Chapter

1

Enrolling for Coverage

Having complete and accurate information on the enrollment form is essential to providing high-quality service to our members. We keep it **simple**. You provide us with accurate enrollment information and we make sure all the systems involved in processing your Capital BlueCross health care coverage are appropriately updated.

You can send valid enrollment information or changes (that are in accordance with your group contract and Certificates of Coverage) on the PlusBilling® Form to us each day (include the applications/change forms with the PlusBilling Form). You also can submit changes weekly or monthly to accommodate your business needs. Or, you can send nonpriority enrollment requests to cbcaaenrollment@capbluecross.com. (Priority enrollment is enrollment required the same day as submission of enrollment request.) Choose the method you prefer. (See the "Enrolling for Coverage" or "Changing Enrollment Information" subsections for details.)

For questions on billing and enrollment processing, feel free to contact Group Services at **1.800.541.3742**. If you have a nonroutine enrollment situation, or a question about benefits or claims, call Group Services at the same phone number for additional information and assistance.

This chapter contains important information about how to enroll members, as well as our specific policies and procedures surrounding member enrollment. As a Group Administrator, you will need to understand and apply much of this information in your daily tasks.

Examples of the forms mentioned in this chapter can be found in the *Forms and Reports* chapter of this manual. *Please note words that are double underlined are defined in the* Reference and Glossary *chapter.* ***Shaded portions in Chapters 1 through 8 apply only to large group customers such as fully-insured Experience-Rated Groups that have 100 or more enrolled subscribers, and large Administrative Services Only (ASO) Groups.***

Eligibility to Enroll

The term "initial eligibility" means the point in time when a member is first eligible to enroll for Capital BlueCross coverage. In addition to each group's own eligibility rules, Capital BlueCross applies the following guidelines to determine initial eligibility. Consult your Capital BlueCross group contract for specifics related to any eligibility limitations for your group.

Specifically, a member who is initially eligible is defined as follows:

1. *An applicant who is:*
    - *Newly hired and can be enrolled at the time of hire or after a probation period established by the group; or*
    - *A member of a Taft-Hartley Health and Welfare Fund who (a) accumulates sufficient hours to qualify the member to enroll for coverage, or (b) is entitled to reenroll for coverage following a labor strike or management lockout, if a lapse of group coverage has occurred.*
2. *A subscriber or dependent who is eligible for, and elects COBRA benefits through the group; or*
3. *An employee of a group when the group:*
    - *Acquires new applicants through the acquisition of another company; or*
    - *Changes benefits allowing applicants to expand their coverage choices during annual enrollment periods.*

If we receive an application to enroll for coverage **more than 60 days** following the date of initial eligibility, we will notify you that the individual is **not eligible** to enroll until the next group annual enrollment period.

All active and/or retired employees, their spouses, and children may be eligible for coverage.

See the *Forms and Reports* chapter of this manual for examples of applications to use for enrollment—our "*Application to Enroll or Change Enrollment*" Form is used for many Capital BlueCross benefit programs. Also included are samples of enrollment forms for specific programs

Note: Coverage purchased through the Federally Facilitated Marketplace (e.g., on HealthCare.gov) will be subject to the marketplace's Small business Health Options Program (SHOP) rules and guidelines for group eligibility, enrollment, and termination of coverage.

Enrolling for Coverage

Enrolling a member is as simple as having the member complete the application, adding group information in the appropriate section of the application, and sending it to us. (Our address is listed on every application.) Encourage your members to complete the application as completely and legibly as possible to avoid enrollment errors and delays.

For COBRA continuant enrollment, please refer to the "COBRA Coverage" section of this chapter.

Please examine the application to make sure all information (including the subscriber's employment status) is accurate and complete before sending it to us. As Group Administrator, you will need to provide certain information on the application (including employer size). Missing or incorrect information can delay processing, and we may have to return the form to you for completion.

Please make sure your **employee signs the application**. If it is not signed, it **will** be returned for a signature.

Remember—Accurate information on the application is crucial because it is used to produce member ID Cards. Correct information also is necessary for claims processing and payment functions to run smoothly for your members.

All active and/or retired employees, their spouses, and children may be eligible for coverage.

Standard Enrollment Guidelines

General guidelines apply to all enrollment activity. Please keep the following in mind while preparing enrollment information about your members:

You have 60 days to notify us about enrollment information! Remember: **You** determine when someone is eligible to enroll (e.g., at date of hire, 90 days after hire, etc.).

- There are two types of enrollment changes—information changes and benefit changes:

  - **Information changes**, such as a change in address or a change in employer size that affects coordination of benefits under the Medicare Secondary Payer Laws (sometimes referred to as MSP) should be sent to us as they happen. **Note:** If your Capital BlueCross coverage was purchased through HealthCare.gov, contact Group Services for direction on the changes Capital BlueCross is permitted to make for you.

  - **Benefit changes mean adding or changing products. Products (Examples: PPO, HMO, BlueCross Dental, BlueCross Vision) may be added or changed during annual enrollment periods, or when a valid Life Status Change occurs. Products may be deleted at any time based on our retroactive policy. (We explain annual enrollment period and Life Status Change in more detail later in this chapter. See the "Retroactive Enrollments and Terminations" section.)**

    Note: If your group enrolled through HealthCare.gov, and your enrollment effective date is 1/1/2015 or later, all changes must be submitted through HealthCare.gov.

- **Enrollment of new dependents** (e.g., birth of an eligible child, adoption of an eligible child) **must take place within 60 days of the birth/adoption, etc**.

- Enrollment of certain categories of dependents may require member completion of additional forms. (For example, if a disabled dependent is included on the application, the subscriber will be sent a Handicapped Certification Form to be completed and returned to us.)

- Some Capital BlueCross benefit programs include the selection of a Primary Care Physician (PCP). Member benefit levels will be affected if this information is not provided on the enrollment form when applicable.

The billing period for Capital BlueCross begins on the member's enrollment effective date. Billing adjustments (credits or debits) are applied to the next bill issued after the enrollment information is received and processed.

- Nonpriority enrollment requests may be sent to cbcaaenrollment@capbluecross.com.

Errors

As the Group Administrator, you need to verify the accuracy of membership in each product as reported on the Capital BlueCross invoice or other approved format. If errors are found, you must report them to us within sixty (60) days of receipt of the invoice or document. Errors reported after sixty (60) days are applied only to invoices going forward, not to invoices from prior periods.

Members may not be added or deleted more than sixty (60) days retroactively if the error is on your part. However, if the error is on the part of Capital BlueCross, you may add or delete a member up to six (6) months retroactively. You are responsible for all premiums for members reported as eligible to us.

Electronic Enrollment Options

Capital BlueCross offers automated tools that expedite enrollment for group customers. These tools reduce administrative costs; minimize the risk of errors associated with manual, paper-laden processes; and ultimately are intended to increase group satisfaction.

In lieu of paper enrollment applications, many Capital BlueCross employer groups have chosen one of our electronic enrollment options, such as the Electronic Group Enrollment Maintenance System (eGEMS®), *e*File℠, or via Capital BlueCross' Group Private Exchange.

What are the Benefits of Electronic Enrollment?

- Electronic enrollment saves valuable human resource department time and effort otherwise spent duplicating tasks and reconciling data.

- Using electronic enrollment processes provides quicker turnaround time for eligibility changes, which means ID cards (when applicable) are generated and mailed sooner.

- Automated processes are less error prone, eliminate the risk for misplaced paperwork, and reduce costs (postage, paper supplies, etc.).

Enrollment/Eligibility Electronic Solutions

Capital BlueCross has four electronic solutions to expedite enrollment and eligibility into our system: eGEMS, *e*File, Capital BlueCross' Group Private Exchange, and Excel to Facets™.

1. **eGEMS (Electronic Group Enrollment Maintenance System)**—eGEMS is a free, user-friendly, web-based enrollment/change application that allows groups to view health plan and benefit information. It allows groups of any size to easily enroll and update enrollment while expediting the claims adjudication and ID card processes.

   Important Points to consider about eGEMS*:*

   - eGEMS is an intuitive, user-friendly, web-based enrollment/change application.
     - Benefit administrators have attested the tool is very easy to use.
     - The application has two transaction types:
       - eGEMS Inquiry—for viewing information only.
       - eGEMS Update—for making and submitting changes.
     - The eGEMS setup takes only a few days once the eGEMS agreement is signed.
   - eGEMS places the benefit administrator in direct control of group and member enrollment.

- Group enrollment entered into eGEMS is updated primarily in "real time." Exceptions include:
  - Primary Care Provider (PCP) changes/additions.
  - Retroactive activity older than 60 days.
  - Coordination of Benefits (COB).

Note: If your group is purchasing SHOP products, you are not able to use eGEMS.

- Each group is assigned a Primary Electronic Enrollment Specialist to assist your account in these functions:
  - Troubleshoot system problems.
  - Address any security concerns.
  - Assist with any data entry questions.
- Daily reports allow the group to confirm the accuracy of data entered from the prior day.
- ID cards, as applicable, are mailed within one to two business days upon receipt of enrollment.
- Implementation can be facilitated by contacting your Capital BlueCross Account Executive or your agent/producer. You also can submit a request by visiting the Employer Portal on our website: capbluecross.com/.
- It is beneficial to use eGEMS for maintenance and annual enrollment period changes.
- In order to maintain efficiency between systems, enrollment through eGEMS is required as part of eBasics℠ coverage (see page 2.16 for additional eBasics information).

2. ***e*File**—*e*File offers four electronic file transfer options allowing groups to submit electronic eligibility for employees specific to commercial business. For Medicare enrollment, groups may also submit electronic eligibility via file transfer. With the capability of *e*File transfer alternatives, groups benefit from automated processes to alleviate additional entry and duplication of effort.

