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

Group Administrator's Manual

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

Revised January 2015

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SECTION 1 – INTRODUCTION

As the administrator of your group's health benefits, we know that your employees look to you for answers to their health insurance questions.

In an effort to make your job easier, we have designed the *Arkansas Blue Cross and Blue Shield Group Administrator's Manual* with you in mind.

We realize there are times when you will need the expertise of your group marketing representative, service representative or your independent agent. However, we also know that with reliable, current information, you are perfectly capable of answering many of your employees' questions. Not only does this save you time, but it can strengthen the relationship you have with your employees.

We hope this manual will be useful. Please let us know if there are additional steps we can take to improve our working relationship with you.

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

SECTION 2 – GROUP ADMINISTRATOR'S RESPONSIBILITIES

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

Please verify the accuracy of information submitted on employee applications and change forms and ensure this information is transmitted to the company.

Eligibility and Timeliness

All permanent, full-time employees (minimum of 30 hours per week; 48 weeks per year) are eligible for group coverage. Please ask new employees to complete and sign an application form or submit an online form for Blueprint for Employers and Blues*Enroll* groups (See "Group Coverage Guidelines").

Arkansas Blue Cross will accept applications signed, dated and received no more than 60 days before the effective date of coverage; all other requirements for "timely" status will be observed.

Applications can be sent three ways:

1. **E-mail** — smallgroupunderwriting@arkbluecross.com
2. **Fax** — 501-378-2926
3. **Mail** — **Arkansas Blue Cross and Blue Shield**
   - **P. O. Box 2181**
   - **Little Rock, AR 72203-2181**
   - **Attn: Small Group Underwriting – 8UCC**

Make sure the application is completed in its entirety. Also, please make sure to **write your group number on all applications and change request forms.**

If the new employee had prior creditable coverage (coverage without a break of 63 days) from a former insurance carrier and was issued a Certificate of Creditable Coverage (a document that proves the employee had coverage), please attach it to the application. However, this is not required.

Explain all eligibility periods to new applicants; make sure all employees understand how effective dates are assigned. Arkansas Blue Cross calculates effective dates on a calendar day basis. The Employer Group Application has been revised to offer only a "day" option for waiting periods.

Examples:

- If the date of hire is June 11, and the group has a 30-day waiting period, the effective date will be calculated as June 11 as the first day and July 10 as the 30th day.
- For first-of-month groups, the effective date would be August 1. If your group has a billing on the 15th of the month , the effective date would be July 15.

Applications for Blues*Enroll* Groups Only

Arkansas Blue Cross will accept online applications transmitted no more than 30 days before the effective date of coverage; all other requirements for "timely" status will be observed.

- Please verify the accuracy of information submitted and make sure this information is transmitted to the company.
- Applications and changes in coverage must be communicated to the company in a timely manner, in the format required by the company, in order to be effective. The company shall not be responsible for any applications or changes in coverage, or errors in such applications or changes, if proper procedures are not followed. The company shall be entitled to rely upon any data submitted by an employee or policyholder in online format.
- Please obtain and maintain the documents described in the "Group Coverage Guidelines" to support eligibility status of employees and dependents. You shall provide these documents to the company upon request.

On advance effective dates and cancellation dates, the online application will not be transmitted to Arkansas Blue Cross until 30 days prior to the effective date.

Waiting Periods

Please explain all waiting periods to new applicants. If your group has special needs related to waiting periods, please contact your marketing representative or independent agent. The request will need to be faxed, mailed or e-mailed on your company letterhead. This documentation will be placed in your group's file for verification of your request.

Group Billing

Make sure your payment reflects the total amount of your group billing; submit only one check for payment. Also, please write your group number and billing invoice number on your check.

Do not add an employee's name to your group billing or pay for an employee whose name does not appear on the billing.

Make premium payments to Arkansas Blue Cross for covered employees and their dependents every month, in advance (**before the due date**).

Submit a change request form when changing from family to individual coverage and **remit the corrected amount when the change appears on the billing. Submit a complete application when changing from individual to family.**

NOTE: Blues*Enroll* groups do not use the change request form.

Remember to accurately and timely report employee and dependent eligibility changes and other information to Arkansas Blue Cross. If you fail to do so, your group is liable to Arkansas Blue Cross for any claims paid in error on behalf of such employees or dependents.

Please remit **page one** of your bill, noting all adjustments to billed amount.

Please retain a copy of **page one** for your records and send the original to:

Arkansas Blue Cross and Blue Shield
P.O. Box 3590
Little Rock, AR 72203-3590
Attn: Customer Accounts

If there is any change in your address, telephone number, etc., please notify your group service representative as soon as possible.

Remember, all correspondence to Arkansas Blue Cross should include your group's name and number and, if applicable, the ID number of any mentioned employees.

Group Policy

The group policy is the legal, binding group agreement. Guidelines will be applied as indicated in this manual; revisions will be made as policies and procedures are updated.

- Make sure that the percentage of eligible employees covered by your group policy stays at or above the minimum number of insured employees as specified in your group policy. If the percentage of the eligible employees covered by your group policy becomes less than the percentage of employee participation specified in your group policy, your group policy is subject to termination. Upon request, you will furnish Arkansas Blue Cross with information regarding current participation and contribution, and if required, provide documents to validate those numbers.

- Make sure that the percentage of your company contribution to employees' premium stays at or above the minimum percentage specified in your group policy. If the percentage of contribution becomes less than the percentage of contribution specified, your group policy is subject to termination. (Minimum contribution to the employee premium is 50 percent [for groups 2-50], but your group may elect to contribute a greater amount.)
- **As the employer, please remember to fulfill your legal COBRA obligations (See "COBRA Section"). Please remember that Arkansas Blue Cross is not responsible for providing COBRA notices to employees or dependents, and Arkansas Blue Cross will not be able to provide benefits under COBRA if you fail to provide the required COBRA notices to your employees and dependents at the times specified in your group policy.**
- Fulfill legal HIPAA obligations; your group agrees to indemnify and hold Arkansas Blue Cross harmless if any action or inaction of your group results in Arkansas Blue Cross being charged with violating HIPAA.
- Provide all employees and dependents appropriate communications and notices from Arkansas Blue Cross.

