Group Administrator Guide

Administering your Regence health plans

Regence

Group Administrator's Guide

Contents

Updated January 2017

Introduction

This guide is designed to help you administer your employee benefits program. It provides detailed information about benefits, eligibility, enrollment, monthly billing statements and claims submission to help you answer your employees' questions.

Because this guide will be used as a reference by different groups with varying benefits, it includes only our standard policies and procedures. *Please refer to your contract and booklet for specific policies pertinent to your group size and benefits. Any special eligibility enrollment procedures or other provisions specified in your contract or booklet supersede materials in this guide.*

The Group Administrator's Role

Your employees will often come to you with questions about their health care benefits. This guide will help you answer many of those questions and provide information you'll need to administer your group's plan.

The following information will help you become familiar with your role as group administrator:

1. **Enroll new employees**
   When new employees are hired, you will provide a brief explanation of your group's benefits and the options being offered. Then, make sure that the proper forms are completed, signed and returned to us on time. Applications for enrollment and changes to enrollment are available at regence.com.

2. **Provide new employees with copies of required member notices, which can be found on regence.com, including:**
   A. Your Special Enrollment Period Rights
   B. Notice of Privacy Practices
   C. Notice of Women's Health and Cancer Rights Act
   D. General Notice of COBRA Continuation Rights, if applicable
   E. Summary of Benefits and Coverage (SBC)

3. **Provide the appropriate creditable or non-creditable prescription drug coverage notice to new employees, those current employees approaching Medicare eligibility, and all employees annually.**
   The creditable coverage grids are available at regence.com.

4. **Communicate benefit changes**
   Occasionally, benefits will change for reasons that may include government requirements (mandated benefits or legislative changes), the development of new technologies or treatments, or contract revisions negotiated with your group. You will be notified as applicable of any benefit or administrative changes. We rely on you to inform your employees about these changes when they occur.

5. **Answer employee questions**
   This guide will be most helpful to you when employees come to you with questions about their Regence coverage. You will find many of the answers here, along with explanations of which forms need to be completed and how and when they should be submitted.

6. Verify eligibility

It is the designated group contact's or group administrator's responsibility to verify that all employees and dependents are eligible under the contract's Eligibility Provisions:

A. Ineligible persons

It is the designated group contact's or group administrator's responsibility to delete terminations from the billing in a timely manner. We can retroactively terminate coverage and refund premiums up to 30 days prior to the date we received your request to terminate a member's coverage as long as no claims have been paid for expenses incurred during the period of ineligibility. If we have paid claims for the member in question, the premium is due and must be paid for that member during the period in which claims are incurred. If this contract is terminated, we shall refund any unearned premium to the group. If this contract is terminated because of material misrepresentation, we shall refund to the group any unearned premium less the amount of paid claims.

B. Eligibility audits

We have an enrollment audit process that helps keep premium for coverage as low as possible by ensuring compliance with eligibility provisions. The enrollment review process includes periodically checking group employment records for compliance with our eligibility requirements. Most eligibility mistakes are the result of misinterpretations of our enrollment provisions. In these cases, we can provide additional information about your options.

C. Discontinuation of coverage

We reserve the right to examine employee records to confirm any employee's employment status. We may also discontinue this contract or coverage for a member on any premium due date with written notice and/or re-rate and collect any additional funds from the group as follows:

1. For fraud or intentional misrepresentation of material fact by the group;
2. For the group's failure to provide us with quarterly state tax and wage detail reports and/or other employment records as deemed necessary to validate eligible employees;
3. For group profile information;
4. For failure to respond to our written request for current status information, including group size, participation and contribution; or
5. For failure to comply with our minimum participation or employer contribution requirements.

Where to Go When You Have Questions

Membership Accounting
If you have questions regarding enrollment and/or eligibility, please contact your membership administrator at 1 (800) 505-6801.