   *Important Points to consider about e*File*:*

   - You are able to use your existing Human Resources/Enrollment (HRIS) system.
   - After you extract data from the HRIS system in a format compatible with our system, the data is electronically transferred to our enrollment system.
   - We provide flexible options for transfer frequency: daily, weekly, biweekly, or monthly.
   - Your selection of one of the four file options is driven by your group size and whether you prefer to send a full file or a file containing only changes made since the last file transmission. (A fifth option is available for Medicare files.)
   - Our implementation process is built on proven, best practices and we test to ensure the integrity of the exchange prior to going live.
   - Test files are used to ensure the highest accuracy rate (usually 90 percent or better) prior to implementation.
   - Implementation can take approximately two to four months, depending on file complexity and any programming requirements for mapping the data from your file format into our system.
   - Our *e*File options are available at no cost to you, although you may incur some programming fees to map your file format to ours.
   - Once your Account Executive or producer is alerted that you are interested in submitting an electronic file format, they will contact the Capital BlueCross Electronic Enrollment team and schedule a conference call with you to properly assess your electronic file options. During the call, the electronic staff will review all four file options (outlined on the following page) and the implementation process for each option.

Note: If your group is purchasing SHOP products, you are not able to use *e*File.

Type of File	Description	Recommended Group Size
Capital Full File	Proprietary, full file format.	Any size group
Capital Flat File	Proprietary, changes only.	Any size group
ANSI 834 Full File	Preferred government format. If the file contains required elements as defined by CMS, it is considered to be HIPAA-compliant.	Any size group
ANSI 834 Flat File	Preferred government format. If the file contains required elements as defined by CMS, it is considered to be HIPAA-compliant.	Any size group
Medicare File Format	Proprietary or ANSI 834 formats accepted; however, CMS rules must be followed.	Any Medicare group

a. **Capital Full File**—is a proprietary "full" file format. This option can be used by any size group.

- This option allows you to submit a full file.
- Our enrollment system compares data against eligibility stored for your account and automatically updates the identified changes.
- Historical data, of critical importance, is preserved. This is not a full replacement file.

b. **Capital Flat File**—This is a "changes only" proprietary file format. This option can be used by any size group.

- This option handles transactions only (i.e., you submit changes only rather than submitting a full file).
- Our enrollment system is updated based on the changes presented.

c. **ANSI 834 Full File**—This is a preferred government, HIPAA-compliant electronic data transaction alternative available to all accounts. Currently there are no group size restrictions.

- Our enrollment system compares data against eligibility stored for your account and automatically updates the identified changes.

- Historical data of critical importance is preserved. This is not a full replacement file.

d. **ANSI 834 Flat File**—This also is a preferred government, HIPAA-compliant electronic data transaction file alternative. The ANSI 834 Flat File is available to all accounts. Currently there are no group size restrictions.

- Comparable to the Capital Flat File option, this format is used to submit changes only.

- Our enrollment system is updated based on the changes you send to us.

e. **Medicare File Option**—Medicare enrollment data can be submitted electronically through an ANSI 834 file or proprietary nonstandard file. The Account Executive/producer can discuss federal requirements regarding options for electronic submission of Medicare enrollment.

To learn more about Capital's *e*File or eGEMS options, submit a request through the Employer Portal on capbluecross.com.

3. **Capital BlueCross' Group Private Exchange**—This revolutionary benefit shopping experience makes it easy for employees to enroll, and it includes an integrated backend benefit administrator tool for group administrators to manage ongoing enrollment and eligibility updates.

Through this arrangement, you select the product or products (from a list of options offered by Capital BlueCross). Employees then access the private exchange shopping site for quick, easy, one-stop shopping. Backed by a sophisticated recommendation engine, we help employees navigate the benefits decision-making process and find the right plan, based on their personal preferences, budget, and tolerance for financial risk. Side-by-side plan comparisons and access to detailed benefit summaries help employees make informed decisions. In addition to enrolling for coverage, employees can verify the dependents on their plan.

The backend integrated administrator tool supports ongoing administrative services to perform benefits enrollment and eligibility management. You have full access and control over employee enrollments—during and after each annual open enrollment period—to perform functions, such as:

- ✓ Managing new hires, family status updates, or employment status changes
- ✓ Viewing current benefits and enrollment history

With around-the-clock access to benefit information, this feature-filled administrator tool also includes a comprehensive library of employer reports (e.g., payroll deductions, enrollment summary, employee elections).

Note that groups using the Group Private Exchange are not eligible for eGEMS or *e*File submissions.

4. **Excel to Facets—**This electronic option for new employer groups allows groups to submit a full enrollment activity roster to Capital BlueCross via a predefined Excel template. The Excel file is uploaded directly to our enrollment system, known as "Facets," using the same process as *e*File. When this option is selected, an employer group is sent the blank Employee Enrollment File along with instructions to get started. The process can be facilitated by your Sales Account Executive.

   Note: This type of electronic enrollment is available to all new groups except those who will be using the eFile process.

Coverage Effective Dates

Initial and newly eligible members are effective as of the date specified by the group and approved by Capital BlueCross. Members should contact their group for details regarding specific effective dates of coverage. These requirements also are described in the group policy.

Termination of Coverage for Members

A member cannot be terminated based on health status, health care need, or the use of the Capital BlueCross adverse benefit determination appeal procedures (or the use of Keystone Health Plan® Central's complaint and grievance procedures). However, there are situations where a member's coverage can be terminated even though the group contract is still in effect.

We will process member terminations based on the effective date you specify, subject to our policies for "Life Status Changes" and "Retroactive Enrollments and Terminations." (See those specific sections in this chapter for more detail.) Keep in mind our systems apply "through" date logic, not "to" date logic. (Example—if you are terminating a member effective July 31—that member's coverage is effective through the end of that day—11:59 p.m. on July 31.)

Note: If a member was enrolled in Capital BlueCross coverage through HealthCare.gov, please report the member termination through the HealthCare.gov website.

Specifics for Enrolling Members

Things about enrollment you'll want to know that happen on a regular basis include:

Annual Enrollment Period

Generally, customers establish one time period each year when members can make enrollment or benefit plan changes. This is called an "annual enrollment" period. Your group determines the annual enrollment period that meets its business needs; however, most groups choose to obtain information about benefit changes just before the start of each benefit contract year (i.e., before Capital BlueCross benefits renew for the next year).

Annual enrollment periods help you manage your information—and ours—efficiently.

During annual enrollment periods, members may typically choose to add programs offered by your group, such as dental or vision plans.

Social Security Numbers and Replacement Identification Numbers

Identity theft using social security numbers (SSNs) is a growing national concern. For many years, companies like Capital BlueCross used subscriber SSNs on member identification (ID) cards, remittance notices, and other forms of communication. To protect member security and privacy, identification for individuals enrolled for Capital BlueCross programs is no longer based on the individual's SSN.

Members are assigned unique, randomly generated member ID numbers *not* based on the subscriber's SSN. The numbers begin with a three-character alpha prefix, followed by a nine-digit number that begins with the number "8," followed by a two-digit member suffix.

Although we have eliminated the use of a subscriber's SSN for external member identification numbers, ID cards, and other member and provider communications, it is still necessary for you to provide the subscriber's SSN when you submit enrollment information to Capital BlueCross. This information is requested to comply with federal reporting requirements, such as 1095 Tax Forms and certain Medicare Secondary Payer reporting requirements. It is also used to cross-check historical information for individuals who were enrolled when the SSN was the primary identification key. Having the SSN on file allows us to provide efficient service to your members. Please be assured Capital BlueCross takes every step necessary to protect personal health information and comply with mandated privacy standards.

Should you have any questions, please contact Group Services at **1.800.541.3742**.

Dependents

Please note the following concerning specific dependent enrollment situations:

Alternate Address for Dependents

If a spouse or dependent's address is different from the subscriber's due to a Qualified Medical Child Support Order (QMCSO), a copy of the court order is required (along with the alternate address) in order to process the address change. Have your employee submit the information to you, so you can submit it along with our application.

Note: If your Capital BlueCross coverage was purchased through HealthCare.gov, contact Group Services for direction on the changes Capital BlueCross is permitted to make for you.

If the different address is due to PA Act 150 (the Spousal and Child Medical Support Act 150 of PA), instruct your employee to contact our Customer Service Department at **1.800.962.2242** (or **1.800.669.7061** for HMO) to request the "*Subscriber Release for Direct Contact with Spouse/Adult Child*" form (NF-25). (See the *Forms and Reports* chapter of this manual for an example of this form.) Have your employee complete the form, have it notarized, and return the form to us at the following address:

Capital BlueCross
Account Administration
PO Box 772612
Harrisburg, PA 17177-2612

Note: If your Capital BlueCross coverage was purchased through HealthCare.gov, contact Group Services for direction on the changes Capital BlueCross is permitted to make for you.

Common Law Marriages

Pursuant to Pennsylvania law, only those common law marriages entered into in Pennsylvania on or before January 1, 2005 are considered valid. If the member resides in another state, a common law marriage entered into in that state may still be valid if that state recognizes common law marriage. As a Group Administrator, you must determine if a spouse is eligible to enroll in your group's coverage. However, you may be contacted by our Underwriting Department if they have any questions about a specific domestic arrangement.

Children Through Age 29

Pennsylvania legislation was passed in 2009 to expand options for insured group health insurance coverage to unmarried children until they reach age 30. This Pennsylvania law provides for additional coverage to be offered at the option of the employer, and is in effect for group policies renewing on or after December 1, 2009. Under the law, the employee may be responsible for the full cost of the coverage for the dependent.

To be eligible, the dependent child must meet the following criteria:

1. Is not married.

2. Has no dependents.

3. Is a resident of Pennsylvania or enrolled as a full-time student at an institution of higher education.

4. Is not covered under another group or individual health insurance policy or entitled to benefits under any government program.

Employers should inform Capital BlueCross at the time of their contract renewal if they wish to offer this additional coverage. You should instruct your employees to complete the *Certification for Dependent Through Age 29*, notify Capital BlueCross when an employee wants to add an eligible dependent to the policy, and submit the form along with a completed *Application to Enroll or Change Enrollment*. You are billed at the single-contract subscriber rate for the coverage of the additional dependent. If you have additional questions about this benefit, please call Group Services at **1.800.541.3742**.

Two months before the initial one-year certification expires, the dependent member is sent a *Dependent Through Age 29 Recertification Letter* to obtain updated information. Additionally, we send you a *Request for Recertification Notice and Report* listing those eligible dependents through age 29.