SECTION 3 – GROUP COVERAGE GUIDELINES

Enrolling New Employees

All permanent, full-time employees (minimum of 30 hours per week and 48 weeks per year) are eligible for group coverage. Please ask new employees to complete and sign an application. All full-time employees should either enroll or waive coverage, if they are eligible for coverage.

Applications for Non-Blues*Enroll* Groups

Applications for insurance coverage should be completed and e-mailed, faxed or mailed to Arkansas Blue Cross or submitted on-line for Blueprint for Employers groups no more than 60 days prior to the effective date of coverage. You may select any of the processes for submitting applications at any time. Please remember that applications that require completion (employers with 2-50 people) will be returned if the application is received more than 60 days *prior* to the effective date of coverage.

Applications may be submitted less than 60 days before the effective date of coverage, but must be received no later than 30 days after the employee's eligible effective date of coverage.

If applications are returned for additional information, Arkansas Blue Cross must receive the completed application in order to be processed timely. (This includes no more than 30 days beyond the employee's eligible effective date of coverage for a timely enrollee.)

Applications can be sent three ways:

1. **E-mail** — smallgroupunderwriting@arkbluecross.com
2. **Fax** — 501-378-2926
3. **Mail** — **Arkansas Blue Cross and Blue Shield**
   P. O. Box 2181
   Little Rock, AR 72203-2181
   Attn: Small Group Underwriting – 8UCC

Applications for Blues*Enroll* Groups

Online enrollment for insurance coverage should be completed and transmitted to Arkansas Blue Cross no more than 30 days prior to the employee's effective date of coverage.

Applications may be submitted less than 30 days before the effective date of coverage, but must be received no later than 30 days after the end of the waiting period.

Coverage Effective Dates

New Employees

A new employee will be eligible for coverage following the new employee waiting period, provided the application is received in a timely manner. A timely application is one that is received during the eligibility period or within 30 days following the end of the waiting period.

Existing Employees

Employees may not apply for coverage or change to family coverage except during a special enrollment period, open enrollment or as the result of a qualifying event. An existing employee must submit an application for himself or herself and any dependents if the employee wishes to become insured or add dependents after eligibility.

Dental Policies

Dental enrollment occurs at initial eligibility or as the result of a qualifying event. (Arkansas Blue Cross must receive applications before the last day of open enrollment for the employee's anniversary month to be the effective date.)

Vision Policies

Vision enrollment occurs at initial eligibility or as the result of a qualifying event. (Arkansas Blue Cross must receive applications before the last day of open enrollment for the employee's anniversary month to be the effective date.)

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

Qualifying Event- When adding or terming a subscriber/member, the qualifying event must be indicated. This will let Arkansas Blue Cross know if the subscriber/member meets criteria for a Special Enrollment Period.

Identification Cards

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

NOTE: This does not apply to multiple option plans. For those plans, the cards are sent directly to the employee.

Coverage Effective Date Guidelines

Member	Qualifying Event	Effective Date	Remarks
Spouse	Marriage	First of month after date of marriage	Application must be submitted within 30 days of marriage
Spouse	Loss of other coverage	First of month after loss of coverage	Application must be submitted within 30 days of loss of coverage
Natural child of employee	Loss of other coverage	First of month after loss of coverage	Application must be submitted within 30 days of loss of coverage
Newborn child	Birth of child	Date of birth	Enrolled within 90 days of date of birth

Adopted child – newborn	Petition for adoption	Date of birth	Enrolled within 60 days of date of birth
Adopted child – not a newborn	Petition for adoption	Date placed for adoption or date of petition for adoption filed	Enrolled within 60 days of placement or filing of petition for adoption
Court ordered coverage for child	Court order	First of month after application received	Custodial parent or child support agency can submit copy of court order
Grandchild / other	Court appointed guardianship or legal custody	First of the month after receipt of application (date of birth if newborn)	Enrolled within 30 days of qualifying event (90 days for newborn); proof of custody or guardianship required
Stepchild	Loss of other coverage, marriage (addition or family members)	First of the month after receipt or date spouse is eligible	Enrolled within 30 days of qualifying event
Current member – mentally or physically incapacitated dependent	Dependent reaches age 26 or dependent maximum age per group contract	First of the month after dependent reaches age 26 (or maximum dependent age)	To prevent any break in coverage, should be enrolled as incapacitated dependent within 30 days (proof of incapacity of dependent form in Forms section)
New member – mentally or physically incapacitated dependent	Dependent over age 19 and was covered on previous group health plan	Date member is effective for new group	Proof of incapacity before age 19 must accompany Application
Reinstatement military personnel	Return from active military duty	Date returned to work	Application must be submitted within 90 days of returning to work

Changes in Coverage

Increase or Decrease in Group Benefits

If you would like to increase or decrease your group's benefits, please contact your group marketing representative before your group's anniversary date. In order to serve your needs, changes need to coincide with your anniversary date.

Loss of Concurrent Coverage

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

- The individual was covered under another group health plan or other health insurance when the employer's plan was first offered.
- The coverage was either COBRA coverage that was exhausted or other group health coverage canceled due to loss of eligibility or due to cancellation of the employer contributions toward coverage.
- The employee requests enrollment within 30 days of other health coverage terminating as a result of loss of eligibility or loss of Advanced Premium Tax Credit(APTC)

New Enrollments or Changes Due to Special Events

Change Due to Marriage

If one of your employees becomes married, an application must be received within 30 days of the date of marriage to be considered a timely addition. The employee (if the employee initially waived coverage), the new spouse and the spouse's eligible dependent children will be added to the group policy effective at the beginning of the policy month following the date of marriage.

A certificate of marriage will be required in all instances (including a difference in last names to verify dependent status).

For Blues*Enroll* — Please obtain a certificate of marriage and make it available to upon request.

If the application is not received within 30 days of the date of marriage, the employee (if the employee initially waived coverage), the new spouse and the spouse's eligible dependent children will have to wait until a special enrollment period or the next open enrollment period to apply for coverage.

Change Due to a Newborn

In order for coverage for a newborn child to be considered timely, an employee will be required to enroll the newborn child within 90 days of the newborn child's date of birth.

