must complete the appropriate application(s) for coverage, if different from the retiree's coverage.

Continuants

Individuals entitled to coverage through COBRA, NYS Continuation or the Young Adult Option are entitled to enroll as the subscriber if the individual received all appropriate notices, the election and first premium payments were timely and we receive the application on time.

For further information, see the Continuance section, later in this guide.

Ineligible Subscribers

The following individuals are not eligible for enrollment in your insurance programs:

- ▶ Employees working fewer than the required hours listed in the eligible employees section
- ▶ Individuals paid for periodic services, such as consultants
- ▶ Contract employees
- ▶ Temporary employees
- ▶ Volunteers
- ▶ Any individual who is not a bona fide employee or former employee

Check with your account representative or legal counsel regarding seasonal employees

Eligible Dependents

The dependent must have an existing relationship with the subscriber, and must meet criteria as defined below, and as contained in the subscriber certificate or plan document. Except as otherwise required by law (e.g., COBRA, NYS Continuation), coverage of dependents is based on the employee or member being the primary person covered under the policy.

Similar to the eligible subscribers section, eligible dependents must meet certain criteria in order to obtain and maintain coverage. In the past, we may have requested certain information to verify eligibility. In today's world of electronic and web enrollment, we generally rely on you to verify dependent eligibility and do not request these documents. We may request information to support enrollment of any dependent at any time, however, so please maintain these records for as long as the individual remains enrolled in our coverage, regardless of how many years he or she remains enrolled. Once the individual terminates coverage, you must retain these records for 10 years. We have included helpful information regarding the types of acceptable documentation normally expected immediately following the definition of each type of eligible dependent.

Eligible dependents must be citizens of the United States, permanent residents or non-immigrants whose authorization status permits an extended stay in the United States. The dependent must have an existing relationship with the subscriber, and must meet criteria as defined below, and as contained in the subscriber certificate. Excellus BCBS HMO coverage requires the dependents to live or reside in the service area, unless enrolled in the Away From Home Care® program for families living apart.



For further information, see the following websites:

Dependent to 26:

<http://www.healthcare.gov/law/features/choices/young-adult-coverage/index.html>

Dependent to 30:

http://www.dfs.ny.gov/consumer/faqs/faqs_S6030_Age29_young.htm

If you have questions about the type of product purchased by your group, please contact your Account Manager or Broker. If you have questions regarding the eligibility of a dependent, please contact Enrollment Processing.

Spouse

A spouse is eligible whenever the couple is legally married in a state or country that recognizes the type of marriage. The definition of spouse includes opposite sex and same-sex spouses, as well as common-law spouses.

As the group administrator, you must permit enrollment for all spouses who qualify and properly apply for coverage.

Following the Supreme Court's decision on June 26, 2015, same sex marriage is legal in all states in the United States. For that reason, we have removed the table contained in previous editions that provided information regarding which states permitted same sex marriage.

Common law marriage is a legal form of marriage in certain states and the District of Columbia. For questions on common law marriage and eligibility, please seek counsel with your own legal advisors.

For information regarding domestic partners, please see the information under Other Adult Dependents of the Subscriber on subsequent pages.



Eligible Child Dependents of the Subscriber

A dependent child must meet criteria related to the relationship with the subscriber, as well as age and, in some cases financial dependency. Please review the following sections for more detail.

Age/Financial Dependency and Other Eligibility Requirements for Dependents

With the enactment of the ACA in 2010, the age and dependency requirements for "children" enrolled in health benefits were significantly changed. These changes became effective for plans that were originally effective or renewed on or after September 23, 2010. In some instances, the ACA changes superseded a New York state law that makes coverage available for children to age 30, either through a rider to family coverage or as a special type of continuation of coverage called the Young Adult Option.

Please note, when submitting a Young Adult Option Certification Form, please ensure a subscriber or young adult signs the form. Please submit forms no more than 60 days prior to the eligibility date of the Young Adult option. Be aware that premium may be required upon submission of the form.

For further information, see the following websites:

Dependent to 30:

http://www.dfs.ny.gov/consumer/faqs/faqs_S6030_Age29_young.htm

If your employees have additional questions regarding a Young Adult Certification form, they can contact our Customer Care department by calling the phone number on their identification card.

If your group's present policy only covers dependents to age 26 and you are interested in coverage for dependents to age 30, contact your broker or Account Manager for a proposal. You may only make this change at renewal.

Please also note that ACA and New York state's dependent to 30 law affect medical plans only. Freestanding dental and vision plans are not affected. These plans may have different age requirements than the health plan or for types of dependents and include eligibility provisions such as the dependent must be a full-time student in college to obtain the higher age limitations.

The following comparison provides information regarding these important laws:

General Provision	ACA	NYS Dependent to 30
Age limit	Under age 26	Under age 30
Children subject to the provision	Children (natural and adopted), legal guardian, stepchildren	Any covered dependent child
Children not subject to the provision	Children dependents not listed above	N/A
Financial dependency	Not required for affected children Is required for all other children	Not Required
Residency with the parent, stepparent adoptive or proposed adoptive parent	Not required	Not required
Residency within NYS or the insurer's service area	Not required	Required
Marital status	May be married	Unmarried
Student status	Not required	Not required
Child is eligible for, or covered by their employers plan		Not eligible

Financial Dependency:

Unless specifically included in the exemption for dependency under ACA or New York state dependent to 30, as shown in the table above, the dependent (e.g., children of a domestic partner) must be financially dependent upon the subscriber for support.

When financial dependency is a requirement of coverage, we recommend the group maintains the following documentation, as applicable, in the member file:

- A sworn and notarized statement certifying that the subscriber and/or covered spouse is responsible for the medical expenses of the child or a sworn and notarized statement certifying that the subscriber is responsible for at least 50 percent of the support of the child
- A copy of the last tax statement indicating that the child was the subscriber's dependent
- Other evidence (e.g., divorce decree) indicating the subscriber has responsibility for the child's medical expenses or new responsibility for at least 50 percent of the support of the child

Proposed Adoptive Child

A proposed child, who the subscriber has consented to adopt and for whom the subscriber has entered into an agreement to support, is eligible for coverage.

If a parent requests coverage for a foreign adoption that has not reached the final stage, or the child is not in the United States at the time the application for coverage is submitted, please contact Enrollment Processing for guidance prior to acceptance of the application or enrollment of the proposed adoptive child.

Documentation requirements include one or more of the following:

- ▶ A statement from the adoption agency or, in the case of a private adoption, other appropriate documentation indicating that the subscriber is the proposed adoptive parent and the approximate or target date of adoption
- ▶ Proof that demonstrates the proposed adoptive child is dependent upon the subscriber during the waiting period prior to the adoption becoming final

If the adoption occurs in a foreign country, obtain a copy of both the original and translated documents.