If the member responds that he/she is eligible, his/her certification is updated for an additional year. If the member does not respond within 60 days, you are sent a *Recertification Removal Notice for Dependent Through Age 29*—notification that the listed members have been removed from coverage. Subscriber/Member Termination Notices are sent to the removed members.

Upon the members reaching age 30, you are sent a *Notification of Dependent Through Age 29 Removal Report* explaining that the members contained on the list have been removed from coverage. Subscriber/Member Termination Notices and Enrollment Notices are sent to the removed members.

Note: If your Capital BlueCross coverage was purchased through HealthCare.gov, contact Group Services for direction on the changes Capital BlueCross is permitted to make for you.

Domestic Partners

Capital BlueCross offers coverage for domestic partners to large (enrollment of 100+ subscribers), mid-market (enrollment of 51-99 subscribers), and small groups (enrollment of 1-50 subscribers). Groups have the option to include coverage for domestic partners. Enrollment of domestic partners for group health coverage is optional and subject to qualifying criteria.

Requests to add domestic partner coverage to your Group Contract must be initiated through your Account Executive. If your group already has this benefit and you want to enroll a domestic partner, please understand that any such requests are limited to the domestic partners of eligible employees. Be sure to have your employee and his/her domestic partner complete and submit to Capital BlueCross the "*Affidavit of Domestic Partnership*" for large groups, or, for mid-market and small groups, the "*Affidavit of Domestic Partnership (Small Group)*." The employee and his/her domestic partner must sign the affidavit.

See the *Forms and Reports* chapter of this manual for examples of the "*Affidavit of Domestic Partnership*" and "*Affidavit of Domestic Partnership (Small Groups).*"

Note: If you purchased your Capital BlueCross coverage through HealthCare.gov, it is your responsibility to maintain your corporate policy on domestic partner coverage.

Note: If your group enrolled through HealthCare.gov, and your enrollment effective date is 1/1/2015 or later, all changes must be submitted through HealthCare.gov.

Disabled Dependents

Capital BlueCross uses the term "disabled dependent" to mean an unmarried child who is incapable of self-support because of physical disability, mental illness, or developmental disability.

To indicate if the dependent being added is disabled, enter disability information in the correct section of the application. If the dependent being added is age 26 or older and disabled, we send information to the subscriber to complete and return for the purpose of certifying a disabled dependent. (A portion of the form must be completed by the dependent's physician.) You will not need to discuss the dependent's status with your employee. (See the Disabled Dependent Certification section in this chapter for more information.)

Note: If you purchased your Capital BlueCross coverage through HealthCare.gov, and the employee reported a dependent over age 26 as disabled or handicapped, we will receive that information from the federal enrollment system. After receiving that information, we will send the employee a *Handicapped Dependent Certification Form* to complete and return with the necessary information.

Autism Spectrum Disorders

As of July 1, 2009, Pennsylvania law requires health insurance policies to include benefits for the diagnosis and treatment of Autism Spectrum Disorders (ASDs). ASDs are a class of pervasive developmental disorders that are characterized by impaired verbal and nonverbal communication skills, poor social interaction, limited imaginative activity, and repetitive patterns of activities and behavior. ASDs are complex and include multifaceted conditions that can be difficult to diagnose and treat.

Members under age 21 who are diagnosed with ASDs may be covered with diagnostic and treatment services, in accordance with the legislation. However, the state mandate exempts health insurance plans offered by employers with 50 or fewer employees from the requirement. Additionally, the mandate does not apply to self-insured employer (ASO) groups.

Commercial insurance coverage for ASDs provides for diagnostic assessments and treatment. Coverage is subject to copayments, deductibles, and coinsurance provisions in the same way as other covered services. Treatment for ASDs must be identified in a treatment plan and reviewed prior to the authorization of services. Members whose health insurance benefits do not include treatment for ASDs may continue to be eligible for coverage under Pennsylvania's Medical Assistance Program, administered by the Pennsylvania Department of Human Services. For additional information, please refer to www.dhs.pa.gov/. If you have questions about your covered benefits, please call Group Services at 1.800.541.3742.

Ward Certification (This applies to Standard [Small] Groups Only)

A ward is a child for whom an adult (other than a parent) has been court appointed as a legal guardian.

Sometimes the relationship between a child and a subscriber is not clear. In these cases, more information is required to make a decision on whether a child can be included as a dependent on a subscriber's contract.

We keep it simple for you and send out a "*Ward Certification Letter*" for the subscriber to complete and return to us. When we receive the letter, the information helps us to determine whether the child is a ward. We will send the subscriber and the group written notification of the decision.

An example of the "*Ward Certification Letter*" is found in the *Forms and Reports* chapter.

Note: If you purchased your Capital BlueCross coverage through HealthCare.gov, and your employee reported a dependent as a "ward," that information will be sent to us through the federal system.

Dependents on Medicare

Encourage the members of your group to notify you when they become eligible for Medicare based on End Stage Renal Disease (ESRD) or entitled to Medicare based on age or disability. Please notify us as soon as you learn of any Medicare eligibility or entitlement (or changes in such) not previously reported.

(Refer to the Medicare Secondary Payer Laws section of this chapter for further information.)

Note: If your group enrolled through HealthCare.gov, and your enrollment effective date is 1/1/2015 or later, all changes must be submitted through HealthCare.gov.

Newborns and Adopted Children

Newborn children are covered under a subscriber's contract for up to 31 days after the birth of the child as provided under Pennsylvania state law Act 81, but **they are not automatically added to a subscriber's contract.** Notify us of the addition of a newborn as soon as possible but no later than 60 days after birth to ensure continuous health care coverage.

If we receive claims for an Act 81 newborn, he/she is given 31 days of eligibility as required by law. However, when you report the newborn as an addition to a subscriber's contract, the contract type will be changed and billing adjustment made back to the child's date of birth.

Your members must enroll newborns or adopted children within 60 days after they arrive. If the child is not added within 60 days, the enrollment cannot be added to your group coverage until your group's next annual enrollment period date. (You will be notified of the denial.)

Always report the addition of a newborn, even if there is no rate change in billing (e.g., if the contract is already a "family" contract with children).

If the contract is not for family coverage until the birth of the newborn, payment for family coverage is necessary retroactive to the billing period for the month in which the child was born, provided enrollment was submitted within 60 days of the birth.

- If the dependent child is born in the time period from the first of the month through the fifteenth of the month, your group is billed for the rate change (if applicable) for the entire month in which the child is born.

- If the dependent child is born in the time period from the sixteenth of the month through the last day of the month, your group is billed for the rate change (if applicable) as of the first of the following month in which the child is born.

Note: If your group enrolled through HealthCare.gov, and your enrollment effective date is 1/1/2015 or later, all changes must be submitted through HealthCare.gov.

Coverage for Children to Age 26

The Patient Protection and Affordable Care Act (PPACA) requires coverage for children up to age 26, regardless of the marital or student status, residence, or financial support. This provision does not cover grandchildren. Capital BlueCross implemented this provision on June 1, 2010, for children who were enrolled under their parent's coverage on that date.

Students

Note: The following section applies, on a group-by-group basis, to large, fully-insured or ASO group nonmedical products, as dependent medical coverage is protected until age 26 under the health care reform law.

Capital BlueCross uses the term "full-time student" to mean an unmarried child, age 19 or older, who attends an accredited university, college, technical, or specialized school on a full-time basis who is eligible for coverage to the age specified in your group contract. Our definition also includes individuals defined by Pennsylvania Act 83 (i.e., full-time students who return from military deployment).

If a dependent is 19 years of age or older, a full-time student (either enrolled or in a medical leave of absence), and your group's benefits allow for student coverage, complete the Student Information section of the application. Enter the student's name, the name of the school, and the expected date of graduation. This information is used to provide full-time student status during eligibility and claims processing for the period of a year. After that time, we generally send information to the subscriber to complete and return to us to verify the student for an additional year. (See more information in the Student Dependent Verification section of this chapter.)

Members With Other Coverage

It is important that we keep accurate records for each member regarding other health care coverage they may have.

If any member has health care coverage with any other Blue plan or another insurance company, the subscriber must complete the Other Insurance Coverage section of the application form.

We use this information to coordinate benefits between insurers in accordance with your group contract.

If any member has Medicare coverage, the subscriber must complete the Medicare Coverage Information section of the application form. (Refer to the Medicare Secondary Payer Laws section of this chapter for further information about coordination of benefits with Medicare.)

We will use this information to assist you in determining whether a product selection is appropriate for a Medicare-eligible/entitled member, consistent with the Medicare Secondary Payer Laws.

What if Someone Doesn't Want to Enroll?

If your group benefit policies allow employees to not enroll in one or more programs you offer, that employee should complete and sign a "*Waiver of Group Health Insurance Coverage*" form. You may submit it with your other enrollment paperwork. (Please note: Most groups have participation requirements as part of their agreement with Capital BlueCross. We have provided more information about Participation Guidelines later in this chapter.)

It is important to remember that the Medicare Secondary Payer Laws prohibit an employer or group from offering Medicare beneficiaries financial or other incentives not to enroll in, or to terminate enrollment in, a group health plan that is, or would be, a primary payer to Medicare.

Changing Enrollment Information

Your employees may use an "*Application to Enroll or Change Enrollment*" form to report enrollment changes, as well as the addition of new members (e.g., newborns). This form also can be used to report termination of enrollment. The completed forms should be sent to the address listed on the form. **Please remember to complete the "Group Information Block" of the application each time an application is submitted to ensure our group information remains current.**

As the Group Administrator, you should examine the application and verify that all information is accurate and complete before sending it to us. Missing or inaccurate information can cause delays in processing, and we may have to return the form to you for more information. Please make sure your employee signs the application containing updated information. Unsigned applications will be returned for a signature.

Note: If your Capital BlueCross coverage was purchased through HealthCare.gov, contact Group Services for direction on the changes Capital BlueCross is permitted to make for you.

The effective date of the change may be the same as the date of the change itself (e.g. the date of a marriage, birth, or adoption), as long as it is submitted to us within 60 days of the event.

If change information is received more than 60 days past the event, the change cannot be made to your group coverage until your group's next annual enrollment period date. (You will be notified of the denial.)