The employee (if the employee initially waived coverage) and spouse (if applicable) will be added to the group policy effective at the beginning of the policy month prior to the newborn child's date of birth. Coverage for the newborn child will become effective on the newborn child's date of birth.

Parental proof (birth certificate listing the policyholder's name as father or mother, court order for child support or paternity test results) will be required when the policyholder is unmarried and/or the child's last name differs from that of the employee. Parental proof may be required at any time.

Change Due to Adoption

In order for coverage for an adopted child to be considered timely, an employee will be required to enroll the newly adopted child within 60 days of the date of adoption or the date the child is placed for adoption for the child to be considered a timely addition.

The employee (if the employee initially waived coverage) and spouse (if applicable) will be added to the group policy effective at the beginning of the policy month prior to the date of adoption or at the beginning of the policy month prior to the date the child is placed for adoption. Coverage for the adopted child will become effective on the date of adoption or the date the child was placed.

Adoption papers are required in all instances.

The coverage shall be canceled upon the dismissal, denial, abandonment or withdrawal of the adoption, whichever occurs first.

Change From Family to Individual Coverage

If one of your employees would like to change from family coverage to individual coverage, please mail a signed application/change form to Arkansas Blue Cross. The dropped dependent(s) will be assigned the next available effective date following the date of receiving the application.

The group administrator's signature will be required on all change forms. This will ensure his or her awareness of changes in family status that may affect COBRA or cafeteria plan requirements.

A change from individual to "other" (employee/spouse, employee/child or family) will require an application be completed to add the dependent.

For Blues*Enroll (Including Small Group)*

If one of your employees would like to change from family coverage to individual coverage, he or she may only do so by selecting a life event or during an open enrollment period. The change will be effective on the premium due date following the date of receipt in the home office. A change from individual to "other" (employee/spouse, employee/child or family) will require an online application be completed to add the dependent using a life event in limited instances or during the open enrollment period.

Change Due to Divorce

In the event of divorce, a change form must be completed to remove the former spouse. A divorced spouse is no longer eligible and must be removed by the end of the month of the date of divorce. The cancellation of spousal coverage requires the group administrator's signature and date. If the former spouse has children, and the employee is not the parent and is not the legal guardian, it is important to note that the stepchild(ren) will no longer be covered on the policy.

IMPORTANT: Please refer to the COBRA section for more information.

Dependent Coverage

A dependent is covered under the family coverage from birth to the end of the billing period in which the child reaches the dependent maximum age of the policy, unless other provisions in the group policy have been agreed to in writing. **NOTE: A dependent child that reaches the limiting age is eligible for COBRA continuation.** It is the employee's responsibility to make sure that his or her dependents are covered. Dependent age coverage is listed on the Schedule of Benefits.

A dependent is defined as the employee's natural child, stepchild or legally adopted child. Employees who have been awarded permanent custody of a child must furnish a copy of the court order stating they are the custodial parent. Temporary custody of a child is not considered a basis for coverage.

Incapacitated Dependents

Continuation of insurance for a handicapped dependent child:

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

Special Circumstances Regarding Coverage

Military Service

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

Over Age 65

A full-time (works 30 hours or more per week) employee who reaches age 65 has the choice of either continuing Arkansas Blue Cross group coverage or becoming a Medi-Pak member. If an employee chooses Medi-Pak, he or she will be billed at his or her home address.

If one of your employees would like to become a Medi-Pak member, please delete the employee from your group billing and submit a Medi-Pak application within 30 days of the last billing. If there is no lapse in coverage, the employee can transfer to Medi-Pak. If the employee chooses to continue Arkansas Blue Cross group coverage, no action is necessary.

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

Centers for Medicare / Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Additions to the Group After Initial Enrollment

New Hires

New hires may be added to the group by completing and submitting an application requesting coverage.

NOTE: Blues*Enroll* groups submit an online application.

Requesting Exceptions

Requesting a waiver of the eligibility period will **not** be granted. A group may, however, request their contract be amended to reflect the creation of shorter eligibility periods for **future** new hires and additions. These eligibility periods must be created for classes of employees only. For instance, sole proprietor, partner or corporate officer would be an identifier for executives. The words "key employee" are not allowed as an identifier.

Omissions and Errors

Arkansas Blue Cross bills every group one time each month. That bill lists each covered employee in the group and an amount due. It is very important that you, as the group administrator, verify that all covered employees are listed on the bill and that any canceled employees are indicated on page one of your bill (please refer to Section 5 for instructions on making adjustments to amount billed). Incorrect removal of an employee may require the submission of payroll records to verify continued employment. We appreciate your help on keeping all records accurate.

Refund of Premiums

If Arkansas Blue Cross cancels the coverage of an employee and/or dependent, premium payments received on account of the canceled employee and/or dependent applicable to periods after the effective date of cancellation will be refunded to the group within 30 days, and Arkansas Blue Cross will have no further liability under your group policy.

If the group cancels coverage of an employee and/or dependent, you are required to request Arkansas Blue Cross refund premiums paid for such employee and/or dependent's coverage within 60 days from the effective date of cancellation of such coverage in order to receive a refund of premium. If the group does not make a refund request within 60 days of the effective date of cancellation of the employee and/or dependent's coverage, it will result in the group waiving refund of any premiums paid for such coverage. The cancellation date of coverage for the employee and/or dependent will be the next billing cycle after the receipt of the group change form.

Retroactive Terminations – PPACA Required Changes Effective Sept. 23, 2010

The Patient Protection and Affordable Care Act (PPACA — through Public Health Service Act section 2712) generally provides that plans and issuers must not rescind coverage unless there is fraud, or an individual makes an intentional misrepresentation of material fact. A rescission is defined in the law as a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent attributable to a failure to pay timely premiums towards coverage. This was effective on Sept. 23, 2010.

This provision limits our ability to make exceptions to retroactively terminate a member's coverage beyond our normal reconciliation process. Although this was put into the law with the good intention of protecting a member from being terminated if they got sick, it has some unintended consequences that may have a negative impact on the member, the group and the insurance carrier. The most common issue to arise is when a group or member does not term on a timely basis. If the member has paid any part of the premium after the requested termination date, we must extend coverage through the time period the premium covers. In many cases this will cause us to term them prospectively.