Adopted Child

Newborn adopted children are eligible for coverage from the moment of birth, if the subscriber:

- ▶ Takes physical custody of the child upon discharge from the hospital or birthing center
- ▶ Files a petition under section 115-c of the New York Domestic Relations Law within 30 days of the birth

If the circumstances do not meet both of these conditions or the child is not a newborn, the child is eligible on the date the adoption is final.

If a parent requests coverage for a child adopted from a foreign country and the child is not in the United States at the time the application for coverage is submitted, please contact Enrollment Processing prior to acceptance for an application for and enrollment of the adopted child. If the adoption is not final, the child must meet the criteria for a proposed adoptive child. See the previous section regarding the requirements for coverage of a proposed adoptive child.

Documentation requirements include one or more of the following:

- ▶ A copy of adoption papers
- ▶ For a newborn adopted child:
 - ▶ A copy of the 115-c petition
 - ▶ Proof that the subscriber has physical custody of the child upon discharge from the hospital or birthing center

If the adoption occurs in a foreign country, obtain a copy of both the original and translated documents.

Legal Guardianship

A child for whom the subscriber is the legal guardian and who is chiefly dependent upon the subscriber for support is eligible. Please note that custody alone is not sufficient. A court must specifically confer legal guardianship. The child is eligible for coverage the date of the court order if the child is already dependent upon the subscriber, later if the child is not financially dependent on the subscriber at the time of the court order.

Documentation requirements include both of the following:

- ▶ A copy of the court order that conveys legal guardianship of the child to the subscriber or spouse. Custody agreements or orders do not convey legal guardianship
- ▶ Proof of financial dependency

Full-Time Student

For products not subject to federal or New York state age limit requirements (e.g., dental), the age limits and eligibility requirements may vary. Please review the subscriber certificate or applicable plan documents for details.

A full-time student must enroll in 12 or more credit hours per semester at an accredited institution of higher learning. Students are not required to attend college during the summer months, but must enroll for the fall semester in the spring, with the intent to return to college in the fall.

We require the group to maintain the following documentation in the member file:

- ▶ Same as established for any other type of dependent based on the relationship between the subscriber and the dependent; plus
- ▶ Proof that the dependent is attending school on a full-time basis
- ▶ We also require that the subscriber complete and submit a student certification form to us on an annual basis



Other Adult Dependents of the Subscriber Domestic Partner

We cover domestic partners in most, but not all, of our benefit programs. Please review the language in the subscriber certificate to determine whether the coverage your group has purchased includes coverage for domestic partners. Our standard domestic partner language includes coverage for both same and opposite-sex partners. Your group may not limit coverage to just one of the two categories, if the language in the certificate includes both types of partnership.

A Domestic Partnership must meet the criteria specified in the subscriber certificate for relationship and financial interdependency.

To qualify as domestic partners, members must demonstrate that they have been living together in a committed relationship for a minimum of six months and:

- Are not married to any other party
- Are a couple of the same sex or opposite sex
- Are 18 years of age or older
- Are not related by blood or otherwise barred from marriage to each other

If the domestic partner meets the criteria as specified in the subscriber certificate, his or her children are also eligible for enrollment in your group's coverage. The ACA requirements do not apply to dependents of the domestic partner, so follow the rules related to New York state's requirements (e.g., the dependent must be unmarried).

We require the group to maintain the following documentation in the member file:

- Affidavit attesting to the domestic partnership
- Certificate of Domestic Partnership or Declaration of Domestic Partnership
- Materials supporting financial interdependency

Adult Child Incapable of Self-Sustaining Employment

A child who is incapable of self-sustaining employment may be eligible to continue coverage beyond the age where coverage would otherwise terminate. One of the following conditions must cause the incapacity:

- Mental illness
- Developmental disability as defined in the NYS Mental Hygiene Law
- Physical handicap

The child must also meet all of the following conditions:

- The condition occurred before the dependent reached the maximum age under the certificate
- The child was covered at the time he or she would have otherwise reached the maximum age under the certificate
- The condition continues to exist
- The child remains unmarried
- The child remains dependent upon the subscriber for support

Our Medical Director reviews all applications for coverage as a handicapped dependent. The Medical Director will determine whether the condition is permanent or temporary. If the condition is temporary, we will periodically request the recertification of the dependent's eligibility, through the submission of a new handicapped dependent form.

Documentation must accompany the application, and include:

- A completed handicapped dependent form
- Proof of financial dependency

Notes: _____

Ineligible Dependents

Unless specifically included above as eligible, the dependent is not eligible for coverage. Examples of ineligible dependents include:

- ▶ Former spouses from the date that the marriage is annulled or ends in divorce
- ▶ Children who are older than the age limit or who do not meet the definition of an eligible dependent specified in the subscriber certificate, e.g., a child who:
 - ▶ turns 30 when enrolled in a product where the group has purchased the dependent to 30 rider
 - ▶ is 26 to 30 years old and marries, moves out of state or is no longer dependent upon the parent for support
 - ▶ is no longer a student for products such as freestanding dental that may include such limitations
- ▶ Adults who merely live together and do not qualify as domestic partners (when coverage includes domestic partners)
- ▶ Grandchildren, unless the grandparent adopts or becomes the legal guardian of the grandchild
- ▶ Foster children placed in the care of foster parents
- ▶ Parents, grandparents, aunts, uncles, brothers, sisters, nieces, nephews and other relatives
- ▶ Foreign exchange students who live with the host family

What Happens When a Dependent Loses Eligibility?

You must process a cancellation transaction immediately when you learn that a dependent is ineligible, or we may not be able to honor your cancellation request. You should ensure that your employees understand that they need to notify you within a few days, but never more than 30 days, after the date of ineligibility.

Those who become ineligible under a subscriber's contract include:

- ▶ Divorced spouse
- ▶ A member who no longer meets the eligibility requirements in the Eligibility Section of this guide
- ▶ Deceased dependent

Note: Please visit our website for updates regarding new federal and state laws pertaining to dependents at [ExcellusBCBS.com/HealthReform](https://www.excellusbcbs.com/HealthReform).

We have compiled the information in this section to assist you with enrollment procedures. Our goal is to help you enroll your members quickly and accurately.

We cannot emphasize strongly enough that you must review and reconcile your bill each month to ensure that our membership records for your group are accurate. If you find any discrepancies, please contact the Enrollment Processing Inquiry Unit immediately.

If you are an administrator for an employer group, you are entitled to establish certain policies for your group, by class of employee, at what point a new employee or rehire may apply for coverage and/or which products are available to each class of employee. The following are important decisions you must make and communicate to us, in order that we may properly create and maintain your group on our system.

Class of Employee

Although the employer has a choice in classifying employees, there are limitations based upon NYS insurance law and regulations. To comply with these limitations, we are providing you with the following list of characteristics to take into consideration when determining employee classifications.