New ID Cards are sent to the subscriber/member in the event a change is made to the member's name, identification number, or group/subgroup ID. (See the *ID Cards and Products* chapter in this manual for more information.)

Be sure to complete the "*PlusBilling Form*" to summarize your changes or terminations. Keep a copy for your records so you can quickly check that all changes have been made when you receive your Capital BlueCross bill.

If reinstating a group member, be sure to indicate "reinstate" on the application and enter the appropriate Life Status Change Code from the back of the application.

If your group cancels coverage with us, we will accept enrollment changes for only 31 days after the group cancellation date.

If you have any questions about how to make changes, or if a change qualifies as a "Life Status Change," contact Group Services at **1.800.541.3742** or contact us on the web at capbluecross.com/ContactUs/E-mailCustomerService/Employer+Secure+Communications.

Updating Information Affecting Coordination of Benefits (COB) with Medicare

From time-to-time, changes in member or group status may occur that impact the proper COB under the Medicare Secondary Payer Laws. This could happen, for instance, if the member retires or if your company expands its number of employees.

It is important that you inform us promptly of any change in group or member status that may affect the proper order of benefits under the Medicare Secondary Payer Laws.

Failure to do so could result in improper claims adjudication, the need for subsequent claims adjustment, and/or receipt of Medicare Secondary Payer demand letters by the employer or group. (If Medicare inadvertently pays for claims that should be charged to the insurer, Medicare creates "demand letters" demanding the amount overpaid and sends them to the claim beneficiary.)

For additional information, see the MSP demand letter and recovery process discussion in the Medicare Secondary Payer Laws section in this chapter, or, see the online information at cms.gov/MLNProducts/downloads/OverpaymentBrochure508-09.pdf. To report MSP-related changes, use the "*MSP Status Form*" available by contacting Group Services at **1.800.541.3742**.

Note: If your group enrolled through HealthCare.gov, and your enrollment effective date is 1/1/2015 or later, all changes must be submitted through HealthCare.gov.

Annual Solicitation of Employer Size Information

Capital BlueCross requests employer size information from your group on an annual basis. By taking a moment to answer a few short questions, you can help us ensure our information is accurate and avoid potential claims processing. (Please see the Medicare Secondary Payer Laws section in this chapter for an explanation of the importance of accurate employer size information for proper coordination of benefits with Medicare.)

We also request employer size information to comply with the requirements of the federal health care reform law. (See "Collecting Employer Information" section later in this chapter.)

What is a Life Status Change?

We can't stress enough the importance of sending us enrollments or changes within 60 days of the date of a change in enrollment "event." We call these important transitions "Life Status Changes."

We define Life Status Changes as:

1. If a subscriber:

    a. Marries and as a result adds the spouse to the subscriber's coverage.

    b. Has a child, adopts or places a child for adoption, acquires a stepchild, or becomes legal guardian of a child.

Remember to send us an application to add newborns to a subscriber's contract. They are not automatically added!

    c. Divorces or separates and as a result no longer has coverage through the spouse.

    d. Moves into the Capital BlueCross 21-county service area.

e. Has a change in employment status (e.g., from part-time to full-time, hourly to salary, union to nonunion).

f. Reinstates terminated coverage (from a leave of absence, layoff, etc.)

2. If a subscriber or subscriber's dependent has a change in Medicare primary status (e.g., Medicare coverage becomes the member's primary insurance due to subscriber's retirement).

3. If a subscriber or subscriber's dependent loses coverage under another benefit plan, including Medicaid or Children's Health Insurance Program (CHIP).

4. If a subscriber's dependent becomes eligible to be reenrolled under the existing coverage due to a change in student status.

5. If a subscriber's dependent becomes eligible for coverage due to a Qualified Medical Child Support Order.

6. If a subscriber experiences the death of a dependent and requests to change coverage resulting in a contract "type" change (e.g., due to the death of a spouse, a family contract now changes to "Subscriber and Dependents," or "Subscriber and Spouse" changes to "Subscriber Only").

7. If a spouse or dependent loses his/her coverage due to the death of the subscriber (e.g., surviving spouse).

   In the event the surviving spouse or dependent(s) elect COBRA coverage, they would enroll as COBRA continuants as mentioned under "Eligibility to Enroll."

   Widows/widowers (working or retired) are permitted to retain coverage if this is your group's policy. (Please notify us in writing if this policy applies to your group.)

Requests for consideration of exceptions to the Capital BlueCross Life Status policy can be made using the "Request for Exception to Life Status Change Policy" form. A sample of this form is found in the *Forms and Reports* chapter of this manual.

Note: If your Capital BlueCross coverage was purchased through HealthCare.gov, contact Group Services for direction on the changes Capital BlueCross is permitted to make for you.

Retroactive Enrollments and Terminations

You can request the enrollment of a new employee, the addition of a spouse or a dependent from an existing contract, the termination of a contract, the removal of a spouse or a dependent to an existing contract, or the removal of a product (e.g., dental, vision) on a retroactive basis.

Enrollment and enrollment changes (including terminations) are accepted for a period of up to 60 days prior to the month the enrollment or enrollment change is received. Retroactive enrollment, enrollment changes, and terminations may be denied under certain circumstances.

For example: If you tell us in March to cancel coverage for someone, March 1 becomes the "determination date," and a termination may be effective January 31 of the same year or December 31 of the previous year. In the event of a death, termination of a contract (or removal of a spouse or dependent) becomes effective the first billing date after the date of death. There are certain exceptions. For example, if your group reports a deceased subscriber who has active dependents remaining on the contract, the retroactive period is limited to 60 days.

Capital BlueCross shall permit retroactive terminations of members that do not violate the rescission provision of the Patient Protection and Affordable Care Act (PPACA) for a period not to exceed sixty (60) days prior to the date on which Capital BlueCross received notice of such termination. By submitting a retro-termination, the contract holder represents and warrants that no member contribution for health coverage cost was obtained from the member for the period of time that relates to the retro-termination period. The contract holder shall indemnify and hold Capital BlueCross harmless for any retro-terminations of members' coverage.

COBRA continuants are protected by federal regulations and, therefore, may require exceptions to the 60-day retroactive time limit.

Note: If your group enrolled through HealthCare.gov, and your enrollment effective date is 1/1/2015 or later, all changes must be submitted through HealthCare.gov.

Group Termination

Capital BlueCross Group termination policy requires that a group notify us of the request in writing prior to the requested termination date, according to the following guidelines:

- For small and mid-market groups, send the request ten (10) working days prior to the requested termination date.
- For large groups, send the request thirty (30) working days prior to the requested termination date.
- For Administrative Services Only (ASO)/Self-Funded groups, send the request ninety (90) working days prior to the requested termination date.

If we have not been notified in a timely manner, the termination effective date will be effective as follows:

- For a request received from the first through the fifteenth of the month, termination will be the last day of the current month
- For a request received from the sixteenth through the end of the month, termination will be the last day of the next month.

Note: If you purchased your Capital BlueCross coverage through HealthCare.gov, please log in to your HealthCare.gov account and report the group termination there.

Changing Coverage to Medicare Complementary

To enroll in (or change enrollment to) Medicare Complementary coverage, we need certain basic Medicare information, including the hospital insurance effective date (Medicare Part A), medical insurance effective date (Medicare Part B), and Medicare Claim Number entered in the Medicare Coverage Information section of our application. (All of this information is found on the member's red, white, and blue Medicare Card.)

We also need to know the reason for the Medicare coverage (i.e., age, disability, and/or ESRD), the subscriber's employment status, and the employer size. It is essential that the subscriber fully completes the Medicare Coverage Information section on the application form, and that you complete the "Group Information Block" on the form. This information allows us to assist you in determining whether this type of coverage is appropriate for the particular Medicare-eligible/entitled member, consistent with the MSP laws.

Note: Remember, if you purchased your Capital BlueCross coverage through HealthCare.gov, please have the employee log in to his or her HealthCare.gov account and report the termination of the under 65 coverage. The employee should then obtain Medicare coverage from the federal government through Medicare.gov.

To enroll in a Medicare Complementary program, the member must be enrolled in both Medicare Part A and Part B and have a Medicare Claim Number. If the member discontinues coverage in either Part A or Part B, he or she is not eligible to remain enrolled in the Capital BlueCross Medicare Complementary program.

Make sure the member has checked the appropriate boxes indicating the reasons for Medicare coverage.

Remember to indicate in the "Group Information Block" whether your company employs 20 or more employees under the MSP laws and whether your company employs 100 or more employees under the MSP laws. It is important to answer both questions based on the application instructions for counting employer size. (Refer to the Medicare Secondary Payer Laws section of this chapter for further information.)

What to Do If Your Group Hasn't Chosen a Medicare Complementary Product

Sometimes when groups first enroll for Capital BlueCross coverage, they do not have any members eligible for Medicare, so they do not select a Medicare Complementary product option. If you find you now need a Medicare Complementary program, your group decision maker should contact your group's Account Executive. We will quickly work with you to assist in finding which of our Medicare Complementary Programs meets your group's needs.

Some groups choose not to offer Medicare Complementary programs to employees and their dependents. If your group does not offer this type of product, Capital BlueCross has individual programs available to those members who are enrolled in Medicare Parts A and B.

Members should contact our member complementary sales area at 1.888.732.4968 or Consumer Market Customer Service at 1.800.730.7219 to receive information and an application for such programs.

Keeping Track of Your Members

We have ways to help you keep track of what's happening to the enrollment of your members on a regular basis. The most common processes and situations are described on this page:

Note: If your Capital BlueCross coverage was purchased through HealthCare.gov, contact Group Services for direction on the changes Capital BlueCross is permitted to make for you.

PlusBilling Form

The "*PlusBilling Form*" is a two-part form we provide to help you report and track your group changes. You should routinely retain copies of PlusBilling forms you send us and compare the forms to your billing statements to ensure all requested changes have been processed. See an example of a "*PlusBilling Form*" in the *Forms and Reports* chapter of this manual.

Age 65 Notification

We notify you approximately four months in advance of the month in which a member is turning 65. Our advance notice allows you to determine what changes may be needed and to update the member's information concerning appropriate group coverage when the member becomes eligible for Medicare.