Below is some guidance from an FAQ published by the Department of Labor (Oct. 8, 2010):

Is the exception to the statutory ban on rescission limited to fraudulent or intentional misrepresentations about prior medical history? What about retroactive terminations of coverage in the "normal course of business"?

The statutory prohibition related to rescissions is not limited to rescissions based on fraudulent or intentional misrepresentations about prior medical history. An example in the Departments' interim final regulations on rescissions clarifies that some plan errors (such as mistakenly covering a part-time employee and providing coverage upon which the employee relies for some time) may be canceled prospectively once identified but not retroactively rescinded unless there was some fraud or intentional misrepresentation by the employee. On the other hand, some plans and issuers have commented that some employers' human resource departments may reconcile lists of eligible individuals with their plan or issuer via data feed or billing only once per month. If a plan covers only active employees (subject to the COBRA continuation coverage provisions) and an employee pays no premiums for coverage after termination of employment, the Departments do not consider the retroactive elimination of coverage back to the date of termination of employment, due to delay in administrative record-keeping, to be a rescission.

Similarly, if a plan does not cover ex-spouses (subject to the COBRA continuation coverage provisions) and the plan is not notified of a divorce and the full COBRA premium is not paid by the employee or ex-spouse for coverage, the Departments do not consider a plan's termination of coverage retroactive to the divorce to be a rescission of coverage. (Of course, in such situations COBRA may require coverage to be offered for up to 36 months if the COBRA- applicable premium is paid by the qualified beneficiary.)

Our legal department has determined this will not cause us to change our termination policies in the Group Administrator Manuals or Certificates of Coverage. Instead, it is the rules for making exceptions that have changed based on the law.

Therefore, legal recommends that if we receive a request from an employer to terminate coverage for a covered person within 60 days after the effective date of termination of such coverage, the question that needs to be asked and answered is, "Did this member contribute

premium payment after the requested termination date?" If the answer is "no," the response should be we will honor your request. Likewise, if we receive a request beyond 60 days from the effective date of termination and a no answer to the question, we will terminate the employee but not refund premium in accordance with the group contract provision. Article IV, Subsection I.

If we receive a request from an employer to "retro-terminate" coverage for a covered person and the answer to the question, "Did this member contribute premium payment after the requested termination date?" is "yes," you should inform the employer, "Federal health care reform regulations prohibit retro termination under these circumstances unless we have proof that the covered person obtained or kept his coverage due to fraud. We will be happy to terminate the covered person's coverage effective at the end of the period for which he or she paid premium."

SECTION 4 – PHARMACY PROGRAM

Overview

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

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

The Pharmacy Program is designed to eliminate the need for claim forms when using a participating pharmacy. Pharmacy claim forms are provided upon request.

The Arkansas Blue Cross/Health Advantage Pharmacy Program, administered through Caremark, contracts with more than 64,000 pharmacies nationwide to ensure employees have access to the medications they need wherever they go.

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

Benefits

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

- Cost savings
- No claim forms

- Nominal copayments and/or coinsurance
- Specialized customer service
- Access to an extensive pharmacy network

When an employee presents an ID card, participating pharmacists (working with the employee's physician) can closely monitor medication therapy.

Pharmacists will be able to determine whether:

- The medication to be dispensed may combine in a harmful way with another medication currently prescribed.
- A prescription duplicates another prescription.
- The dosage or amount is being over-used or under-used.

ID Cards

Arkansas Blue Cross members will receive an ID card to be used for both medical and pharmacy.

Covered Medications

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

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

Medications Not Covered

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

Using the Program

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

To find a participating pharmacy, employees may ask their pharmacists if they are members of the Caremark network, or call the toll-free number on their ID card for information on the nearest participating pharmacies. Access to the online pharmacy locator can be found at: www.arkansasbluecross.com.

Participating Pharmacy Procedure

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

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

Non-Participating Pharmacy Procedure

In State

If an employee uses a nonparticipating pharmacy in their state of residence, the prescription is not covered through the Enterprise Pharmacy Program and is not eligible for reimbursement from the insurer.

Out of State

If an employee uses a nonparticipating pharmacy outside their state of residence, the prescription is not covered through the Pharmacy Program and is not eligible for reimbursement from the insurer.

Generics vs. Brand-Name Medications

Choosing generic medications, rather than brand names, will save your employees money.

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

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

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

- When a brand-name medication is dispensed and there is no generic available that is suitable for substitution, or the physician has indicated on the prescription "dispense as written," the employee pays the brand-name copayment and/or coinsurance.
- If a brand medication is dispensed when a generic medication is available and the physician has not indicated "dispense as written," the employee will pay the

coinsurance (if applicable) and the second- or third-tier copayment plus the difference in price between the generic and the brand dispensed, or the cost of the medication, whichever is less.

Where to Call For Help

The toll-free number for Caremark (1-800-863-5561) is on the back of your employees' ID cards. Caremark can provide information on:

- Participating pharmacies
- Covered and non-covered medications
- How to receive additional claim forms

Frequently Asked Questions

Q. How does the employee use the ID card at the pharmacy?

A. The employee gives the pharmacist a health plan ID card when requesting the prescription (new or refill). The employee provides the pharmacist with: patient name, date of birth and gender. The employee pays the pharmacist the appropriate amount (deductible or copayment and/or coinsurance) in accordance with the group's benefits.

Q. Why should the employee use a participating (network) pharmacy?

A. The employee receives maximum benefits (and processing convenience) when using a participating pharmacy.

Q. What if the employee obtains a prescription medication from a nonparticipating (non-network) pharmacy?

A. If an employee uses a nonparticipating pharmacy, the prescription will be denied.

Q. What is a specialty medication and why is it required to be filled at a specialty pharmacy?

A. A medication is designated as a specialty medication because of how it is administered, its approved indication, its unique nature, or its high cost. These medications usually require special handling and home storage demands, crucial patient education and careful monitoring. Such medications include, but are not limited to, growth hormones, blood modifiers, immunoglobulins and medications for the treatment of hemophilia, deep vein thrombosis, hepatitis C, Crohn's disease, cystic fibrosis, multiple sclerosis and rheumatoid arthritis.