Member Services
We have knowledgeable member services specialists who can quickly and accurately answer your employees' specific questions about benefits and claims:

A. Fully insured groups: 1 (888) 367-2116
B. Self-insured groups: 1 (866) 240-9580

When you have specific questions regarding benefit changes, new programs, etc., please call your producer or your Regence account executive.

Web Address
regence.com

Eligibility and Enrollment Guidelines

This section outlines our administrative policies about eligibility and enrollment. Complete eligibility information is included in your contract and benefit booklets. In the contract this information is found in the "Member Eligibility" section; in the benefit booklet it is in the "Who Is Eligible" section.

Group plans have an annual enrollment period at the group's renewal, which is often called open enrollment. Open enrollment is the window of time from the first of the month prior to the group's renewal through the last day of the renewal month. Employees and dependents who did not enroll when initially eligible may enroll during this period. Coverage begins the first day of the group's renewal month. Employees eligible for a special enrollment period do not have to wait for an annual enrollment period (see below).

1. **New Hires**
   Generally, all new employees will become effective the first of the month following satisfaction of the new-hire probationary period requirement. Exceptions would be groups with additional options, such as becoming effective on date of hire. Please refer to your Group Master Application to validate your group's new-hire probationary requirements. Your Regence membership administrator can help you determine the date your new employees become eligible for coverage. Changes to your group's probationary period can be made only during the annual open enrollment period, to be effective on the date of renewal.

   Note: As of 2014, the probationary period for your employees cannot exceed 90 days.

   Eligible employees must be actively employed at the time of enrollment.

   Once members are enrolled, we will send member ID cards to the address provided in the member's record.

   Newly hired employees and their eligible dependents have **30 days from the date they first become eligible** to submit an Application for Enrollment/Change. Employees and dependents who do not submit their applications within the specified time period will be classified as late enrollees and will not be eligible to submit applications until the group's next annual open enrollment period (or the occurrence of an event that triggers a special enrollment opportunity); see "Special Enrollment Period."

Employees who decline medical/dental coverage for themselves or their dependents when they are initially eligible will be required to complete a Waiver form. If an employee declines due to having other coverage, we require that the name of the other carrier and the employee's policy number be provided on the form. Waiver forms are available at regence.com or in the Forms section of Employer Center. Employees who involuntarily lose other coverage may be eligible to enroll in the plan before your next open enrollment period provided we receive an Application for Enrollment/Change within the required timeframe.

2. Dependents are limited to the following:

A. The person to whom the employee is legally married (spouse).

B. Domestic Partners:

1. Oregon-certified same-sex domestic partner: Eligibility will be included in all Oregon-based group health benefit plans. A same-sex domestic partner who registers a domestic partnership will become eligible for group coverage on the first of the month following the date the domestic partnership is registered and the couple receives a Certificate of Domestic Partnership (similar to how a new dependent spouse is added). We will continue to allow employer choice on the addition of non-certified domestic partners.

2. Non-certified domestic partners: These couples are either same-sex couples who have elected not to register at any Oregon county clerk's office or opposite-sex couples. If an employer provides same-sex and/or opposite-sex domestic partner coverage, the couple may enroll the domestic partner according to the eligibility provisions described in your benefit booklet. (The employee must provide an enrollment application and the current affidavit we require for proof of domestic partnership.)

C. The employee's child, spouse's child or domestic partner's child who is under age 26 and who meets the following criteria:

1. Natural child, step child, adopted child, or
2. A child for whom the court has appointed legal guardianship, or
3. A child for whom a legal qualified medical child support order (QMSCO) has been issued

D. The employee's child, spouse's child or domestic partner's child who is age 26 or older and incapable of self-support because of a developmental disability or physical handicap that began before their 26th birthday. An Affidavit of Qualifying Dependent Eligibility form with written evidence of the child's incapacity must be received within 31 days of the child's 26th birthday or the employee's effective date, whichever is later, and either:

1. The child is enrolled immediately before their 26th birthday, or
2. The child's 26th birthday preceded the employee's effective date and the child had been continuously covered as the employee's dependent on group coverage since that birthday.