We send you a "*Medicare Eligibility Notice*" letter and "*Members Approaching Age 65 Report*" to provide the following information about the member approaching age 65:

1. The subscriber's name, subscriber ID, and address.

2. The name and birth date of the member approaching age 65.

3. Information related to your group/subgroup and the product applicable to the contract as of the date the report is produced. (This is "internal" information we use.)

We also send a notice, the "*Overage 65 Notification*" letter, to the subscriber approximately four months in advance of the member reaching age 65. This letter provides information about the member's eligibility for Medicare coverage. If your group does not want letters mailed to your subscribers, please contact your Account Executive.

Certain federal regulations govern health care coverage for employees age 65 or older. The Age Discrimination in Employment Act (ADEA) pertains to employees age 40 or older and applies to companies employing 20 or more people. The MSP laws also govern the working aged (i.e., active employees age 65 and over and/or the spouses of active employees who are age 65 and over). See the Medicare Secondary Payer Laws section of this chapter for important information determining correct health care program enrollment.

Capital BlueCross permits groups to offer commercial coverage that is primary to Medicare according to federal law. Otherwise, a Medicare-eligible member must enroll in a group or individual programs specifically designed to complement Medicare coverage.

If we discover a member enrolled in one of our Medicare Complementary Programs does not have both Medicare Part A and Part B, you are notified and the member's coverage is terminated. If the individual obtains both Part A and Part B again, he/she may be reenrolled in group programs with Medicare Complementary coverage for up to 60 days retroactively.

- **If your company employs fewer than 20 people** (as calculated under the MSP laws), the individual reaching age 65 must enroll for Medicare benefits (even if employed) and convert to one of our Medicare Complementary programs, if offered by your group. A member age 65 or over employed by a group with fewer than 20 employees is not eligible to remain on basic group health care coverage.

- **If your company employs 20 or more people** (as calculated under the MSP laws), record those actively employed on the "*Application to Enroll or Change Enrollment*" (or other approved enrollment document used by your group), and return it to us. These members remain on the same coverage they had as active employees (group primary).

If we do not receive a response to the "*Members Approaching Age 65 Report,*" the member's coverage may possibly be terminated or claims rejected.

COBRA Continuants

When an individual continues carrying your group coverage as a COBRA continuant, you should use the application form to tell us the individual is a COBRA continuant. You (or the group's COBRA administrator) are responsible for billing and collecting monthly premium from the COBRA continuant. A brief summary of COBRA regulations is found in the Policies and Regulations section of this chapter.

Disabled Dependent Certification

When enrolling a disabled dependent (or when a currently enrolled dependent becomes disabled), your member should provide the following information on the application form:

1. Enter the name of the disabled dependent in the Handicapped Dependents section of the application.

2. If the disabled dependent is enrolled for Medicare coverage, enter the Medicare Claim Number, the Medicare Part A and Part B effective dates, and the reason for Medicare entitlement (e.g., disability) in the Medicare Coverage Information section of the application. If there is no Medicare coverage, write "No Medicare" in the "Medicare Claim No." space. If information is not provided, we will assume there is no Medicare coverage.

Disability information can also be sent to us on the "*Overage Dependent Terminations*" Report by writing "Disabled" next to the disabled dependent's name.

Note: If you purchased your Capital BlueCross coverage through HealthCare.gov, and the employee reported a dependent over age 26 as disabled, we will receive that information from the federal enrollment system. After receiving that information, we will send the employee a *Disabled Dependent Certification Form* to complete and return with the necessary information.

When a subscriber/member indicates a member is disabled, we send the subscriber a "*Handicap Certification Cover Letter*" and "*Handicap Dependent Certification Form.*" (The letter contains instructions for completion of the "*Handicap Certification Form.*") Examples of both forms are found in the *Forms and Reports* chapter.

When the subscriber receives the "*Handicap Dependent Certification Form,*" Section I is to be completed by the subscriber, and Section II is to be completed by the attending physician. (We require the Section II information be completed by an M.D. or a D.O.)

When the Handicap Form is returned to us, our Clinical Management medical personnel review the physician's information and approve or reject the application. If approved, the disabled dependent is added to the contract and you and the subscriber are notified of the approval.

If not approved, the dependent is not added to the contract, and you and the subscriber are notified. The dependent is offered an Individual Products (nongroup) Enrollment Notice.

Our Clinical Management Department may review the disability status as appropriate to the medical condition and request recertification on a periodic basis.

If a dependent child has a physical or mental disability and is eligible for Medicare benefits, please refer to the Medicare Secondary Payer Laws section of this chapter.

If you have any questions about disabled dependent enrollment, contact Group Services at **1.800.541.3742** or contact us on the web at capbluecross.com/ContactUs/E-mailCustomerService/Employer+Secure+Communications. If your employees have questions relating to this topic, refer them to our member Customer Service Department at **1.800.962.2242** (**1.800.669.7061** for HMO members).

Overage Dependents

We notify you in advance of a child on a contract reaching the age when he or she no longer qualifies for coverage under your group's Plan. This usually occurs approximately two months before the dependent's birth date. We do this in advance to allow you time to determine what changes may need to be made to ensure continuous health care coverage for an eligible dependent child.

We send you a "*Notification of Dependent Removal*" cover letter and "*Overage Dependent Terminations Report*" to provide the following information about the member approaching the group's limiting age:

1. The subscriber/member's name, subscriber ID, and address.

2. The name and birth date of the dependent child being removed.

3. The effective date for the removal (i.e., the termination date) of the dependent child.

4. Additional information shown on the report relates to group/subgroup information and the product(s) applicable to the contract as of the date the report was produced by our system files. (This is "internal" information we use.)

We also send notification to the subscriber approximately two months in advance of the member reaching the limiting age in an "*Overage Dependent Information Letter.*" The letter provides information regarding continuation of benefit options available for the member. If your group does not want letters mailed to your subscribers, please contact your Account Executive.

Unless we are notified otherwise, the dependents listed on the "*Overage Dependent Terminations Report*" are removed from your group's contract on the termination date shown. If we are not notified within 60 days of the date of the "*Overage Dependent Information Letter,*" the overage dependents are not permitted to reenroll until your group's next annual enrollment period.

In order to ensure continuation of coverage for an eligible dependent child, it is important that you notify us immediately about any dependent child who is to continue coverage on a contract.

If the dependent was a full-time student (or a student on a medical leave of absence) on the date he/she was removed from the contract, or will be a full-time student for the next scheduled school session and attendance is broken only for school vacations or summer breaks, the dependent should continue coverage on the contract effective the **same** date as the termination date shown on the "*Overage Dependent Terminations Report.*" (This applies to large, fully-insured or ASO groups on a group-by-group basis.)

A dependent child being removed is not eligible for group health benefits as of the termination date noted on the "*Overage Dependent Terminations Report.*" An Individual Products (nongroup) Enrollment Notice is offered to overage dependents not eligible for coverage as handicapped or student dependents.

If you have any questions about how to make overage dependent enrollment changes, contact Group Services at **1.800.541.3742** or contact us on the web at capbluecross.com/ContactUs/E-mailCustomerService/Employer+Secure+Communications.

Student Dependent Verification

Note: The following section applies, on a group-by-group basis, to a large, fully-insured or ASO group, only until the group implements the new Federal Health Care Reform Law providing coverage for children up to age 26.

If a dependent is 19 years of age or older and a full-time student (or a student on a medical leave of absence), and your group's benefits allow for student coverage, send us this information on the application form or write it on the "*Overage Dependent Terminations Report.*" Send us the student's name, the name of the school, and the expected date of graduation. This student dependent verification is valid for one year from either the effective date for adding the member, or the effective date for the member's student status eligibility. (To "verify a dependent as a student" means to confirm eligibility for group health care benefits.)

Approximately two months before the initial student one-year verification expires, we send the subscriber a "*Student Reverification Letter*" to obtain updated student information. If we do not receive a response from the subscriber after sending this letter, the dependent about to be removed from your group appears on a "*Students Terminated From Reverification Process Report.*" This report is produced monthly and sent to you along with a "*Reverification Removal Notice*" cover letter.

When the subscriber responds to the "*Student Reverification Letter,*" we reenter the student information provided for the dependent and the student status is verified for another year.

It is important that you encourage the members of your group to notify you of any change in student status (i.e., graduation, marriage, withdrawal from school, or a change from full-time to part-time student status).

If we receive information on a change of status directly from a member, we notify you so you can update your records accordingly. We send you an "*Ineligible Student Notification Letter*" when we are notified that due to a change in status, a dependent child is no longer eligible for coverage.

Capital BlueCross provides coverage for full-time student dependents up to age 25 for all small- and mid-market groups (2-99 enrolled subscribers). Large groups retain their current student age election upon renewal, unless otherwise requested.

Act 83 (Extension of Health Insurance Benefits for Certain Military Personnel)

In 2006, legislation was enacted to add a provision to extend health insurance coverage for returning Pennsylvania National Guard and Reserve Component of the Armed Forces of the United States soldiers/airmen who, prior to their military service, had health insurance coverage issued in Pennsylvania and were full-time students at institutions of higher learning at the time of military deployment.

In order to qualify, returning soldiers/airmen must:

- Be a member of the PA National Guard or a Reserve Component;
- Be ordered to active duty for 30 or more consecutive days;
- Be a full-time student at time of deployment who is eligible for coverage under his/her parents' health insurance program issued in Pennsylvania;
- Reenroll as a full-time student for the first term beginning 60 or more days after release from active duty; and
- Submit the required documentation (Blank forms are available through the Pennsylvania Department of Military and Veteran Affairs (DMVA). Samples of these forms are contained in the Forms and Reports chapter of this manual):
    - Notification to Insurer of Placement on Active Duty (DMVA Form 83-1)
    - Notification to Insurer of Completion of Active Duty (DMVA Form 83-2)
    - Notification to Insurer of Re-Enrollment as Full-Time Student (DMVA Form 83-3)

Employees No Longer Eligible for Coverage

When an employee leaves your company, you need to notify us that group coverage for that individual is ending. Depending on the size of your group, the employee (and/or his or her dependent[s]) may be eligible to continue group coverage as a COBRA continuant. However, we suggest that when an employee terminates, you notify us to cancel your group coverage for that individual immediately. If an individual qualifies as a COBRA continuant, we will process that information when you send it to us and adjust enrollment appropriately.