Q. What is a prior authorization?

A. A program that requires physicians to obtain certification of medical necessity prior to drug dispensing due to administration, its approved indication, its unique nature, or its high cost.

Q. Can an employee get a 90-day supply of medication?
A. Certain medications, referred to as maintenance medications, can be obtained at a 90-day supply if the member has already filled a 30-day supply of that medication. Maintenance medications are usually prescribed to treat conditions of a long-term or chronic nature, such as diabetes, arthritis and high blood pressure.

Q. How do employees get prescriptions filled when traveling?
A. When employees plan to travel out of state and are on maintenance (ongoing, planned) medication, they may be able to obtain enough medication to last until they return home by contacting their usual pharmacy in advance.

If an employee becomes ill or injured while traveling, he or she may use any network pharmacy; he or she will need to show the pharmacist a health plan ID card.

The network pharmacy can submit the claim electronically and the employee will pay a copayment.

The employee also can pay for the medication "out-of-pocket" and submit a claim for reimbursement later.

NOTE: Employees should ask if the pharmacist is a member of the Caremark network; it may save them the trouble of filing.

Q. Can a family member pick up an employee's prescription?
A. Yes, another responsible member of the family may obtain the medication at the employee's request.

Q. Do purchases of prescriptions with the pharmacy program go toward meeting the true out of pocket (TrOOP)?
A. Copays, coinsurance and deductibles on covered prescription costs all count toward meeting the true out of pocket (TrOOP) maximums.

Q. On a newly enrolled group, does the deductible that an employee met with a previous carrier count toward meeting the pharmacy program deductible (if any)?
A. Meeting a drug deductible with a previous carrier does not count toward the annual drug card deductible when a group enrolls with Arkansas Blue Cross.

SECTION 5 – GROUP BILLING PROCEDURES

Group Remittance Due Date

Your group billing payment is due on the first day of the billing cycle (payment by the due date will ensure that changes are reflected on your next billing). You should receive your group billing approximately 10 days prior to the due date. Payment for health care protection is, therefore, paid in advance. For example, if your due date is the first of the month, payment is received and credited for the first day through the end of the month. If your due date is the 15th of each month, pre-payment would extend from the 15th of the month through the 14th of the next month.

Group Billing Instructions

Please refer to the sample billing (sections 5-3 through 5-5).

Pages One and Two of Group Bill - Instructions

Page one is for all adjustments (deletions) for employees terminating employment. Page two is a duplicate of page one for your records.

Example: Deletions

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

It's important to note that if your company fails to provide timely notice of a change in the eligibility status of an employee or dependent, it will result in the group being liable to Arkansas Blue Cross and Blue Shield for any claims paid in error.

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

Calculate your amount of adjustments and enter it in the space provided under the amount due. Subtract the "total of adjustments" from the amount due and enter it in the space provided for total premium remitted. (Please make sure that you return page one with your check; your check matches the total premium remitted; and that your group and invoice numbers are on the check.)

Page One of Group Bill - Sample:

NOTE: PAGE TWO IS A DUPLICATE OF PAGE	Page: 1 Group Number: 000005

ONE FOR YOUR RECORDS.

Invoice Number: 10000463
Coverage Period: 09/01/97 to 10/01/97
Date Prepared: 08/21/97

Anywhere Arkansas
000 East Broadway
North Little Rock AR 72203

For Billing Questions:
Unit ID:

Please return this page with your payment.
Use the return envelope to mail your payment.
Remember to write your group number on your check.

Payment due: 09/01/97

*** Group Billing Summary ***

Roster Total	$492.00
Carry Forward	
Deletions due to terminations	$246.00
Amount Due	$246.00
Adjustments	_____
Total Premium Remitted	_____

Note: All Adjustments to the invoice amount must be recorded below or on a separate sheet. In lieu of this, a photocopy of your billing with the adjustments indicated may be forwarded with your payment.

****

Adjustments: (Deletions only – Do not add or make changes to bill)

Name	ID Number	Amount	+/-

Total of Adjustments $ _____

****

Page Three of Group Bill - Description

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

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

Page Four of Group Bill - Description

Contract Type Counts

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

E-billing

Non-Blues*Enroll* Groups

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

- Secure invoice delivery
- The ability to make adjustments to the invoice
- Online payment capabilities
- Consolidated invoices (health, dental, life and vision)
- The capability to accrue up to 18 months of invoice history online
- Ability to download invoices into Excel or PDF formats
- Ability to construct reports from invoices

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

In addition, **eBill Manager** allows you to make adjustments to the invoice for situations where cancellations or coverage reductions were not already created. Follow the online instructions to remove employees that no longer are on the health plan or to adjust the

coverage level (employee only, family coverage, etc). Your payment due amount will be appropriately adjusted.

A condition of using **eBill Manager** is the requirement to obtain and retain all change form documents (signed by the employee) authorizing changes to coverage levels or for dropping health coverage. While these documents no longer are required to be submitted to create these transactions, it is required that these documents be retained by the employer as a condition of the e-billing contract.

NOTE: Invoices cannot be adjusted for additions to the health plan membership; all additions to the health plan still require an employee application. Subsequent invoices will show the results from the additions.

eBill Manager is supported by the regional internal and external group service representatives. For help in obtaining access to **eBill Manager** or for assistance in using the product, please contact your local regional office.

Blues*Enroll* Groups

Please remember that you're required to obtain and retain all "Change Form" documents (signed by the employee) authorizing changes to coverage levels or for dropping health coverage.

Additions to the health plan membership must be made through Blues*Enroll*, and the invoice cannot be adjusted to reflect new enrollees (these will be adjusted on the next invoice).

SECTION 6 – TERMINATION OF GROUP INSURANCE

Termination for Non-Payment of Dues

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

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

- Payment of all premiums which are due or unpaid at the time of termination, **or**

- Reimbursement of all claims incurred and paid during the grace period, whichever is greater.

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

Arkansas Blue Cross does **not** assume your responsibility to giving timely notice of termination, or of COBRA rights or other options available to any group member (employee) whose coverage ends due to non-payment of premium.