Note: Once an employee has dropped coverage for an overage child for any reason including but not limited to Medicaid eligibility, the child is not eligible to be added back on as the employee's dependent.

3. When a Covered Employee Moves to Hawaii

An active employee who moves to Hawaii is no longer eligible for Regence coverage. A temporary move of four weeks is permitted.

The State of Hawaii requires that benefits for active employees living in Hawaii (regardless of where the group is located) be administered according to Hawaii law. This applies to all types of groups, including self-insured plans (ERISA has a specific exception for Hawaii). It applies to active employees only and does not apply to retirees or COBRA enrollees.

4. Special Enrollment Period

Employees may be eligible for a special enrollment period for themselves or their dependents if they did not enroll when initially eligible and one of the following occurs:

A. Loss of coverage or eligibility for premium assistance

1. If an employee or dependent involuntarily loses coverage under another group health plan or other health insurance due to loss of eligibility under the special enrollment rights of the Health Insurance Portability & Accountability Act (HIPAA), including exhaustion of COBRA coverage, they may be eligible to enroll on this group plan. Coverage will commence on the first day of the month following the date of loss, provided the Application for Enrollment/Change is received within 30 days.
2. If an employee or dependent involuntarily loses coverage under Medicaid or the Children' Health Insurance Program (CHIP) or becomes eligible for premium assistance under Medicaid or the Children's Health Insurance Program (CHIP), the employee or the dependent has 60 days from the date of the triggering event to exercise the special enrollment right.

B. Addition of new member due to a family status change (marriage, birth or adoption)

1. In the case of marriage, coverage will commence for the employee (if not already enrolled), spouse and all other eligible dependents on the first day of the month following the date of marriage and after Regence has accepted the application, provided the application is received within 30 days of the date of marriage.
2. In the case of a natural born child, coverage for the newborn (and employee, spouse and other dependents if not already enrolled) will commence retroactive to the date of birth, provided the application is received within 60 days of the date of birth.
3. In the case of an adopted child, coverage for the adopted child (and employee, spouse and other dependents if not already enrolled) may be added to a contract effective the date of placement, provided the application and placement paperwork is received within 60 days of the date of placement.

Electronic Enrollment Options

1. Online Enrollment

Regence understands the importance of effectively managing your employee benefits. That's why we are pleased to offer Online Enrollment. Designed for busy administrators like you, this robust, Web-based benefits management tool is available at no additional cost to your organization.

A. The benefits of using online enrollment are:

- Save time by easily adding new hires and processing life event changes online.
- Because your enrollment time is much faster, your employees will receive their member ID cards sooner.
- Your group eligibility rules are built into the system.
- You can print a confirmation page to save for your records.
- Benefit information is available online 24/7.
- You can generate reports customized to your information needs.
- Employee Self-Service option – This allows your employees to make their own benefit elections and changes throughout the year.
- You can grant additional access to your producer to perform enrollment additions and changes for you.

B. Availability and support

- Online enrollment support start site: Register for a webinar and view training videos.
- Access to a customer service line that is staffed by a support team who can assist with navigation and questions.

If you are interested in using online enrollment, please contact your membership administrator or your Regence account executive.

2. Electronic enrollment using ANSI 834

An American National Standards Institute (ANSI) 834 transaction allows employer groups and other data trading partners to submit enrollment data for Regence members. Enrollment data can consist of full audit files showing all members or change files that indicate newly added members, terminated members or members with changes in their demographics or benefits.

If you are interested in utilizing this type of tool for your enrollment files, please contact your Regence account executive for eligibility guidelines.

Electronic Resources and Tools

Regence provides easy access to electronic billing, benefit and employee/dependent information using Employer Center.