- ▶ Conditions pertaining to the employment or a combination of these conditions:
- ▶ Geographic location of employment (e.g., New York, Ohio, Pennsylvania). This does not pertain to the employee's address or minor differences in geographic location, such as by ZIP code
- ▶ Earnings (e.g., commissioned, noncommissioned)
- ▶ Method of compensation (e.g., hourly, salary)
- ▶ Hours (e.g., full-time, part-time)
- ▶ Occupational duties (e.g., management, non-management)
- ▶ Family status of the employee (e.g., single, family)



An employer may not establish employee classifications that do not conform to federal or state labor laws, are discriminatory, patently unfair or that create adverse selection.

Common employee classifications include:

- ▶ Active/retiree
- ▶ Hourly/salary
- ▶ Management/non-management
- ▶ Union/non-union

Please note that our systems include COBRA and Young Adult Options (Dependent to 30) as standard employee classifications. Although these individuals were not generally the subscriber when enrolled as a non-continuant, we must include these employee classifications in order to enroll these individuals as the subscriber once enrolled in continuation.

Your group may request a change to its employee classifications throughout the year, provided you submit the request in writing at least 30 days in advance. These changes apply prospectively. To request a change to your group's employee classifications, please contact your group's account manager or broker.

Probationary Period

A probationary period is the period of time an employee must wait after the hire date before enrollment in the employer's group coverage. This is also referred to as the employer-waiting period. An employer may establish probationary periods that vary for its employee classifications, but there must be only one probationary period for each employee classification.

For example, an employer may establish a probationary period of 30 days from date of hire for salaried staff and the first of the month following the date of hire for hourly staff. Other common probationary periods are:

- Date of hire
- 60 or 90 days from the date of hire
- The first of the month 30 or 60 days from the date of hire

Employees must meet the probationary period before enrollment, even if the employee experiences an event that would otherwise entitle the employee to a special enrollment opportunity.

Beginning with renewals on or after January 1, 2014, an employer's probationary period may not exceed 90 days from the date the employee became eligible for coverage. As a result, if your group had a probationary period longer than 90 days or was equal to first of the month following 90 (or more) days from the date of hire, upon renewal the following must occur:

- An employee who was hired before the renewal date and under an older, longer probationary period, must be enrolled as soon as the employee meets the 90-day maximum probationary period. The following examples illustrate the treatment of these employees:

A. Employee is hired October 1, 2013. Employer has a probationary period equal to first of the month following 6 months of employment. Employee is eligible for coverage January 1, 2014, as more than 90 days have passed prior to January 1.

B. Employee is hired December 1, 2013, for the same employer as above. If the employer chooses 90 days from date of hire as the probationary period for new hires effective January 1, 2014 and forward, this employee is eligible to enroll effective March 1.

Notes: _____

Important information regarding Probationary Period Changes for 2014

As of January 1, 2014, employer groups will no longer be able to impose waiting periods of longer than 90 days to new employees.

Change An Existing Probationary Period

Your group may request a change in probationary period for a class of employee once per year, provided you submit the request, in writing, at least 30 days in advance. The changed probationary period applies only to employees hired after the change. To request a probationary period change, please contact your group's Account Manager or Broker.

Rehired Employee

Your group may establish a policy that the probationary period does not apply to rehired employees. A rehired employee is one who has a break in employment of at least one day, but not more than six months.

Our default policy is that rehired employees must meet the probationary period. If your group wants to waive the probationary period for rehires, it must establish this policy by notifying us at least 30 days in advance of the effective date. To change the rehire policy, please contact your group's Account Manager or Broker.

Key Employees:

Your group may request to waive the established waiting period for an employee who is a key employee. We define a key employee as one who is in:

- An advanced level of management; or
- A highly skilled professional or technical position; and
- A position that is extremely difficult to recruit for and fill; and
- The inability to fill that position could cause the organization to fail or go out of business

Typically, this definition applies to CEOs, CFOs, medical doctors (particularly in rural settings) and certain IT positions.

If your company wishes to request a waiver of the probationary period, send a letter on company letterhead explaining the full details of the situation, including the impact if the position remains unfilled, along with any other supporting documentation that may be appropriate and relevant. This waiver is on a case-by-case basis. If we grant a waiver for one employee, it does not guarantee that we will grant any future waivers.

You are responsible to obtain the Certificate of Coverage (COC) issued by the prior carrier or other creditable source of coverage from the member. You must maintain this information as part of the subscriber or dependent's records, as specified in the eligibility section. We may request the COC from you at any time.

If the group enrollment form indicates that other coverage existed, but the section is incomplete, we will send a "portability" letter to the member, requesting the information above.

Cancellation Reason Codes

It is important to select the proper code when submitting a cancellation. Please refrain from using the same or a few codes for every transaction. These codes trigger certain transactions in our systems, including whether or not an individual is offered a conversion policy upon termination.

Primary Care Physician (PCP) Enrollment Requirements

The primary care physician information is a requirement for enrollment for HMO products. Please note, we will return enrollment requests for HMO products that do not have PCP information completed.

Primary Care Physician Change Request

Due to requirements in the Health Insurance Portability and Accountability-Act (HIPAA) privacy regulations, group administrators, brokers and Account-Managers may not update the PCP information on the member's behalf. Members must contact Customer Care, or visit our website to make PCP changes.



Transactions to add a subscriber or dependent(s)

If you do not submit these transactions on time, we will deny your request and the subscriber or dependent must reapply at the next open enrollment period or special enrollment opportunity.

Exceptions to the 30-day retroactivity period:

- ▶ Adding a subscriber to COBRA continuation of coverage. The COBRA law provides for an extensive notice and election period. We will honor a request to reinstate a member to coverage as a COBRA continuant for a period of up to 179 days for a subscriber related event and 239 days for a dependent related event. We encourage you to wait until the continuant pays his or her first premium before you reinstate the coverage or you may be liable for the premium. Please note that you must still submit the original transaction to terminate the individual within the standard 30 days. The reinstatement to coverage as a COBRA continuant is the only portion that is an exception.
- ▶ Adding a subscriber to NYS continuation of coverage. The notice and election period for NYS continuation is much shorter than COBRA. We will honor a request to reinstate a member to this coverage for a period of up to 95 days for a subscriber event and 125 days for a dependent event.

The subscriber/dependent must pay the premium at the time he or she elects NYS continuation

- ▶ Adding a subscriber to the Young Adult Option (YAO). The election period for initial enrollment allows for retroactive enrollment. We will honor a request to enroll a Young Adult if we receive the request within 60 days of the termination date.
- ▶ The subscriber/dependent must pay the premium at the time he or she elects this opt

Transactions to change a subscriber or dependent(s)

Benefit changes are restricted to your open enrollment period. An exception is when your group has different products for members when Medicare is primary. If your group has these products and you provide timely notice, we permit product changes at the point when Medicare changes status from secondary to primary or the reverse. We also allow product changes during a Special Enrollment Period or if there is a newly eligible dependent.