What Constitutes Payment

Please note that it is **not** sufficient, for purposes of meeting premium payment obligations under your group contract, to simply put a check in the mail. In order to constitute payment and prevent the automatic termination of all coverage upon expiration of the grace period, the full amount due must actually be received by Arkansas Blue Cross at its principal office, Sixth and Gaines Street, Little Rock, Arkansas, on or before the expiration of the grace period. If the check is dishonored or if, for any other reason, Arkansas Blue Cross does not receive final, valid payment in full of all amounts due, automatic termination at the end of the grace period will occur as if the dishonored check or other invalid payment had never been received.

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

Delinquency Procedures

Approximately 20 days after the premium due date, a delinquency letter will be sent to the group.

If payment has not been received by the end of the group's grace period and coverage has been terminated according to Arkansas Blue Cross' records, a termination letter will be sent confirming the group's automatic termination at the end of the grace period for non-payment of premium.

NOTE: No notice is required to terminate your group contract for non-payment of premium. Termination (and all insurance coverage under your Arkansas Blue Cross contract) occurs **automatically without notice** when the full premium amount is not actually received in the form of a valid, final payment at our principal corporate office at Sixth and Gaines Street, Little Rock, Arkansas. However, as a courtesy to you to try to avoid an inadvertent termination and minimize the costly disruption of service and reinstatement charges (if reinstatement is allowed), we generally use the procedures below to inform you of the status of your premium payments:

Reinstatement Procedures

In the event your group contract terminates for non-payment of premium, your group coverage **may** be eligible for reinstatement in the sole discretion of Arkansas Blue Cross, provided certain conditions are met to the satisfaction of Arkansas Blue Cross. The following is required for reinstatement to be **considered**:

- Payment for all premiums due by cashier's check.
- Payment, by cashier's check, of a non-refundable reinstatement application fee in the amount of $350 (or other amount as may be determined by Arkansas Blue Cross) to cover reinstatement processing, and
- Completion and return of a signed group application for reinstatement.

The above requirements must be met within 15 days of the date of the "confirmation of termination" letter. Your request will then be forwarded to a designated underwriter for review. Following review (which we will attempt to complete on most applications within 3-5 business days), your group will be notified of our decision regarding the reinstatement request.

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

Termination of Insurance per Group Request

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

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

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

Standard Ineligibility Period After Termination

A group that terminates for any reason will not be considered for reinstatement or new contract coverage for a period of six months.

If a policy terminates because the policyholder has failed to pay the premium, the policyholder shall not be eligible to reapply for another policy with the company for a period of six months from the date the policy was terminated. If the policyholder wishes to reapply, and still owes premium or claims from a previous cancellation, no reapplication will be considered until the policyholder pays- (via cashier's check)- either all premiums which were due but unpaid at the time of termination, or reimbursement to the company for all claims incurred and paid during the grace period, whichever is the greater amount; and a $500 fee (or such other amount as Arkansas Blue Cross may require) to cover the various costs resulting from the termination and reinstatement. Arkansas Blue Cross reserves the right to refuse to issue a policy or consider coverage for any group that has previously been terminated for non-payment of premium and failed to pay all amounts due to Arkansas Blue Cross within 60 days of such termination.

SECTION 7 – COORDINATION OF BENEFITS (COB)

COB Savings

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

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

Example 1

Arkansas Blue Cross as Primary Payer

Arkansas Blue Cross would pay 80 percent

- **$1,000 x 80% = $800**

If Arkansas Blue Cross is the primary payer, we will pay contract benefits (80 percent). In the above example, $800 would be the 80 percent contract benefit.

Example 2

Arkansas Blue Cross as Secondary Payer

The other insurance company would pay 80 percent *****

- **$1,000 x 80% = $800**

Arkansas Blue Cross pays the difference

- **$1,000 - $800 = $200**

Charge	$1,000	Our allowance	$800
Other paid	$ 800	We pay	$200
Balance	$ 200		

*** Other insurance companies may or may not pay 80 percent**

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

COB Letters

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

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

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

- Our letter labeled **C-00010** asks if dependents or the employee are covered by any other insurance policy.

- Once a year, our COB files are updated using the information provided in response to our letter labeled **C-00020;** it asks if there have been any changes in your employees' coverage by other insurance companies.

- Our letter labeled **C-00030** asks for clarification of custody in regard to the insurance of your employees' children. (In case of divorce, the parent with custody of the child is primary unless the court has declared otherwise.)

Please encourage your employees to respond as quickly as possible to the COB letters. We are grateful for the opportunity to serve your employees, and it helps us serve them with the right information available.

SECTION 8 – HOW TO FILE A CLAIM

We have made it easier for you and your employees to file a claim. Whenever medical treatment is received at a physician's office, hospital or other health care provider, your employee should present an Arkansas Blue Cross ID card. This is the first step toward receiving benefits under the benefit program.

In most cases, the provider will file a claim. Arkansas Blue Cross then will pay the health care provider and send the employee a Personal Health Statement showing the amount of payment and the amount the employee is responsible for paying as well as other important information.

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

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

As always, if you or your employees have any questions about a claim, please call customer service for help. We are happy to serve you.

SECTION 9 – GENERAL GUIDELINES ON COBRA

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

- Notifying all employees and their covered dependents of their rights under COBRA when they first become covered under the group health plan, using correct and up-to-date language;
- Notifying, within 14 days of a qualifying event, all employees and their covered dependents of their continuation rights, benefits, and premium rates for the plan(s) in which they are eligible, using correct and up-to-date language;
- Adhering to election rights of qualified beneficiaries;
- Correctly administrating coverage of COBRA continuants on an ongoing basis until rights to benefits are exhausted.

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

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

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

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

General Notices of COBRA Rights and Obligations

The following is a brief summary of the process that occurs between Arkansas Blue Cross, Ceridian and the employer.

- Employer notifies Ceridian of newly covered employees and dependents by submitting electronic forms to Ceridian via the Web, sending a file in Ceridian specifications or sending these notices to Ceridian by fax or mail using paper forms.
- Ceridian sends out general notices via the U.S. Postal Service first-class mail with proof of mailing once the group informs Ceridian of the newly covered employees and dependents and archives the notices.

Initial Qualifying Event / Election of Employee

Employer notifies Ceridian of the qualifying event within 14 days of the qualifying event by submitting electronic forms to Ceridian via the Web, sending a file in Ceridian specifications, or sending these notices to Ceridian by fax or mail using paper forms.