In Employer Center you can:

A. Order a member ID card
B. Request to receive email alerts notifying you when a new bill has been generated
C. View and pay your bill online
D. View group contract and benefit summaries
E. View a roster of your active employees and dependents

If you need assistance in using or accessing Employer Center, please contact your membership administrator.

Employee/Dependent Termination

If an employee or dependent no longer meets the contract's eligibility requirements, they must be terminated from coverage effective the last day of the month in which eligibility ends.

In situations where a group has moved from Family to Employee Only or Employee and Children Only coverage, dependents who are no longer eligible will be terminated from coverage. Members of new or existing groups who are losing coverage because the group is changing to Employee Only or Employee and Children are not eligible for COBRA or state continuation coverage.

In the case of an employee's death, the employee will be terminated as of the date of death; any dependents will be cancelled effective the last day of the month of the employee's death.

For all termination requests, please contact your membership administrator in writing or by phone within 30 days.

If it has been more than 30 days, federal health care reform requires that certain criteria be met to allow a retroactive cancellation due to an administrative delay in record-keeping. When that happens, retroactive cancellations may be accepted as long as:

1. The plan covers only active employees (or those on COBRA).
2. The member did not contribute to any premium beyond the requested effective date of cancellation.
3. The member did not have any expectation of coverage beyond the requested effective date of cancellation.

If you would like to request member cancellation(s) effective more than 30 days retroactive, please contact your membership administrator or complete and submit a Request for Retroactive Cancellation form to confirm that the member(s) and your group meet the above criteria.

All retroactive termination requests received more than 60 days after the requested termination date will be processed on a prospective basis only. The member's coverage will be cancelled on the last day of the month in which the initial termination request was received.

Note: The group will be responsible for all premiums incurred due to the late notification of terminations.

If an employee or dependent(s) are no longer eligible for coverage, it may be possible for them to continue their coverage. If COBRA/non-COBRA continuation is selected, the remaining active members will be enrolled on their own coverage.

Rehire Provisions

Rehire After Layoff
For groups that are eligible for Oregon Continuation, a special provision applies to re-enrolling after layoff. If an employee is rehired and returns to active work within nine months of being laid off, they and any previously enrolled dependents may re-enroll under the contract on the date the employee is rehired, regardless of any lapse in coverage. Your group must notify us that the employee is being rehired following a layoff, and the necessary premiums for coverage must be paid. All contract provisions will resume when the employee re-enrolls whether there was a lapse in coverage or not. Any exclusion period not completed at the time the employee was laid off must be satisfied. However, the period of the employee's layoff will be counted toward the exclusion period. When the employee is rehired, they do not have to re-satisfy any group eligibility waiting period required by the contract.

Rehire—Non-Layoff
Outside of the rehire-after-layoff provision specific to Oregon Continuation groups (1-19), the below provision applies to all other circumstances under which a former employee is rehired:

An employee will not be required to re-serve a new-hire probationary period if they are rehired within three months by a small group (1-50) or six months by a mid-size or large group (51+).

Please contact your membership administrator with any questions on the rehire policy.

Employees Moving from Part Time to Full Time

Members who start as part-time employees and then meet full-time hour requirements will be added to coverage per the part time to full time designation on the Group Master Application.

If an existing employee drops below the required work hours and is removed from coverage, then returns to the required number of hours, they will not be required to re-serve the new-hire probationary period. The member will be eligible to resume coverage the first of the month following return to full-time hours.

Member ID Cards

Once enrollment is complete, we will send member ID cards to employees using the addresses we have on record. If a duplicate card is needed, the employee can call Member Services or sign in at regence.com, where the employee will be able to change the level of the card (see below for explanation).

Card Level
Employees can choose between a family-level or member-level card. A family-level card will list all family members on the same card. Two identical family-level cards will be generated and mailed to the employee's home, regardless of how many family members there are. A member-level card will display one member per card. Each member will receive one card. If an employee does not make a card-level selection, a family-level card will be provided.