We refer to the following and other similar changes to the member's information, as demographic changes:

- ▶ Last name or corrections to the spelling of names
- ▶ Address
- ▶ Phone number

You may submit demographic changes at any time. These changes become effective as of the entry date. For a name change, please submit the request in writing or via the Web. We suggest you request and maintain a marriage certificate, divorce decree or other records to support a name change.

Transactions to cancel a subscriber or dependent(s)

The ACA placed restrictions on cancellation transactions that it defined as rescissions. The definition of rescissions is different from the prior industry standard. Please be certain you read this information carefully as you may be required to provide advance notice of termination to your employees or dependents, and it may restrict your ability to terminate coverage as of the requested date.

A subscriber may voluntarily terminate coverage entirely or remove a dependent at any time during the year. The subscriber does not have to wait until open enrollment. Voluntary terminations must be submitted 30 days in advance. Once disenrolled, the subscriber must wait until open enrollment or a special enrollment opportunity to rejoin group coverage or add the dependent to his or her coverage.

Enrollment Opportunities

There are three times when employees or dependents may enroll. The first is at the point of initial eligibility (e.g., new hire, birth). The second opportunity is when an event occurs (e.g., divorce, loss of coverage) that qualifies the employee or dependent for a special enrollment period. The final opportunity is at the annual open enrollment period. The following sections explain these three periods.

Initial Enrollment

If an employee does not enroll himself/herself or dependents when initially eligible, he or she will not have a second opportunity until open enrollment or a special enrollment event.

New Hire

A new employee is eligible to enroll at the end of the probationary period established for his/her class of employee.

Rehire

In accordance with the rehire policy selected by your group, the rehire is eligible either from the date of hire or at the end of the probationary period. See the Probationary Period section for further information.

Newly Eligible Dependent

The following events qualify a dependent for addition to the subscriber's coverage:

- Marriage (the spouse and any stepchildren)
- Birth (the newborn)
- Adoption (the adoptive or proposed adoptive child)
- A Qualified Medical Child Support Order (QMCSO) is issued

Special Enrollment Period

Certain events qualify employees and/or dependents for enrollment opportunities during the plan year, rather than at open enrollment. These events typically are major life events that affect coverage decisions. However, these events do not supersede your probationary period. An employee is not entitled to enroll until the end of his/her applicable probationary period.

If a member submits an application on a timely basis, it is your obligation to accept and forward applications for enrollment, whenever one or more of the following events occur.

The image shows a 'GROUP ENROLLMENT FORM' from Excelsus. A large red 'APPROVED' stamp is placed over the center of the form. The form includes sections for:

- Group Information (Group #, Subgroup #, Class)
- Subscriber Information (Name, Address, Phone, Email)
- Dependent Information (Name, Date of Birth, Relationship)
- Enrollment Options (Checkboxes for various plan types like COBRA, Family, etc.)
- Reasons for Enrollment/Change (Checkboxes for New Hire, Open Enrollment, etc.)
- Signature and Date fields for both the Group Administrator and the Subscriber.

Involuntary Loss of Coverage.

Loss of coverage under another employer's or spouse's plan due to:

- ▶ Change in working hours
- ▶ Termination of employment
- ▶ Divorce
- ▶ Other employer terminates coverage

Former Dependent Regains Eligibility for Coverage

- ▶ A dependent who is 27 years old moves back into New York state
- ▶ A 21-year-old dependent returning to college regains eligibility for a freestanding dental product with 19/23 coverage for dependents

Medicare Status Changes

- ▶ Medicare eligibility or Medicare primary/secondary status change, which necessitates a change of product

Network Limitations

- ▶ The subscriber moves out of the service area of a limited network health plan (e.g., HMO), and your group offers other coverage without a limited network

Eligibility for Government Sponsored Program or Premium Assistance

- ▶ Loss of eligibility for a government-sponsored program, such as Medicaid
- ▶ The employee or children become eligible for premium assistance through Medicaid or Child Health Plus in an eligible state, such as New York state or Pennsylvania

Please note that voluntary loss of coverage does not qualify either an employee or dependent for a special enrollment period.

Notes: _____

Annual Open Enrollment Period Information

Once per year, an employer must offer employees the opportunity to participate in open enrollment.

Subscriber/Member

Open enrollment does not supersede the probationary period. An employee is not entitled to enroll until the end of his/her applicable probationary period.

Employee Options at Open Enrollment

Open enrollment is the time when employees may:

- ▶ Change benefits if the employer offers more than one product to the employee's class of employees (e.g., union employees)
- ▶ Enroll in coverage, if the eligible employees declined enrollment when initially eligible or subsequently dropped coverage
- ▶ Add dependents who did not enroll at initial eligibility or a subsequent special enrollment opportunity, and who are eligible to re-enroll at open enrollment

Required Documents for Group Activity

Please submit new benefit, change to benefit, and termination of benefits requests to the Sales department.

Adding a new benefit

This transaction is to add an entirely new product offering (e.g., a second health plan option to your existing package of benefits, such as a high deductible health plan). You must provide a signed rate sheet for the new plan offering.

- Please indicate in your communication that you are adding a new plan and not replacing an existing offering
- New applications are required for all members who are not presently enrolled with us and who elect the new benefit(s) or are making a plan change to the new offering
- If you are performing subscriber maintenance via the Web, you must wait until we have added the new benefit to your group before submitting subscriber requests. Please note in your communication that you have Web access

Change an existing benefit

This transaction is to change everyone enrolled in existing Product A to a new Product B (e.g., from a PPO with a \$20 copay to a PPO with a \$25 copay). You must provide:

- A signed rate sheet
- A memo or similar document to indicate the transfer of all membership from Product A to Product B

Please indicate in your communication that you are replacing your current plan with the selected option.

Terminate an existing benefit

This transaction is to terminate a benefit package without replacement. For example, your group has determined that it no longer wishes to offer a product.

Please provide us with a memo or similar document that includes:

- The specific package you wish to terminate
- The effective date of termination
- Instructions regarding the treatment of terminated members.
For example, transfer members from Product C to Product DT

Terminate the group or subgroup

This transaction is to terminate all coverage for one or more group or subgroup. For example, your group no longer provides coverage for retirees or has closed a location. Please provide us with a memo or similar document that includes:

- The specific group and/or subgroup you wish to terminate
- The effective date of termination

- Instructions regarding the treatment of terminated members. For example, please advise us if members are terminated from one subgroup, if they should be transferred to another subgroup that the plan offers.

Medicare

Medicare is a federal health benefits program available to people based on age (65 or over), disability or condition (e.g., end-stage renal disease).