Ceridian sends out the Qualifying Event Notices via the U.S. Postal Service first-class mail with proof of mailing once the group informs Ceridian of the qualifying event, and archives the notices.

Employer notifies Arkansas Blue Cross to terminate coverage by writing the employee name, ID number, amount of adjustment, and if amount is "plus" or "minus," employees' names and contract number on page 1 of your bill with a minus sign and the amount of premium.

Employee/dependent(s) has 60 days — from the date of the notification to the employee or the benefit termination date, whichever is later — to elect COBRA coverage.

If the employee/dependent(s) elects coverage, Ceridian bills him/her for all premiums due to current date.

From the date of COBRA election, the employee/dependent(s) has 45 days to return the full payment to Ceridian.

When Ceridian receives payment, a form called a Participant Update (on pink paper, see sample form) is sent or faxed to the employer (usually a 48-hour turnaround).

Upon receipt of the Participant Update form, the employer is to fax the form to the Customer Accounts Division to reestablish appropriate coverage.

Customer Accounts Fax Number:
(501) 378-3248
Or mail to:
Arkansas Blue Cross and Blue Shield
P. O. Box 2181
Little Rock, AR 72203-2181
Attn: Customer Accounts

Ongoing Administration

Relationship Between Ceridian and Employer

Ceridian bills COBRA continuants in advance, on or about the 19th of the month.

The COBRA continuant's premium payment must be postmarked on or before the applicable 30-day grace period expiration date.

Ceridian remits an activity report (Participant Status Report) and a check to the group for all premiums collected, on or about the 10th of the month, after the month of coverage.

Ceridian notifies the group of all enrollment changes or terminations of COBRA coverage throughout the month by sending or faxing Participant Update forms.

Relationship Between Arkansas Blue Cross and Employer

Arkansas Blue Cross bills the group in advance for the following month of coverage.

Since the COBRA premium will not be sent to the group until the following month, Arkansas Blue Cross will bill in arrears for premium due, or refund the group premium paid whichever is applicable.

It is the responsibility of the group to notify Arkansas Blue Cross of any COBRA participant's enrollment changes or terminations by faxing the Participant Update form upon receipt from Ceridian to Customer Accounts at (501) 378-3248.

If you, the group administrator, have questions about COBRA, and your employer is using Ceridian's services, please feel free to contact Ceridian's Enhanced Services Team at 1-877-622-0947 or enhancedservices@ceridian.com.

Please do not give the toll-free number or e-mail address to individuals insured through your employer group, as they will need to continue to call the toll-free number previously set up for them.

Also, should anyone have questions about this process, or become aware of any problems experienced while using this process, please let us know so that we can contact Ceridian for a response and action.

Sample Participant Update Form

Ceridian National Service Center

Participant Update Form

Important: Notify Carrier of this Change Immediately

	Group Administrator		Continuant Name
To:	Group Name	**Re**:	Continuant Address
	Group Address		

Action: i.e. Cancellation, Termination, Reinstatement, Election and Reason

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

*Cov Type	Carr Code	Carrier Name	Option	Status	Group Number

M	ABC1	Arkansas Blue Cross and Blue Shield	A	Indiv+2/Fam	024281001

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

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

SECTION 10 – ARKANSAS LAW GOVERNING CONTINUATION OF COVERAGE BEYOND TERMINATION

Groups not eligible for the Consolidated Omnibus Reconciliation Act (COBRA) may be subject to Arkansas' continuation of coverage law; in certain situations this law will allow the extension of coverage for up to 120 days.

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

- Be continuously covered under the policy for at least three consecutive months prior to employment termination or change in dependency status; and
- Make the election by notifying Arkansas Blue Cross in writing no later than 10 days after the employment termination or change in dependency status.

Continuation shall terminate on the earliest of:

- 120 days after the date the election is made;
- The date the covered person fails to make any premium payments or the policyholder fails to pay the premium to the company;

- The date on which the covered person is or could be covered by Medicare;
- The date on which the covered person is covered for similar benefits under another group or individual policy;
- The date on which the covered person is eligible for similar benefits under another group plan;
- The date on which similar benefits are provided for or available to the covered person under any state or federal law;
- The date on which the policy terminates.

Should you need additional information, please contact your group service representative.

SECTION 11 – FREQUENTLY ASKED QUESTIONS

Listed below are some of our group service representatives' frequently asked questions. Please feel free to call us with any questions. However, you may want to refer to these questions and answers for certain information.

Q. If an employee is on disability leave, how long will he/she be covered on the group plan?

A. The *maximum* period of time an employee on disability can be covered through the group is *six months*. At the end of the six months, the employee would have the following options:

- Return to work;
- State of Arkansas 120-day continuation policy;
- Convert to COBRA, if applicable; or
- Drop coverage.

Q. I have an employee who was canceled from our group by mistake. How do I add them to the group again?

A. Contact your group service representative within 30 days of cancellation, and request that the employee be added back to the group coverage. The underwriting department may require payroll records to prove continuous coverage.

Q. Do Blues*Enroll* groups have an open enrollment at the time of our anniversary?

A. Yes. Employees who wish to be added to your group health insurance program or who want to make changes to their coverage can do so during their open enrollment period.

Q. Do you have continuous coverage if you transfer from a group policy to the Arkansas Blue Cross conversion policy?

A. Yes. Arkansas Blue Cross' conversion policy requires no medical underwriting.

Q. When can an employee who is getting married change to family coverage?

A. An application must be received within 30 days of an employee's marriage to be considered a timely addition. The new spouse will be added to the group policy effective at the first of the month following the date of the marriage. A copy of the marriage license will be required.

Q. An employee just found out that she is pregnant. When should she change from an individual policy to a family policy?

A. The employee should change from single to family coverage within 90 days of the birth for the application to be considered timely.

Q. An employee has a family policy and needs to add a dependent. What do they need to do?

A. Please see sections regarding marriage, new births and adoptions.

Q. An employee would like to change a policy from family to individual. When will the change be effective?

A. The change will be reflected on the next billing cycle, after approval of the change request form.

SECTION 12 – FORMS

You can find any of the forms or applications by visiting www.arkansasbluecross.com and logging in to Blues*Enroll* or by contacting your group service representative. If you need any forms other than the ones indicated, or if you need other supplies that are not listed, please contact your group service representative for assistance.