Rules Applying to Employees and Dependents Age 65 or Older

A. You must give the employee the appropriate creditable/non-creditable drug coverage letter regarding enrollment in Medicare Part D.

B. In groups with fewer than 20 employees, an actively employed individual who is enrolled on Medicare may continue in the group with the same benefits, but Medicare will pay as primary. However, the group coverage will not duplicate benefits provided by Medicare.
   1. Non-Duplication of Medicare—When, by law, this coverage would not be primary to Medicare Part B had your employee or their dependent properly enrolled in Medicare Part B when first eligible, benefits will be reduced to the extent that those benefits are or would have been provided by Medicare Part B, regardless of whether or not your employee or the dependent chooses to accept those benefits. In addition, if your employee is eligible for Medicare, we will not pay your employee or their provider for any part of expenses incurred if your employee's provider has opted out of Medicare participation.

2. Group with 20 or more employees are required to offer active employees age 65 or over and dependents age 65 or over of active employees of any age the same group health care benefits offered to other employees and dependents under age 65. If such employees and dependents qualify for Medicare on the basis of age, this group health care coverage will be primary to Medicare.

Please contact your legal counsel if you have questions regarding your responsibilities.

COBRA

COBRA applies to employer groups that have employed 20 or more employees for 50% or more of the typical business days in the preceding calendar year, with the exception of federal government plans and church plans. To the degree permitted by this law, part-time employees may be counted as a fraction of a full-time employee.

The group is responsible for determining eligibility for its employees and dependents. It is the group's responsibility to provide notification of available continuation options to eligible members. Electing COBRA does not guarantee eligibility, and your membership administrator will validate the information on the Application for Enrollment/Change.

Please contact your legal counsel if you have questions regarding your responsibilities.

Visit the COBRA administration website.

Non-COBRA Continuation of Coverage

A group that is not required to offer COBRA continuation of coverage must offer continuation of group coverage benefits upon loss of eligibility of coverage. If your group is not eligible for COBRA, there are other options for continuation of group coverage. Please refer to your contract for details. You must notify your employees and their enrolled dependents of their continuation rights. Regence will also provide members with notification of their continuation rights in the Certificate of Coverage.

To elect continuation, the employee or dependents must request non-COBRA continuation within 60 days following termination of coverage.

The maximum continuation of benefits period is nine months; however, there are circumstances that can result in an earlier termination of the continuation of benefits.

Note: For small groups in Clark County, Washington, the non-COBRA continuation benefit is one month.

Notice of Orthodontic Waiting Period

When Regence replaces a previous employer's dental plan:
Dental contracts with an orthodontia benefit include an orthodontic waiting period, which will be waived with proof of any prior dental coverage (if there hasn't been a lapse in coverage). Prior dental coverage is not required to have included prior orthodontic coverage. This applies for group dental coverage moving to Regence, not for new hires joining the group dental plan.

Understanding Your Group Bill

We will generate an invoice no less than 15 days prior to the due date. All premium payments are due on the first day of each month. We request that you pay the total amount billed; any adjustments will appear on the next billing. If paying by check, please include the stub located on the bottom of your invoice.

You can have your premium deducted directly from your group's bank account by filling out a Surepay agreement form.

Members' Social Security numbers will not be included on the bill. Instead, the covered employee will be listed by name and date of birth. The invoice will include type of coverage, covered members and subtotal amounts (medical, dental, etc.), followed by total premium due per member. Please review the following information on your invoice each month for accuracy and contact your membership administrator with any discrepancies:

A. **The Billing Summary** – Description of all activity since your last billing
B. **Current Month Billing** – Amount billed for this billing period
C. **Adjustment** – Any adjustment debit or credit not reflected on the last bill
D. **Variance** – Difference between original amount billed and adjusted amount billed based on updated eligibility and how those two amounts compare to the amount paid
E. **Outstanding Balance** – Any balance due from a previously reconciled billing period based on premium adjustments
F. **Unapplied Premium** – Premium that has been received but not applied to a billing invoice
G. **Total Amount Due** – Amount to be paid by the first of the month

Delinquency or Nonpayment of Premium

Payment **must** be paid in full or within 90% or more of the total amount due (tolerance level) to avoid delinquency.

