



## **BlueCross BlueShield of Illinois**

### **2-150 Group Resource Guide**

#### **Welcome to Blue Cross and Blue Shield of Illinois**

We recognize the importance of health insurance to you, your company and your employees. Health insurance is one of the most vital benefits an organization offers its employees.

This Group Resource Guide is designed to assist you in administering your health plan. Information in this document includes guidelines, procedures, important contacts and much more. Our goal is to make the administration of your health care benefit plan as simple and efficient as possible.

Your account representative or broker will notify you of any updates, which will be available on our Web site at [www.bcbsil.com](http://www.bcbsil.com). Copies of the Group Resource Guide are available in PDF format and can be found online.

We hope this guide will prove helpful whenever you have questions about the administration of your health plan. Your comments and suggestions are always welcome and can be provided to your BCBSIL account representative or broker.

Thank you for choosing Blue Cross and Blue Shield!

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*Information and forms are also available online at [www.bcbsil.com](http://www.bcbsil.com).*

## **Important Contacts**

### **Full Service Unit/Member Services**

Send these documents to the appropriate Member Services address: new hire applications, new member additions, address changes, family/dependent changes, member cancellations/reinstatements, ID card requests, claim inquiries and Dental membership and Illinois State Continuation/COBRA.

Send PPO, BlueChoice Select, BlueEdge HSA, BlueEdge HCA documents to:

<p>BlueCross and BlueShield of Illinois Quincy – Member Services 1400 North 30<sup>th</sup> Street Quincy, IL 62301</p>	Membership Phone	(800) 541-2768
	Membership Fax	(217) 228-9110
	Membership Inquiry Fax	(217) 221-3271
	Claims Phone	(800) 541-2767
	BlueCare Connection	(800) 232-7108
	Prescription Drug Inquiries	(800) 423-1973
	Dental Inquires	(800) 367-6401
	Fort Dearborn Life	(800) 348-4512 <a href="http://WWW.FDL-LIFE.COM">WWW.FDL-LIFE.COM</a>
	BCBSIL Provider Finder	<a href="http://www.bcbsil.com">www.bcbsil.com</a>
	BlueCard	(800) 810-BLUE (2583)
	Vision Care	(877) 393-8844
	Group Answer Line / Supplies	(866) 726-2767

### **Blue Cross and Blue Shield of Illinois Sales/Marketing Offices**

BCBSIL Downers Grove  
1020 West 31<sup>st</sup> Street  
Downers Grove, IL 60515  
(630) 824-5500

BCBSIL Rockford  
2787 McFarland Road  
Rockford, IL 61107-5908  
(815) 639-1500

BCBSIL Springfield  
2151 West White Oaks Drive  
Springfield, IL 62704-6495  
(217) 698-5100

## Forms

Forms are available online at *www.bcbsil.com*. If you do not have Internet access, complete a Request for Supplies form (OB3658) and send it to your Blue Cross and Blue Shield of Illinois (BCBSIL) representative or broker.

<b>Medical Plan Forms</b>		
<b>Employer Enrollment Forms</b>	<b>Form No.</b>	<b>Send to:</b>
2-150 Benefit Program Application (BPA)	GA-10-9-SMGRP	Your Blue Cross and Blue Shield representative or broker
2-150 Benefit Plan Selection Form (BPS)	GA-10-9-SMGRP-BPSF	Your Blue Cross and Blue Shield representative or broker
BAE/BluePrint Producer's/Employer's New Business Checklist	20910	This form does not need to be submitted to us. It is a tool for your own use.
Group Information Form	20561	Your Blue Cross and Blue Shield representative or broker
BluePrint – BAE –CPO Employee Application Form/Medical Questionnaire/Waiver of Coverage  <i>New Hire Applications: send to the Member Services office listed at right based on product.</i>  <i>Open Enrollment Applications: send to your Blue Cross and Blue Shield Representative.</i>	20084/ 20085/ 20086	<u>BAE PPO and Alternative Plan:</u> Blue Cross and Blue Shield of Illinois Quincy Member Services 1400 North 30 <sup>th</sup> Street Quincy, IL 62301-3476  <u>BA HMO:</u> Blue Cross and Blue Shield of Illinois Rockford Member Services 2787 McFarland Road Rockford, IL 61107-5908  <u>CPO:</u> Blue Cross and Blue Shield of Illinois Danville Member Services 3290 E. Main Danville, IL 61834-9395
HCSC/FDL Disclosure Form	EB4644	For employee information only – do not submit to BCBSIL
<b>Account Maintenance and Supply</b>		
Enrollment Change Request Form (Use for miscellaneous membership changes – including COBRA election)	EB4633	Submit this to your Blue Cross and Blue Shield representative or broker
COBRA Notification Form	No form number – electronic format only	For information only – do not submit to BCBSIL
Disabled Dependent Certificate	OB-540	Member Services