As the group administrator, we respectfully ask that you check each form for completion, accuracy and timeliness. We are unable to process incomplete forms, and this could delay your employee from receiving benefits.

Group Employee Application

Please use this form to enroll an employee in your group's health program.

NOTE: Blues*Enroll* groups use an online application to enroll an employee in a group's health program; an employee who declines coverage initially must complete the waiver section of the online application. All employees are required to complete an online application when enrolling.

Incapacitated Dependent Form

Members who are in the process of requesting that a child be considered as an "incapacitated dependent" for continuing health coverage should use this form.

Change Request Form

This form is used to make changes to a currently enrolled employee's address, name and telephone number or to cancel coverage for an employee and/or dependent(s).

Dental Application and Change Form

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

Vision Application and Change Form

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

Health Claim Form

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

Dental Claim Form

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

Vision Claim Form

This form is used to request reimbursement for services received from providers who do not participate in the Davis Vision network.

Prescription Claim Form

This form is used to submit prescription charges for reimbursement in cases where the member has made payments.

SECTION 13 – HOSPITAL ADMISSION PRE-CERTIFICATION/PRE-NOTIFICATION REQUIREMENTS

Hospital Admission Pre-certification/Pre-notification Requirements for Arkansas Blue Cross Blue Shield and Affiliates

Product Line	Inpatient Precertification and Continued Stay Review	Inpatient Pre-notification	Outpatient Pre-Certification
Arkansas Blue Cross and Blue Shield	Not Required Exception: FEP	Required for all out of network and out of state admissions	Not Required
Federal Employee Program (FEP)	Required (Please Note: All FEP cards have an Arkansas Blue Cross logo and ID numbers begin with "R"		Not Required
Health Advantage	Not Required	Required for all out of network and out of state admissions	Not Required
Blue Advantage Administrators of Arkansas	Refer to customer service as self insured employer groups have different requirements	Refer to customer service as employer groups have different requirements	Refer to customer service as employer groups have different requirements
USAble Life Group Health	Not Required	Required for all out of network and out of state admissions	Not Required

If you have questions regarding pre-certification requirements for any member for any of our products, please call the customer service number on the back of the member's ID card.

Definitions:

Admission Pre-certification – The process of evaluating the appropriateness of an admission against established medical necessity criteria and assignment of initial length of stay at the time of admission into an acute care facility or at the time of notification by the facility of the member's admission.

Continued Stay Review - The process of evaluating the appropriateness of continued inpatient stay during the inpatient confinement.

Admission Pre-notification – Notification of the hospital admission only. No medical necessity review is required.

Outpatient Pre-certification – The process of evaluating the appropriateness of an outpatient procedure/service against established necessity criteria.

Necessity Criteria – Approved criteria, which includes nationally recognized medical necessity review criteria.

SECTION 14 – TRUE BLUE PPO

True Blue PPO (preferred provider organization) is a network used by fully insured products including Arkansas Blue Cross, the Federal Employee Program and BlueCard. It is made up of doctors, hospitals and other health care professionals who sign contracts with True Blue PPO agreeing to accept our allowance to care for covered employees.

Frequently Asked Questions

Q. Can employees choose their own doctor and/or hospital?

A. Yes, employees can go to any provider they wish, whether they are PPO providers or not. However, if they go to a provider that does not participate in the True Blue PPO, Arkansas Blue Cross insurance will pay less of the doctor or hospital bills after they have met their deductible than if they had gone to a PPO participating provider. In other words, Arkansas

Blue Cross will pay more of the bill after they meet their deductible if they go to a PPO participating provider.

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

A. Normally, an employee will pay 20 percent more, depending on the group contract.

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

A. If the present doctor, obstetrician/gynecologist, or pediatrician has contracted with True Blue PPO, the employee can remain with their doctor, and their covered charges will be paid on an in-network basis.

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

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

Q. Why should an employer choose a PPO?

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

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

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

Q. **What about dependents who live outside of a PPO area? Are their claims paid as in-network or out-of-network?**

A. Any dependent that lives in an out-of-network area, and seeks treatment in that area, must use a participating Blue Cross Blue Shield provider, except in case of accident/emergency, for the claims to be paid as if they were in-network. If it is not an accident/emergency, claims are paid as out of network. In order for claims to be handled as quickly as possible, please make sure dependents are aware of how to use an in-network provider and what is considered an emergency.

Q. How can a doctor or hospital get into the PPO?

A. If a doctor or hospital wants to discuss participation in the PPO, they can contact the network development representative at the regional office.

Q. Whose responsibility is it to call to pre-certify a hospital admission?

A. It is the covered employee's responsibility to call to pre-authorize a hospital admission.

Although a covered employee's physician's office may often make the call, the employee is responsible to make sure he or she has been pre-certified for a hospital admission, whether by the covered employee personally, the doctor, or someone else, such as another member of the household.

Q. How are out-of-state employees covered?

A. Out-of-state employees who live outside our network areas are covered under a standard comprehensive major medical plan. This is true for newly enrolled groups and currently enrolled groups that change to the PPO.

Q. **Does an employee have to fill out different claim forms or follow different claim filing procedures now that we are under the PPO?**

A. The claim forms and claim filing procedures are the same under the PPO as under your old plan.

Q. What are the PPO areas? How does an employee know if they are in-area or out-of-area?

A. They should consult the PPO directory to see which doctors and other health professionals have contracted with the PPO. The provider directory may be accessed online at arkansasbluecross.com.

SECTION 15 – THE BLUE BOOK

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

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

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

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

SECTION 16 – THE FAMILY AND MEDICAL LEAVE ACT OF 1993 (FEDERAL LAW)

Employer Responsibilities

Groups That Are Subject To This Act

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

Family Leave

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

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

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

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

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

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

Keeping the employee's coverage in place and paying for it during the leave of absence will keep the employer in compliance with the requirement that the coverage resume unchanged when the employee returns from the leave. If the employee's coverage were to lapse during the leave, he or she would have to reapply for coverage, subject to the group's probationary period.

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

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

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