Reminder notices are sent on accounts that are past due.

Any account that is not paid within the tolerance level by the 30th day after billing will be terminated for non-payment. Cancellation letters will be sent to the group. Members will receive a cancellation letter.

Groups that have been cancelled for non-payment may request reinstatement in order to be considered for continuation of coverage. The request must be in writing and should include an explanation for the delinquency. Any request for reinstatement received after four weeks from the date of cancellation will require an exception and would be granted only by written agreement from Regence. A group will not be considered for more than **one reinstatement within a 12-month period**.

Bankruptcy

In the event of a bankruptcy filing, please notify the appropriate Regence membership administrator of the file number and date of filing.

Note: Please include specific information on Chapter 7 and Chapter 11 processes.

Termination of Group Coverage

If your group wants to terminate coverage, we ask that you send the request in writing to your producer or Regence account executive indicating the effective date, reason for termination and new carrier name. We will generate a final billing after termination and issue a refund if there is a credit on the account following its termination.

Filing a Claim

A member must present their member ID card when obtaining covered services from an in-network provider. Any additional information that is requested must also be provided. The provider will furnish us with the forms and information we need to process the claim.

If the member obtains covered services from a out-of-network provider, the member must submit a claim to Regence. For information on how to submit a claim, please refer to the benefit booklet.

Within 30 days of receipt of a claim, we will notify the member of the action we have taken. This 30-day period may be extended by 15 days under certain circumstances (as outlined in the benefit booklet).

Family and Medical Leave Act of 1993 (FMLA)

The federal Family and Medical Leave Act (FMLA) guarantees up to 12 weeks of unpaid leave each year to workers who:

A. Need time off for birth or placement of a child for adoption or foster care
B. Need to care for a spouse or immediate family member with a serious illness
C. Are unable to work because of a serious physical or mental health condition

The FMLA is an employer law covering private employers with 50 or more employees or public employers of any size. This law affects the health benefit plans maintained by employers that are required to comply.

Employers are required by FMLA to continue to provide group health benefits at the same level and under the same conditions as if the employee had continued to be actively at work. An employee entitled to COBRA continuation as a result of not returning to active employment following FMLA leave will be entitled to COBRA continuation coverage, the duration of which shall be calculated from the date the employee fails to return from the FMLA leave.

For specific questions, call your Regence account executive or contact the Department of Labor for a complete copy of the FMLA law.

Please contact your legal counsel if you have questions regarding your responsibilities.

Member Appeals Process

If Regence has notified a member in writing that a claim or request for services or supplies has been denied in whole or in part, the member or the member's authorized representative may request a review of the complaint or denial by calling or writing to Regence within 180 days after receiving notice of the denial or the action that led to the complaint.

Regence will send an acknowledgement letter and notification of the appeals process to the member or the member's authorized representative. If the member's treating provider determines that the member's health could be jeopardized by waiting for a decision under the standard process, the provider can request an expedited appeal. Regence will respond to the expedited appeal within 72 hours of receipt of the appeal request.

Forms

Forms can be found on our website at regence.com and in the Forms section of Employer Center.

Regence BlueCross BlueShield of Oregon
is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueCross BlueShield of Oregon
100 SW Market Street | Portland, OR 97201

REG-12462B-17/01-OR

Questions?

Call Regence toll free: **1 (888) 367-2116**

regence.com

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PLEASE NOTE: This online version of this manual is the official document. If working with a printed copy please validate you are working with the most current information by verifying the last updated date on the cover compared to the official version online.

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711).