ALWAYS cancel a terminating employee's coverage immediately, so our participating providers will know who is/is not eligible for coverage.

Note: If you purchased your Capital BlueCross coverage through HealthCare.gov, please have the employee log in to his or her HealthCare.gov account to terminate coverage. The employee is now able to enroll in other coverage, and the federal system will transmit the termination to us.

Individual Products (Nongroup) Enrollment

When the termination of any member (subscriber, spouse, and/or dependent) on your group is reported to us as an enrollment change, we may offer the member the opportunity to enroll in Individual Products coverage. Questions about Individual Products can be answered by our member Customer Service Department at **1.800.730.7219** or contact us on the web at capbluecross.com/ContactUs/E-mailCustomerService/Employer+Secure+Communications.

Some important points to remember include:

- The coverage offered provides continuous coverage for the member as long as we are notified in a timely manner and premiums are paid by the due date.
- The member may receive an "Individual Products Enrollment Notification" (a copy of this document is contained in the Forms and Reports chapter).
- PPACA (health care reform) compliant Plans (HMO, PPO, and CareConnect℠) as well as short term products are available on an Individual Basis. However, no new enrollment is permitted into the PersonalBlue℠ products.

- Vision and Dental coverage is available for Individual Product subscribers. They may be purchased through capbluecross.com or by calling **1.800.451.1181**.

- If there is a question about COBRA, please see the COBRA section of this chapter.

If your group cancels Capital BlueCross health care coverage in order to obtain other health insurance, we do not generally offer Individual Products enrollment privileges to any of your group's members.

Employers May Not Pay Individual Premiums

As the employer, you cannot pay the cost of individual health insurance premiums for your active employees. Such action may violate several laws, including, but not limited to, ERISA (Employees Retirement Income Security Act), MSP (Medicare Secondary Payer), ADA (Americans with Disabilities Act), and ACA (Affordable Care Act).

Capital BlueCross will reject payment from an employer for an individual policy for an active employee if we know or have reason to believe such payment violates a federal or state law, statute, regulation, or rule.

Information About Enrollment Policies and Regulations

COBRA

> *This information advises you of the existence of COBRA and your obligation to comply with the requirements of that federal law. NOT all requirements pertaining to COBRA regulations are included in this manual. Additional questions on COBRA and further explanation of the law should be referred to your legal counsel.*

If your company employs 20 or more employees, the federal Consolidated Omnibus Budget Reconciliation Act of 1985, called COBRA, requires that you notify employees and their dependents of their right to continue health care coverage for a limited period of time following a qualifying event. Employees may receive up to 18 months of coverage. Dependents may receive up to 36 months of coverage. A qualifying event is one which might cause a subscriber or a dependent to lose his or her health care coverage.

Qualifying events may include:

- The employee's death.
- Voluntary or involuntary termination of the employee's employment (other than for gross misconduct) or reduction in hours.
- Divorce or separation of the employee.
- The employee's entitlement to Medicare benefits. (This only qualifies the spouse and/or dependent child for COBRA.)
- A dependent ceasing to be a dependent under the applicable provisions of the Certificate of Coverage for health care.
- The employer's commencement of bankruptcy proceedings under Chapter 11 of the United States Code.

You must notify every COBRA-eligible person of his or her right to continue health care coverage at the time coverage first begins and within specific time limits after a qualifying event, as provided in COBRA regulations. As an employer, you are responsible for becoming familiar with these and other required steps contained in the law. Also, when the time period is up for the employee/dependents, you must send us termination information to terminate coverage for the employee/dependent(s).

In accordance with federal law, groups with fewer than 20 employees cannot continue an individual's health care coverage as a COBRA continuant. COBRA is only offered as an interim insurance until the eligible person's qualifying event concludes or the coverage period ends.

Mini-COBRA

Pennsylvania Act 2 of 2009 ("Mini-COBRA") requires small groups with 2-19 employees to offer health care continuation coverage to qualified employees and dependents who lose their insurance as a result of a qualifying event. (The extended coverage extends to medical and drug coverage only.)

If you have questions about mini-COBRA, more information is available at https://www.capbluecross.com/wps/wcm/myconnect/cbc-public/cbc/employers/findgroupplan/small-group/health-plans/minicobra or call Group Services at **1.800.541.3742**.

Health Care Reform

Helping You Understand Health Care Reform

Since the enactment of the Patient Protection and Affordable Care Act (PPACA)—the legislation commonly referred to as health care reform—Capital BlueCross has worked to ensure our customers and members understand how the law impacts them and how their Plans and coverage are affected. We look forward to continuing this necessary and important work as part of our charge to serve you and your employees.

The health care reform law will continue to change many aspects of the way companies like Capital BlueCross do business. As a result, it will bring about a number of changes for our employer groups as well.

While our initial focus centered on early reforms such as zero-cost share preventive care and grandfathering, our efforts have widened to now include additional and equally significant measures. Certainly, a considerable amount of work remains to fully implement all the provisions. Rest assured we will continue to be here to lead you through the complexities of the law while providing you and your workforce with the best resources possible. For more information on how health care reform affects employers, see capbluecross.com.

Medical Loss Ratios

Very generally, the **medical loss ratio (or MLR)** is a measure of how much of each premium dollar received from individuals or groups is used to pay for health care services and clinical quality efforts.

Many different factors can impact MLR levels. For example, Capital BlueCross has served as the so-called "insurer of last resort" in the individual market, making "guaranteed issue" products available regardless of health status. Because of the special needs of the population being served, the MLRs for these products can be higher than that of other individual products. The MLRs for our other products also can vary significantly from year to year because health care services are subject to fluctuating patterns of use and health conditions, such as flu outbreaks.

The definition of MLR under the new health care reform law, which is contained in an interim rule issued December 2010, is complex. For example, there are adjustments for taxes and fees as well as other factors such as risk adjustment and reinsurance. Also under the law, the MLR is to be calculated separately by state, company, and by product line.

Rebates and Administrative Requirements

The health care reform law sets minimum MLR requirements: 85 percent in the large group market (at least 101 employees) and 80 percent in the small group (at least one, but no more than 100 employees) and individual markets. Insurers that do not meet these minimum standards must provide rebates directly to group policy holders. For certain church groups, rebates may be provided directly to enrollees.

Collecting Employer Information

We request that employers report specific information to Capital BlueCross, such as:

- Your federal tax identification number, the W-9 federal tax name of your company, and your W-9 federal tax classification.

- Your group size—determined by the average number of individuals employed by your company during a specific calendar year.

- If you are governed by ERISA (Employee Retirement Income Security Act of 1974); if you are a nonfederal governmental plan (e.g., commonwealths, municipalities, and counties); or if you are a nongovernmental, non-ERISA plan (e.g., a church plan).

Note: Self-insured groups and the following products and programs are **excluded** from the MLR regulation: the Children's Health Insurance Program (CHIP), Short Term Major Medical, Medicare, stop loss, life, long- and short-term disability, dental, vision, and flexible spending accounts.

A prompt response by groups is necessary because if rebates are due, we cannot issue them to you without the information listed above.

We collect the required information in this way: We contact you (groups) by letter or email, asking you to visit the Employers Web Portal (capbluecross.com/wps/wcm/connect/cbc-public/cbc/employers) and under "Reporting," click the link for MLR Questionnaire to complete the questionnaire and supply the necessary MLR information. Once all the information is collected, we will calculate rebates, if due, and issue payments to eligible groups by the next U.S. Department of Health and Human Services (HHS) deadline.

Retroactive Terminations

Ideally, when an employee leaves a group, Capital BlueCross is notified promptly and the amount of the employer's premium payment is adjusted appropriately in advance of the next scheduled payment. However, we are routinely asked to retroactively adjust premium payments to reflect prior employee departures, in some cases many months after the employee's employment ended. Another interim rule impacts our ability to accommodate these types of requests from employer groups going forward.

This results from a new and expanded definition of "rescission." Rescissions now generally include any cancellation or discontinuance of coverage that has a retroactive effect, except to the extent the cancellation or discontinuance is attributable to a failure by the employee or employer to timely pay required premiums or contributions toward the cost of coverage. Such rescissions are now covered by a process for appeals and external reviews, which allows a member to pursue a disputed retroactive termination through the appeals process.

The Practical Effect

If we receive requests for retroactive terminations and premium adjustments, we ask our groups for appropriate assurances to the effect that no contributions of any funds for health care coverage have been obtained from any employee for any period beyond the date of termination of the employee's coverage. This information rests solely with our group customers and is not independently verifiable by us. We changed our procedures to require notification of requested retroactive terminations from our groups within a 60-day window (although we will continue to allow groups the ability to retroactively terminate in the case of fraud or misrepresentation). Our applications, group policies, administrative manuals, and group invoices were revised to reflect these requirements.

Employer Mandate

Employers with 50 or more full-time employees and full-time equivalent employees are required to offer and fund specific levels of health care coverage or face financial penalties. This part of the health care reform law is known as the "Employer Mandate."

We encourage you to continue checking our online health care reform portal at capbluecross.com/wps/wcm/connect/cbc-public/cbc/healthcarereform for updates, reform basics, and video overviews.

Essential Health Benefits

Essential Health Benefits, a cornerstone of health care reform, are a set of health care services that must be covered by small group (2-50 employees) and individual health plans. All of our Individual and Small Group products contain all the Essential Health Benefits. Large groups (51 or more employees) are not required to offer these benefits, but if they do, no annual or lifetime dollar limits may be applied to them.

Essential health benefits include:

- Ambulatory patient services
- Chronic disease management
- Emergency services
- Hospitalization
- Laboratory services
- Maternity and newborn care
- Mental health and substance abuse disorders services
- Pediatric oral (dental) and vision care
- Preventive and wellness services
- Rehabilitative services and devices

For more information on how health care reform affects employers, go to capbluecross.com.