There are different types of Medicare fee for service coverage

1. Part A - Institutional coverage such as hospital or skilled nursing facility following inpatient hospital stay
2. Part B - Professional medical services, outpatient hospital services, ambulance services, durable medical equipment and supplies, services of other qualified health care professionals such as physical therapists
3. Part C - Medicare Advantage Plan
4. Part D - Prescription drug coverage

- For questions regarding Medicare Parts C and D, please contact us at 1-800-724-8544

Medicare Secondary Payer (MSP) Rules and Regulations

Medicare has rules regarding when it is the primary or secondary payer of benefits. You, as the group administrator, are responsible for understanding how these MSP rules and regulations apply to your group and to report your group's size accurately.

Working aged rules

- If company has 19 or fewer employees during the specified time frame, Medicare is primary
- If company has 20 or more employees during the specified time frame the subscriber is actively working and the subscriber receives his/her health benefit as a condition of employment, Medicare is secondary and we are primary

Disability rules (for members who are Medicare-eligible and are under age 65)

- If company has fewer than 100 employees during the specified time frame, Medicare is primary
- If company has 100 or more employees during the specified time frame and subscriber is actively working, Medicare is the secondary payer and we are primary
- If a subscriber is not in active employee status, regardless of company size, Medicare is primary to subscriber's plan for Medicare eligible members

End-stage renal disease (ESRD)

- For members with permanent kidney failure, Medicare bases its primary/secondary status on a diagnosis consistent with ESRD

- ▶ A member has a 30-month coordination period where the health insurer is the primary payer before Medicare
- ▶ At the end of the coordination period, Medicare becomes primary
- ▶ If a member receives a successful kidney transplant, Medicare eligibility may end
- ▶ We require a letter from the Medicare office advising us when Medicare ends
- ▶ We correspond directly with a member who is eligible for Medicare due to ESRD
- ▶ We require dialysis and transplant information to determine Medicare primacy

This is a simplified explanation, and there are many exceptions to the above rules and regulations. Special rules apply to owners of companies, chamber/trust/associations groups, clergy/religious order members, part-time employees, domestic partners and same-sex spouses.

Please visit [Medicare.gov](https://www.Medicare.gov) for additional Medicare information.

Continuation of Coverage

There are two types of continuation: COBRA and NYS Continuation. Your group is responsible for properly administering these programs. We provide some general information below and links to additional resources. We recommend that you consult with your advisors (e.g., legal counsel) if you have specific questions or unique situations, as these laws and regulations are quite complex.

Please Note: The employer group must be in active status in order to offer Continuation of Coverage.

COBRA

COBRA (Consolidated Omnibus Budget Reconciliation Act) is a federal law. It applies to employers with 20 or more employees who provide group health plans. It applies regardless of whether the plan is insured or self-insured. It does not apply to groups who are not employers.

COBRA provides your employees, or their dependents, with the right to keep the group health insurance benefits they would otherwise lose, on the occurrence of specified events, provided they make the proper election and pay premium on a timely basis. Your group is responsible to properly administer COBRA and NYS continuation, as applicable.

Who is Eligible?

Employee – Up to 18 months of continued group coverage must be offered to the qualified employee and dependents for the following qualifying events:

- ▶ Termination of employment, whether on a permanent or temporary basis

- Employees whose work hours were reduced, and no longer qualify for coverage
- Employees whose class of employment changed and no longer qualify for coverage
- Dependents of terminated employees
- Employees who voluntarily leave employment

Up to 29 months of continued group coverage must be offered to the qualified employee and dependents if the employee is disabled, as specified in the COBRA law and regulations.

Dependent – A qualified dependent may elect COBRA independently of the employee when the qualifying event causes the dependent to lose coverage. Up to 36 months of continued group coverage must be offered for these qualifying events

- Death of the covered employee
- Medicare eligibility of employee
- Divorce/legal separation from the covered employee
- Loss of “dependent child” status under the plan (e.g., age-off)

Termination of Coverage

COBRA continuation of coverage terminates at the earliest of the following:

- Reaching the maximum continuation period
- Non-payment of premium

For additional information on COBRA, please review the information at the following website:

<http://www.dol.gov/COBRA/>

COBRA Timeline

Below is a chart to reference that will assist with avoiding Retroactive requests

	Employee Loses Eligibility for Employer’s Health Plan	Dependent Loses Eligibility for Employer’s Health Plan
Employee must notify employer of event	N/A	Within 60 days of event that causes ineligibility
Employer must notify Employee of COBRA rights	W/in 44 days from the date of the qualifying event *	W/in 44 days of the date employee notified the employer of the qualifying event*
Employee’s election period	W/in 60 days from date employer notifies employee of COBRA rights	W/in 60 days from date employer notifies employee of COBRA rights
Employee pays 1st premium	W/in 45 days of COBRA election	W/in 45 days of COBRA election
Employer submits app to EHP	W/in 30 days of initial premium payment	W/in 30 days of initial premium payment
Maximum # of days elapsed	179 days	239 days

New York State Continuation

New York state continuation applies to any insured plan, regardless of the group's size and whether or not the group is an employer. It does not apply to self-insured plans. It does not apply to free-standing dental or vision plans.

New York state requires the availability of a total of 36 months of continuation for any individual who is entitled to continuation. The 36 months is in combination with any continuation already utilized under COBRA (where applicable), it is not in addition to COBRA. COBRA does not apply (e.g., loss of coverage for a non-employee).

New York state insurance law expands the availability of continuation to dependents who are not otherwise included under COBRA (e.g., same-sex spouse).

The termination reasons for NYS continuation are similar to COBRA.

For additional information on New York state's continuation requirements, please review the information at the following website:

http://www.dfs.ny.gov/consumer/faqs/faqs_cobra.htm

NYS Continuation Timeline

Below is a chart to reference that will assist with avoiding Retroactive requests

	Employee or Member Loses Eligibility for Health Plan	Dependent Loses Eligibility for Employer or Member's Health Plan
Employee must notify Employer or Group Admin of event	N/A	Within 60 days of event that causes ineligibility
Employer or Group Administrator must notify	Allow 30 days	W/in 44 days of the date employee notified the employer of the qualifying event*
Employee of continuation rights		
Employee or Member's election period	W/in 60 days of date: 1. Employer notifies employee of continuation rights 2. Group administrator notifies member of termination of eligibility, or actual termination date, whichever is later.	1. Employer notifies employee of continuation rights 2. Group administrator notifies member of termination of eligibility, or actual termination date, whichever is later.
Employee pays 1st premium	Simultaneously with election	Simultaneously with election
Employer submits app to EHP	With in 30 days of initial premium payment	With in 30 days of initial premium payment
Maximum # of days elapsed	120 days	150 days

Certificate of Coverage/Prior Coverage Information Needs

Certificate of Coverage

We send Certificates of Coverage to members who terminate coverage with the health plan, regardless of the reason coverage terminates.