Rate Calculation

Under the health care reform law, small groups are defined as those having fewer than 51 employees. Beginning in 2014, at the start of a fully-insured small group's plan year, all health insurers are required to use a common rate calculation method. The premium rates for these group members may vary based solely upon three factors: the group's physical location (county), along with the age and tobacco use status of each covered member. In addition, for rating purposes, families can only be charged for a limited number of children under age 21.

This means every person covered by the group, including dependents, will likely have a different rate. For families, those rates will be added together to determine the rate for the entire family. As a result, each covered employee will be listed with his or her unique rate calculated on the monthly premium statement. Also, the addition or removal of a dependent will immediately impact the subscriber's total rate and the group's rate on the group's next monthly bill.

Plan Mining—Metal Levels

Under health care reform, individual and small group products (2-50 employees) are designated Bronze, Silver, Gold, and Platinum. These "metal levels" reflect the actuarial value of the plan and are intended to allow for an easy comparison of plans with similar value.

Actuarial value is the ratio of total expected payments by the plan for essential health benefits (EHB) after cost-sharing features—such as deductibles, coinsurance, copayments, and out-of-pocket limits—to the total costs of EHB group members are expected to incur.

For example, a health plan with an actuarial value of 80 percent would be expected to pay an average of 80 percent of a standard population's expected medical expenses for EHB. Individuals covered by the plan would then be expected to pay the remaining 20 percent in the form of cost-sharing, such as deductibles and copays.

The government categorized these plans into metal levels, which are defined in the following table:

Metal Level	*Actuarial Value*
Bronze	60%
Silver	70%
Gold	80%
Platinum	90%

Women's Preventive Care

The Affordable Care Act requires women's preventive care covered with no member cost share. Among the services required to be covered are well-woman visits, pregnancy and disease screenings, prescription contraceptive methods and counseling, support for new mothers, and screening and counseling for interpersonal and domestic violence. This provision applies to medical and prescription drug plans, with the exception of BlueJourney HMO, BlueJourney PPO, and Medicare Part D Prescription Drug Coverage (PDP).

This benefit currently affects large (nongrandfathered groups only—if groups are grandfathered, their renewals will be generated reflecting current plan design) and small groups. There may be further guidelines and specifics released surrounding this provision by the HHS.

For further questions on this topic, see your Account Executive.

1095 Tax Forms

The Affordable Care Act brought changes to the information reporting responsibilities of insurers and employers. In particular, health insurance companies and certain employers are now required to provide information to members and the Internal Revenue Service (IRS) to confirm their members have minimum essential coverage (MEC).

The new information reporting systems are similar to the current Form W-2 reporting systems in that an information return (Form 1095-B or Form 1095-C) is prepared for each applicable employee, and these returns are filed with the IRS using a single transmittal form (Form 1094-B or Form 1094-C). Generally, the information on these forms includes the name, address, and social security number (or date of birth) of members and their dependents who were provided MEC during the previous calendar year and the months they were provided such coverage.

An employer's health plan and number of employees determine the filing requirements. On a general basis, insurance companies use Form 1095-B (Proof of Health Coverage for Members) and Form 1094-B (Transmittal of Health Coverage Information Return) to report individuals covered by insured employer-sponsored group plans. Small employers with self-insured health plans also use Form 1095-B and Form 1094-B to report individuals covered by small employer self-insured health plans. Applicable large employers (employers that had, on average, at least 50 full-time employees, including full-time equivalent employees) file Form 1095-C (Employer-Provided Health Insurance Offer and Coverage) and Form 1094-C (Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns). These forms are required if the employer offers an insured or self-insured plan, or does not offer any group health plan.

Subscriber/Member Termination Notification Letters

Federal regulations no longer require that we issue Health Insurance Portability and Accountability Act (HIPAA) Certificates of Creditable Coverage when an individual leaves a group health care plan. Instead we will send the terminated member a "*Subscriber/Member Termination Notification Letter*." A copy of this letter is contained in the *Forms and Reports* chapter.

Medicare Secondary Payer (MSP) Laws

Provisions of the Medicare Secondary Payer Laws

As an employer offering a group health plan, it is your responsibility to enroll individuals in health and prescription drug products consistent with MSP laws. These laws establish Medicare as the secondary payer to group coverage in many instances of dual coverage. They also prohibit discrimination against Medicare beneficiaries in the offering of group coverage.

MSP laws are complex and can be confusing to even seasoned group Administrators. This information is meant to assist you in complying with MSP laws when determining enrollment and other matters for subscribers and their family members who are covered under both your group health care coverage and Medicare. Please be aware this is not the complete text of the law, but is a summary of information we believe will be of help to you. ***This summary is purely informational and does not modify your policy or coverage in any way and should not be viewed as legal advice or opinion.*** *If you have issues not addressed in the following material, or questions concerning your obligations under MSP laws, please review MSP laws and/or consult with your own legal counsel.*

The MSP statute and regulations are located at 42 U.S.C. §1395y(b) and 42 C.F.R. Part 411 and can be found in a law library. You also can find information at cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer.html. Please remember only the employer can make decisions regarding how individuals should be enrolled correctly.

Nondiscrimination

MSP laws generally prohibit groups from taking into account whether an enrollee has Medicare coverage based on age, disability, or ESRD. Thus, for example, a group may not generally charge employees enrolled in Medicare higher premiums than other employees who are not enrolled in Medicare. MSP laws also contain specific nondiscrimination provisions that apply in different contexts. For instance, MSP laws generally require groups to offer subscribers (and their spouses) age 65 or older who have coverage based on the subscriber's "current employer status" the same benefits under the same conditions as such individuals (and their spouses) under age 65. MSP laws generally prohibit groups from differentiating between the benefits they provide to members who have ESRD and others enrolled in the group health plan based on the existence of ESRD, the need for renal dialysis, or in any other manner.

Prohibition on Financial Incentives

Under MSP laws, groups may not offer Medicare beneficiaries financial or other benefits as incentives not to enroll in, or to terminate enrollment in, a group that is, or would be, a primary payer to Medicare. Specific penalties apply for violations of this prohibition.

Coordination of Benefits Rules

MSP laws require, in certain situations, employers to provide group health care coverage as primary insurance to certain persons who are eligible for, or entitled to, Medicare. Coordination of benefits under MSP laws is determined largely on the basis of three factors: (1) Medicare eligibility/entitlement, (2) employer size, and (3) employment status. For this reason, we generally request this group and member information in the enrollment process and may request updates from you and/or your members concerning these topics. In general, Medicare is the secondary payer (and the group is the primary payer) when all of the criteria for any one of the following rules are met:

The Working Aged Rule

Medicare is the secondary payer when all the criteria for the following apply:

- The individual is entitled to Medicare based on age (i.e., age 65 or over).

- The individual has group coverage based on his or her (or a spouse's) "current employment status."

- The employer has "20 or more employees" as defined under MSP laws. (An employer is considered to employ "20 or more employees" for purposes of the Working Aged Rule if the employer employed 20 or more employees for each working day in each of 20 or more calendar weeks in either the current OR preceding calendar year.)

If a "Working Aged" individual (for whom the group would be the primary payer) chooses not to receive group coverage, he or she may enroll in Individual Products Security℠ coverage. The employer MAY NOT, by federal law, offer group Medicare Complementary coverage to an individual who has declined group health care coverage in favor of Medicare coverage as the primary insurer. In other words, the employer MAY NOT purchase group Medicare-eligible program coverage for persons covered by this provision who have chosen Medicare as their primary payer.

Special rules apply if you are part of a multiple employer group health plan. For instance, a multiple employer group health plan that has at least one employer with "20 or more employees" must pay primary for all claims associated with a Working Aged individual enrolled in the plan. However, the multiple employer group health plan may file an election request with the Centers for Medicare and Medicaid Services (CMS) on behalf of each Working Aged individual (both subscribers and their spouses) who receive health care coverage through participating employers with less than 20 employees (as defined under MSP laws).

The Disability Rule

Medicare is the secondary payer when all the criteria for the following apply:

- The individual is entitled to Medicare based on disability.
- The individual has group coverage based on his or her (or a family member's) "current employment status."
- The employer has "100 or more employees" as defined under MSP laws. (An employer is considered to employ "100 or more employees" if the employer (a) has employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year, or (b) is part of a multiple employer group health plan that includes at least one employer with "100 or more employees" on 50 percent or more business days during the previous calendar year.)

If a Disabled individual (for whom the group would be the primary payer) chooses not to receive group coverage, he or she may enroll in Individual Products Security coverage. The employer MAY NOT, by federal law, offer group Medicare Complementary coverage to an individual who has declined group health care coverage in favor of Medicare coverage as the primary insurer. In other words, the employer MAY NOT purchase group Medicare-eligible program coverage for persons covered by these provisions who have chosen Medicare as their primary payer.

The End-Stage Renal Disease (ESRD) Rule

Medicare is the secondary payer when all the criteria for the following apply:

- The individual is eligible or entitled to Medicare based on ESRD.
- The individual has group coverage (with no size or "current employment status" requirements).
- The individual receives dually covered items or services within 30 months of the date of Medicare eligibility (the "ESRD Coordination Period").

It is important to remember that, regardless of the number of employees an employer has, or whether the individual has coverage based on "current employment status," the group is generally the primary payer for persons who have Medicare eligibility or entitlement based on ESRD for a period of up to 33 months from the first dialysis. The 33-month period consists of (1) a three-month waiting period for an ESRD patient to become eligible for Medicare, plus (2) a 30-month ESRD Coordination Period (beginning with Medicare eligibility), during which Medicare is typically secondary to group health plan coverage.

Since an individual is not generally eligible for Medicare until the third month after the month in which a regular course of dialysis is started, only basic (group primary) health care coverage is typically in force for the first three months of dialysis. The three-month waiting period may be shortened, however, if the patient participates in a self-dialysis training program or receives a kidney transplant.

Since the 30-month ESRD Coordination Period begins with Medicare eligibility, and the date of eligibility may turn on many factors, it is important for you to obtain and communicate to us basic treatment information in order to allow us to coordinate benefits properly.