Once a member receives a Certificate of Coverage, he/she may use the letter as proof of prior coverage while applying for new health insurance.

Prior Coverage Information Needed When Adding a Member

A Certificate of Coverage is not required upon a member's initial enrollment. However, the applicant must complete the other coverage information section on the group enrollment form with the following information:

- ▶ Previous coverage effective date
 - ▶ Previous coverage termination date
 - ▶ Previous coverage enrollment (family, individual, etc.)
 - ▶ Name of previous insurance carrier
 - ▶ Type of coverage (medical, dental, etc.)
 - ▶ Identification number of policy
 - ▶ If enrolling via the Web, all of the above information must be provided.
- We are providing general information as you may receive questions from members covered under your policy.

Coordination of Benefits (COB)

What is Coordination of Benefits?

- ▶ Most health insurance contracts or certificates have a clause that allows the benefits of one policy to be coordinated with those of another. This clause, referred to as coordination of benefits, describes which policy is considered first, or "primary," for claims payment
- ▶ Please refer to your member certificate to review the COB clause
- ▶ A plan that does not contain a COB clause consistent with these rules is always primary

NOTE:

- ▶ Be sure that subscribers complete the "Other Coverage" section of the group enrollment form
- ▶ These rules do not apply when one policy is Medicare
- ▶ Please notify us if there is a change to an employee's other coverage information. We want to be certain our records are accurate so we process the claims correctly

Rules to determine which plan pays first

- If a person is covered under one medical plan as an employee and under another plan as a dependent, the plan under which he/she is an employee is primary
- If a child is covered under both plans, the birthday rule is applied to determine which contract is primary. Under this rule, the plan of the parent whose birthday (month and day) falls earlier in the year is primary
- If both parents have the same birthday, the plan that covered the parent longer is primary
- If a plan uses a rule based on gender of the parent, then the plan of the male parent is primary

NOTE:

Most insurance plans use the birthday rule to determine which plan pays first when the member has more than one active insurance policy. TPAs (Third Party Administrators) may use the male primary rule to determine which policy is primary for self-insured plans. Insurance policies issued in New York state must use the birthday rule.

Rules for children of separated or divorced parents

- The policy of the parent who the court has made responsible for health care insurance is primary
- The policy of the parent who has custody of the child is primary
- If the court has not placed responsibility on one parent to insure the children and the parents have joint custody, the birthday rule applies
- If the natural parent elects to have coverage under the policy of the stepparent, we will consider the policy to be that of the natural parent

NOTE: In some instances, we may ask for a copy of a member’s court decree.

Rules for an active and non-active employee

- The plan that covers the policyholder as an active employee is primary
- If the policyholder has the same employment status (active/retired) under both plans, the plan with the earliest effective date is primary

Notes: _____

Retroactive Policy

The retroactive policy governs the length of time you have to submit transactions to us. It allows us to review and make possible exceptions to membership additions, terminations and changes in group benefits beyond the (30 day) event date.

There are many reasons why we have established this policy, but most important are:

- ▶ Prevent adverse selection
- ▶ Subscriber and group satisfaction
- ▶ Reimburse our providers on time and accurately for the services rendered to our members
- ▶ Limitations regarding the ability to retract claims.
- ▶ Reduce administrative and provider costs when we must adjust or retract claims
- ▶ Comply with Federal and NYS requirements
 - ▶ Rescission Law and regulation
 - ▶ Ensure that only eligible persons are covered per NYS insurance law and our subscriber certificates.

August						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

Rescission

The rescission provisions of ACA apply regardless of whether the product is grandfathered or non-grandfathered. The provisions apply to all group health plans including HMOs, Healthy New York group products and Medicare Complimentary products. The rescission provisions do not apply to HIPAA excepted products, such as freestanding dental and vision, Medicare Advantage and Medicare Supplemental products.

If you do not comply with the rescission limitations in ACA, the federal government may assess fines on your group or the issuer of coverage. You may find more details at www.healthcare.gov and at www.hhs.gov.

The information provided in this document does not provide regulatory compliance or legal advice. The intent is to raise your awareness of important issues so that you may seek guidance from your own legal counsel or tax advisor, as needed.

Q: What is a rescission?

A: A rescission occurs when a health plan or issuer initiates:

- ▶ A cancellation or discontinuance of coverage that has a retroactive effect; or
- ▶ A cancellation that voids a policy as of the enrollment date for the subscriber or member

The ACA regulations provide an example where an employee's hours dropped below the threshold to qualify for health insurance, except that the employer did not find the change until later. The employee continued to contribute towards the health insurance plan, so the employer is not

entitled to cancel the coverage retroactively. The regulations and guidance also reference retroactive terminations when an employee or member has paid any portion of the premium or has a “Reasonable expectation of coverage.”

Q: What is not a rescission?

A: A cancellation or discontinuance of coverage is not a rescission if it relates to a:

- Cancellation or discontinuance of coverage that is prospective (e.g., for a current or future date)
- Failure to pay premiums or required contributions to the cost of coverage on time, in which case the cancellation or discontinuance of coverage may be effective retroactive to the date of default

Q: When is a rescission permissible?

A: A rescission is permissible when the person completing the application has:

- Performed an act, practice, or omission that constitutes fraud, or
- Makes an intentional misrepresentation of material fact, as prohibited by the plan or coverage

NOTE: in New York State, cancellations for fraud must be prospective, with 30-calendar days advance notice.

Retroactivity – COBRA, NY State Continuation of Coverage & Young Adult Option (YAO)

COBRA:

The COBRA law provides for an extensive notice and election period. We will honor a request to reinstate a member to coverage as a COBRA continuant for a period of up to 179 days for a subscriber related event and 239 days for a dependent related event.

We encourage you to wait until the continuant pays his or her first premium before you reinstate the coverage or you may be liable for the premium.

Please note that you must still submit the original transaction to terminate the individual within the standard 30 days. The reinstatement to coverage as a COBRA continuant is the only portion that is an exception.

NY State Continuation of Coverage:

The notice and election period for NYS continuation is much shorter than COBRA. We will honor a request to reinstate a member to this coverage for a period of up to 95 days for a subscriber event and 125 days for a dependent event.

The subscriber/dependent must pay the premium at the time he or she elects NYS continuation.

Young Adult Option (YAO) :

The election period for initial enrollment allows for retroactive enrollment. We will honor a request to enroll a Young Adult if we receive the request within 60 days of termination date.

The subscriber/dependent must pay the premium at the time he or she elects this option.

Tips regarding the termination of an Employee

There are actions your group can take to protect itself from the likelihood that an employee can claim that his/her termination of coverage is a rescission and therefore prohibited. Here are a few suggestions:

- ▶ Remind employees frequently that coverage ends when employment ends, unless the employee elects COBRA or NYS Continuation, as appropriate
- ▶ When an employee is terminated or otherwise leaves employment, provide the employee with the COBRA or NYS Continuation notice immediately
- ▶ Be certain to stop withholding employee contributions immediately at the point the employee loses eligibility for coverage

Tips regarding the termination of a Dependent

Though agencies of the federal government have issued some guidance about the ACA, rescissions and the applicability to dependents who lose eligibility, much remains uncertain. It is prudent for your group to educate itself regarding the ACA. Consult with your own legal advisors and consultants in situations where the right to terminate a dependent is not clear. There are still actions your group can take to protect itself from a prohibited rescission, as follows:

- ▶ Remind employees frequently that it is their responsibility to report a change to a dependent's eligibility within 30 days
- ▶ Provide the dependent with a COBRA or NYS Continuation notice immediately
- ▶ Submit cancellation transactions through the Web to ensure timeliness
- ▶ Immediately adjust the employee's withholding for any change in rate tier
- ▶ Regarding cancellation dates:
 - ▶ When cancelling members with ID numbers that begin with a "2" and do not contain an alpha character, use the last day of the month as the cancel date
 - ▶ When cancelling members with ID numbers that are eight digits long with an alpha character in the middle, use the first day of the next month

Notes: _____

Retro Activity Exceptions – When retro request is not required

Death: We will terminate coverage for a deceased member who is not an active employee up to 90 days without a death certificate, up to and one year after the date of death with a death certificate. We expect you to submit terminations due to the death of an active employee within 30 days of the date of death.

Divorce: We will terminate the coverage for a divorced spouse retroactively up to 90 days from the current date of divorce. A request that exceeds 90 days from the date of divorce must be submitted for retroactive review. We may require a copy of the divorce decree or a divorce certificate as part of our review

Self -Funded Group Requests

If your group is self-funded, and you have questions regarding retroactive activity, please contact your Account Manager or Account Service Consultant.

New Information Reporting Requirements under the Affordable Care Act (ACA)

Information Reporting by Health Coverage Providers

(Section 6055 of the Internal Revenue Code)

For more information go to:

<http://www.irs.gov/Affordable-Care-Act/Employers/Information-Reporting-by-Providers-of-Minimum-Essential-Coverage>

<http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-on-Information-Reporting-by-Health-Coverage-Providers-Section-6055>

Excellus BlueCross BlueShield must report certain health coverage information to the IRS for individual direct pay members off exchange, SHOP (Small Business Health Options Program), small groups and large groups insured beginning in January 2016 for calendar year 2015. The information provided will include any months when individuals were covered by minimum essential coverage and will be used to verify the individual shared responsibility requirement.

In addition to the IRS reporting, Excellus BlueCross BlueShield must also send statements to individuals (Form 1095-B) who had minimum essential coverage in the reporting year. These statements are similar to W2 forms and will include the same information that is reported to the IRS. They give individuals information they will need when they file their taxes – only these statements are used to determine if they will have to pay the Individual Shared Responsibility Payment for not having minimum essential coverage.

Excellus BlueCross BlueShield is also now required to ask for individual Social Security numbers in order to meet new reporting obligations under the Affordable Care Act. The IRS will use the individual name and Social Security number combination to match coverage reported on Form 1095-B to the coverage reported on tax Form 1040. As a result, new Social Security number solicitation letters have been created and will be mailed periodically by Excellus BlueCross BlueShield to individuals who have a missing or invalid Social Security number.

*Self-funded plan sponsors can use a combined form (Form 1095-C, including Part III) to file reporting information for both Sections 6055 and 6056.

Section 6055 - Reporting to IRS		
Form #:	Filed by:	Filing Due Date:
<p>Form 1094-B Transmittal of Health Coverage Information Returns http://www.irs.gov/pub/irs-pdf/f1094b.pdf Instructions: http://www.irs.gov/pub/irs-pdf/i109495b.pdf</p> <p>Form 1095-B Health Coverage http://www.irs.gov/pub/irs-pdf/f1095b.pdf Instructions: http://www.irs.gov/pub/irs-pdf/i109495b.pdf</p>	<p>Excellus BlueCross BlueShield will submit Form 1094-B and data from Form 1095-B to the IRS.</p> <p>NOTE: SSN's that are reported to the IRS must not be masked.</p>	<p>If filing electronically*: March 31st of the year following the coverage year</p> <p>If filing by paper: February 28th of the year following the coverage year</p> <p>The first returns are due March 31st, 2016</p> <p>*Providers that file more than 250 forms must file electronically.</p>
Section 6055 - Statements to Individuals		
Form #:	Filed by:	Filing Due Date:
<p>Form 1095-B Health Coverage http://www.irs.gov/pub/irs-pdf/f1095b.pdf Instructions: http://www.irs.gov/pub/irs-pdf/i109495b.pdf</p>	<p>Excellus BlueCross BlueShield will send Form 1095-B statements to individuals that had minimum essential coverage in 2015.</p> <p>NOTE: SSN's that are on the Statements to Individuals can be masked for privacy. Excellus BlueCross BlueShield will partially mask the SSN in the following format (example: XXX-XX-1234)</p>	<p>The Form 1095-B statements are due to individuals by January 31st, 2016.</p>

Information Reporting of Offers of Health Insurance Coverage by Employers

(Section 6056 of the Internal Revenue Code)

For more information go to:

<http://www.irs.gov/Affordable-Care-Act/Employers/Information-Reporting-by-Applicable-Large-Employers>

<http://www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-on-Reporting-of-Offers-of-Health-Insurance-Coverage-by-Employers-Section-6056>

Employers with 50+ FTEs must file returns (Forms 1094-C & 1095-C) to the IRS beginning in 2016 for calendar year 2015. These returns provide information to the IRS to show whether the employer is or is not providing coverage to employees and that coverage meets minimum value and affordability levels. These returns will show if employers are compliant with the Employer Mandate.

*Self-funded plan sponsors can use a combined form (Form 1095-C, including Part III) to file reporting information for both Sections 6055 and 6056.