Dual Eligibility Rules

If an individual is eligible for or entitled to Medicare on the basis of ESRD and also entitled to Medicare on the basis of age or disability, the MSP provisions for dual entitlement govern coordination of benefits. As a general rule, the 30-month ESRD Coordination Period applies and the group is primary, even for those individuals already enrolled in Medicare because of age or disability. However, Medicare remains the primary payer if the group was already the secondary payer for an individual entitled to Medicare on the basis of age or disability when that individual becomes eligible for Medicare on the basis of ESRD. Once Medicare becomes primary for an ESRD beneficiary, it remains primary until Medicare coverage for ESRD ends.

Employer Size

Employer size, not group health plan enrollment, is used to determine primary and secondary payer status. For purposes of calculating employer size under MSP laws, "employee" means all classes of employees, regardless of whether such employees have enrolled in the group health plan, including (a) full-time employees, (b) part-time employees, (c) leased employees if they would be counted as employees of the entity under Internal Revenue Code section 414(n)(2), (d) all employees who are members of an affiliated service group under the Internal Revenue Code § 414(m), and (e) all employees who are considered to be employed by a "single employer" under Internal Revenue Code 52(a) or (b).

Penalties for Noncompliance

The federal government can enforce these provisions and levy interest, fines, or surcharges against employers. It is the group's responsibility to comply with MSP laws and promptly report to Capital BlueCross any changes in status that affect coordination of benefits with Medicare.

Medicare Secondary Payer Demand Letters and CMS Recovery Process

If you receive a Medicare Secondary Payer "demand letter" from CMS, it means CMS believes Medicare has mistakenly made primary payment on a claim for which the group should have made primary payment. In such letters, CMS demands the recipient (typically the employer or group) reimburse Medicare for the overpayment.

If you receive a demand letter, forward the following information to us immediately:

- A copy of all of the demand letter materials received from CMS.
- A signed authorization form (available from the Capital BlueCross MSP Unit at **717.541.3776**) granting us the authority to communicate with CMS on your behalf concerning the alleged debt.

When we receive a demand letter from you, we will investigate to determine whether the demand is valid. Based on your instructions, we will generally either process the claim or submit documentation to CMS rebutting the alleged debt.

If CMS does not receive a response to a demand letter by the date designated in the letter (i.e., the 61st day after the demand letter is issued) or it does not accept the defense asserted by the employer/group, it may send an "intent to refer letter" informing the employer/group that it intends to refer the debt to the U.S. Department of Treasury for further debt collection. The employer/group may again submit documentation at this stage rebutting the alleged debt.

Please send copies of all MSP demand letters and other collection related notices to us immediately at the address below, so we can assist you:

MSP Demand Notices
PO Box 61830
Harrisburg, PA 17106-1830

It is important that you send the materials promptly in order to avoid the imposition of interest in connection with any valid demands.

Questions and Answers Concerning the Medicare Secondary Payer Laws

We are including a frequently asked question and answer section in this chapter to provide you with some additional information about MSP. The following are answers to common questions related to MSP laws. Contact your own legal counsel for a more detailed explanation of these laws.

Do MSP laws apply to employers?

Yes. While Capital BlueCross may assist employer groups in understanding these laws, it is up to the employer groups to comply with the laws (and to enroll members in appropriate products consistent with these laws).

Are the rules the same for all employers?

No. Different rules exist for large and small employers. For additional information, see the Working Aged and Disabled Rule discussions in the Medicare Secondary Payer Laws section of this chapter, as well as the Employer Size discussion.

How are employees counted for the purpose of compliance with MSP rules?

To determine the number of employees, an employer should count the number of actual (full-time and part-time) employees, as well as leased employees, and not just those employees enrolled in the group health plan. In addition, specific aggregation rules apply. See discussion of Employer Size Rule.

What rules apply to employers with fewer than 20 employees?

Neither the Working Aged nor the Disabled Rules apply to employers with fewer than 20 employees, as determined under MSP laws. However, all employers must follow the rules governing individuals who are eligible for Medicare on the basis of ESRD.

When does an individual have "current employment status"?

Under MSP laws, an individual has "current employment status" if he or she is actually working for the employer or is the employer. The term "current employment status" also includes individuals who are not actively working in certain limited instances. As a general rule, if the employee is receiving compensation subject to employment tax, such as FICA, "current employment status" usually applies. Thus, individuals on short-term disability and seasonal workers on furlough may have "current employment status." For additional information concerning when an individual who is not actively working is still considered to have "current employment status," refer to the MSP laws directly.

The subscriber's employment status is key to the coordination of benefits with Medicare, even if it is the dependent member who is covered by Medicare. The subscriber is the one who provides access to the group coverage, generally through current or former employment.

Please note that Capital BlueCross CANNOT DETERMINE who has current employment status. You must provide us with this information and keep such information current and accurate.

How does the ESRD Rule differ from the Working Aged and Disabled Rules?

The ESRD Rule differs from the Working Aged and Disabled Rules in several important ways. First, under the ESRD Rule, the size of the group and the employment status of the employee are not considered in determining the primary coverage. Second, coordination of benefits is based on Medicare eligibility or entitlement, rather than just Medicare entitlement. Finally, under the ESRD Rule, the group is permitted to pay secondary to Medicare after the 30-month ESRD Coordination Period is complete. By contrast, under the Working Aged and Disabled Rules, Medicare remains secondary as long as the conditions of the rules are met.

The ESRD Rule is complex and we stand ready to assist you. For instance, we may be able to assist you by obtaining information concerning the ESRD Coordination Period directly from CMS on your behalf. If you have questions, consult with your legal counsel for additional information concerning application of the ESRD Rules.

Requirements for Enrolling for Group Insurance

The key to a successful group health care program is to have a good cross-section of the population enrolled. At Capital BlueCross, we never exclude someone from group coverage based on medical history or past usage of health care services. In order to enroll a representative cross-section of people, we apply participation guidelines widely used in the industry for just that purpose. We follow this practice so the health insurance risk is spread evenly in order to protect our customers' premium dollars and to guard against inflated rates for our insured programs.

Our basic requirement is that 75 percent of eligible employees must enroll for fully-insured group health care coverage in the small, mid-market, and large segments, and for ASO (self-insured) coverage for groups in the 10-99 size segment.

Additional participation guidelines (in effect when this manual was published) are as follows:

- Small group (less than 51 employees)/member participation requirements will be waived during a special enrollment period that runs from November 15 through December 15 for a January effective date only.

- Mid-market and large groups not meeting 75 percent participation may be subject to additional rate impacts.

- For fully-insured small and mid-market groups, and ASO 10-99 groups, at least 25 percent of enrolled subscribers must reside in the Capital BlueCross 21-county service area (30-mile border leniency will be applied). One hundred percent of enrolled HMO subscribers must reside in the Capital BlueCross 21-county service area (30-mile border leniency will be applied).

- Only active employees who work a minimum of 20 hours per week, receive a W-2 form, and are eligible to select benefits are counted toward the minimum participation requirement. A group may set a higher hourly requirement if desired. The maximum number of hours a group can set for eligibility purposes is 40 hours. (Groups must consider their own penalties under PPACA if over 30.)

- We generally require 75 percent participation of eligible employees. This participation requirement applies to ASO size 10-99 groups and all fully-insured health, drug, dental, and vision products.

- Voluntary BlueCross Dental℠ and Vision℠ product participation requirements are at least 25 percent participation in addition to certain requirements for enrollment. Please consult your Account Executive or producer for more detail.

- Combined enrollment in any Capital BlueCross product (including enrollment in HMO coverage) counts toward the minimum health coverage participation requirement.

- Retirees (or COBRA-enrolled employees) may still enroll in the group health plan but are EXCLUDED from the participation requirement calculation.

- Any group with retirees constituting more than 20 percent of the group's total enrollment is subject to review by Capital BlueCross' Vice President, Actuarial Services.

- In circumstances where only the HMO product is offered with other programs, different participation requirements may apply. Your Capital BlueCross Account Executive will discuss these circumstances with you during program selection.

- Groups enrolled in our Capital BlueCross private exchange enrollment tool may have different participation requirements. Your Capital BlueCross Account Executive will discuss these circumstances with you during program selection.

- PPACA limits an employer to no more than a 90-day waiting period for eligibility. Other conditions for eligibility may be permissible. Please seek advice from your legal counsel for any questions regarding special conditions.

For smaller businesses, the chart below indicates the minimum number of employees in order for a group to be eligible for coverage:

*Small Group Participation Requirements**	
Total Eligible Employees	*Minimum Participation Required***
1	*1*
2	*2*
3	*3*
4	*3*
5	*4*
6	*5*
7	*6*
8	*6*
9	*7*
10	*8*
11	*8*
12	*9*
13	*10*
14	*11*
15	*11*
16	*12*
17	*13*
18	*14*
19	*14*
* *Except during special enrollment period.* ** *Total enrolled employees plus valid other insurance waivers.*	

The participation guidelines noted here apply to products issued by Capital BlueCross, Capital Advantage Insurance Company, Capital Advantage Assurance Company, and Keystone Health Plan Central. Other product lines may have different participation requirements.

Please note underwriting compliance guidelines for health and other products are subject to change.

Your Account Executive can also help you develop a Plan to ensure your group meets the minimum participation requirements. Call your Account Executive or broker for more information.

Make sure each employee declining coverage completes a "*Waiver of Group Health Insurance Coverage.*" (See the *Forms and Reports* chapter in this manual for an example of this form.) Return these completed forms to your Account Executive with your other completed applications.

Checking Group Participation

From time to time, the Capital BlueCross Underwriting Department audits the participation of group customers in our programs.

When your group is selected for an audit, you are asked to provide information similar to the information you provided when you first chose Capital BlueCross group coverage. This information may include: the Employer's Report for Unemployment Compensation (PA Form UC-2); other out-of-state UC-2 forms; tax documents filed for a business that verifies the owner, business partners, and corporate officers; and other documents which include each employee's social security number for review by Underwriting.

The purpose of our audit program is to ensure all customers continue to be treated fairly and pricing for our programs accurately reflects an appropriate cross-section of individuals within our service area.

> *Remember, any questions about participation may be answered by your Account Executive, or you may contact Group Services at* ***1.800.541.3742****. You may also contact us on the web at capbluecross.com/ContactUs/E-mailCustomerService/Employer+Secure+Communications.*