Section 6056 - Applicable Large Employers Reporting to IRS

Form #:	Filed by:	Filing Due Date:
<p>Form 1094-C: http://www.irs.gov/pub/irs-pdf/f1094c.pdf</p> <p>Instructions: http://www.irs.gov/pub/irs-pdf/i109495c.pdf</p> <p>Form 1095-C: http://www.irs.gov/pub/irs-pdf/f1095c.pdf</p> <p>Instructions: http://www.irs.gov/pub/irs-pdf/i109495c.pdf</p>	<p>Insured Large Employers (50+ FTEs)</p> <p>Form 1094-C must be used to report summary information to the IRS for each employer and to transmit Forms 1095-C to the IRS.</p> <p>Form 1095-C is used to report information about employees.</p>	<p>If filing electronically*: March 31st of the year following the coverage year</p> <p>If filing by paper: February 28th of the year following the coverage year</p> <p>The first returns are due March 31st, 2016</p> <p>*Employers that file more than 250 forms must file electronically.</p>

Section 6056 – Applicable Large Employers Statements to Employees

Form #:	Filed by:	Filing Due Date:
<p>Form 1095-C: http://www.irs.gov/pub/irs-pdf/f1095c.pdf</p> <p>Instructions: http://www.irs.gov/pub/irs-pdf/i109495c.pdf</p>	<p>Insured Large Employers (50+ FTEs)</p> <p>Form 1095-C is used to report information about employee.</p>	<p>The first statements are due to employees January 31st, 2016.</p>

Section 6055 & 6056 - Self-funded Large Employers Reporting to IRS

Form #:	Filed by:	Filing Due Date:
<p>Form 1094-C: http://www.irs.gov/pub/irs-pdf/f1094c.pdf</p> <p>Instructions: http://www.irs.gov/pub/irs-pdf/i109495c.pdf</p> <p>Form 1095-C: http://www.irs.gov/pub/irs-pdf/f1095c.pdf</p> <p>Instructions: http://www.irs.gov/pub/irs-pdf/i109495c.pdf</p>	<p>Form 1094-C is used to report summary information to the IRS for each employer and to transmit Forms 1095-C to the IRS.</p> <p>Self-funded Employers must also complete Part III of Form 1095-C.</p> <p>Upon request, Excellus BlueCross BlueShield will provide available data for Part III of Form 1095-C to Self-funded Employers.</p>	<p>The first returns are due March 31st, 2016</p> <p>If filing electronically*: March 31st, 2016</p> <p>If filing by paper: February 28th, 2016</p> <p>*Employers that file more than 250 forms must file electronically.</p>

Section 6055 & 6056 - Self-funded Employers Statements to Employees

Form #:	Filed by:	Filing Due Date:
<p>Form 1095-C: http://www.irs.gov/pub/irs-pdf/f1095c.pdf</p> <p>Instructions: http://www.irs.gov/pub/irs-pdf/i109495c.pdf</p>	<p>Self-funded Employers must complete Form 1095-C.</p> <p>Upon request, Excellus BlueCross BlueShield will provide available data for Part III of Form 1095-C to Self-funded Employers.</p>	<p>The first statements to employees are due by January 31st, 2016.</p>

To stay updated on items responsible for the group to submit, please refer to the irs.gov website.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules

The HIPAA privacy regulations protect the security and privacy of an individual's PHI. PHI is individually identifiable health information transmitted or maintained in any form or medium. Some examples of protected health information are name, address, birth date, Social Security number, unique subscriber ID number, claim payment and diagnosis. Unless the member expressly authorizes release, or as otherwise permitted by the regulations, the disclosure of PHI is restricted to the member or his/her health care provider.

How HIPAA affects you as the group administrator

In accordance with privacy regulations, we must use due diligence in verifying the identity of our caller. We obtain the information in order to authenticate calls to our Enrollment Processing department:

1. The group leader's name
2. The name of the company (group)
3. The group number associated with the group

We need the above information to protect the privacy of your group and members. Please advise your members that they will have to authenticate themselves when calling our Customer Care department by providing their Social Security number, unique subscriber ID number, name and address.

PHI Disclosure

We cannot disclose Protected Health Information PHI to anyone other than a member without a completed Authorization to Share Protected Health Information form on file. The form authorizes us to disclose information to the person whom the member has designated. Members may download this form from our website and return it to our mailing address.

Please advise your members that our Customer Care Advocates are unable to assist a spouse without an authorization form on file. We recommend that you include an authorization form when submitting the initial enrollment request for married or domestic partnered couples. If a member has a dependent child 18 years or older, an authorization must be on file for Customer Care to discuss the child's PHI with the child's parent or stepparent.



Family Members

When a member calls Customer Care regarding family members, please note the below information:

- If family member is age 18 or older, we need an authorization on file
- If caller is calling regarding a family member under age 18, we can release the information, unless a protected health diagnosis is involved (see below)

Protected Health Diagnosis

If the call is regarding one of the protected diagnoses below, other laws apply that prevent the release of information without the member's authorization.

The following diagnoses require specific authorization to release the information, even when the patient is under the age of 18. Extenuating circumstances, particularly with infants and very young children, will be addressed on a case by case basis.

- ▶ Sexually transmitted diseases - New York Public Health Law
- ▶ Substance abuse - Federal law
- ▶ Abortion - New York Public Health Law (this does NOT include pregnancy)

The following diagnoses have a protected age of 18, so information can be released to the personal representative (most commonly, the parent) without an authorization on file. Once the minor turns 18, a specific authorization will be needed for these three conditions, along with the release of any other protected health information.

- ▶ Genetic testing - New York Civil Rights Law
- ▶ Mental health - New York Mental Hygiene Law
- ▶ HIV - New York Public Health Law

This information does not intend to dispense legal advice. If you are uncertain how the various state and federal privacy rules apply to your organization's group health plan, please seek legal counsel as necessary. If you would like more information about the HIPAA Privacy Rule, you can obtain information at <http://www.hhs.gov/ocr/privacy/index.html>.

Frequently Asked Questions

Should I wait to submit a termination request for an employee until after the employee responds to the COBRA offering?

No. Please submit termination requests as they occur. If an employee later opts for COBRA within the guidelines, we will reactivate his or her coverage.

Is the addition of a newborn child a qualifying event to add a spouse to coverage?

Yes, the addition of a newborn is a change in family status that is a qualifying event to add a spouse.

If a member wants to change his or her last name, what is required?

Please submit the change in writing or as a Web request. You should maintain documentation to establish the basis for the name change.

If a group receives a court order to add a dependent, what is required to add the dependent?

When you submit an application to add an eligible dependent pursuant to a court order such as a Qualified Medical Child Support Order (QMCSO), the court order is required, along with completed application and QMCSO Enrollment Form.

Can I send activity requests with my bill?

No, please submit activity via the Web, secure email process or a group enrollment form.

If I feel my bill is incorrect, what do I do?

Check the activity changes listed on the invoice and if you find a discrepancy, please contact Enrollment Processing immediately. Remember, most activity is subject to the 30-day retroactivity period.

Should I adjust my payment based on activity requests that are not reflected on the bill?

No, please pay as billed. This activity will appear on the next bill.

How do I obtain a benefit summary?

Please contact your Account Service Consultant to obtain a benefit summary.

Can members of my group change their addresses?

Yes, if they sign up for online member access, they can do this themselves. Please note, the group representative will be notified of this request.