<b>Dental Plan Forms</b>		
BlueCare Dental HMO Benefit Program Application (BPA)	GA-10-3 HCSC	Your Blue Cross and Blue Shield representative or broker
Dental HMO Producer's Agreement	EB1570	Your Blue Cross and Blue Shield representative or broker
Dental Application and Policy Change Form (for Blue Care Dental)	20634	Dental Network of America Two TransAm Plaza Drive Oak Brook Terrace, IL 60181
BlueCare Dental Claim Form	20350	Dental Network of America P.O. Box 5005 Oakbrook Terrace, IL 60181
PreDent Dental Service Report	PD1	Blue Cross and Blue Shield of Illinois PreDent Plan for Care P.O. Box 2935 Chicago, IL 60690

<b>Other Forms</b>		
<b>Claim Forms</b>	<b>Form No.</b>	<b>Send to:</b>
Medical Claim Form	20479	Blue Cross and Blue Shield of Illinois P. O. Box 1364 Chicago, IL 60690-1364
<b>Administrative Form</b>		
Group Administrator Transaction Form	20406	Blue Cross and Blue Shield of Illinois P.O. Box 1364 Chicago, IL 60690

# **Eligibility/Enrollment/Maintenance**

- Eligibility
- Enrollment Process
- Selecting and Changing Medical Groups/IPAs, Woman's Principal Health Care Provider (HMO only)
- After Enrollment
- Coverage Changes
- Member Cancellations, Section Changes and COBRA
- Conversion
- Reinstatement

## **Eligibility**

### **Eligible Employee**

An eligible employee must be a full-time employee who is scheduled to work a minimum number of hours per week as determined by the employer and who is on the permanent payroll of the group. Part-time and seasonal employees are not eligible.

For groups under 100 lives, the minimum can be no lower than 30 hours per week. For groups 100 lives and over, the minimum can be no lower than 20 hours per week. If not specified otherwise on the Benefit Program Application, the minimum will be set at 30 hours for the group.

### **Eligible Dependent**

To be eligible for enrollment as a covered dependent, an individual must be:

- the spouse of an eligible member;
- an unmarried dependent child of an eligible employee (or the employee's spouse) by birth or legal adoption – under age 26 (or under age 30 for military veteran);
- a child placed in the home, pending adoption (documented by a social worker or attorney) – under age 26 (or under age 30 for military veteran);
- a child who is not living with the member, but for whom the member is required by law to provide health coverage – under age 26 (or under age 30 for military veteran);  
or
- a child who is dependent upon the member for support maintenance because of a developmental or physical disability will be covered regardless of age, as long as the child was covered before reaching the limiting age designated in the group policy.
- a child dependent who is a military veteran must reside in Illinois.

*Written verification of disability from a physician may be required. The Group Administrator must notify Blue Cross and Blue Shield when a child meets the limiting age so that a Disabled Dependent Certification form can be sent to the member for completion.*

### **Grandchildren and foster children**

Grandchildren and foster children are not eligible for coverage unless such children have been legally adopted or are under the member's legal guardianship. Legal documentation must be provided with the application.

### **Domestic Partners**

An employee's same-sex or opposite-sex domestic partner is eligible to enroll if the employee can attest to the eligibility criteria in the "Affidavit of Domestic Partnership" (BCBSIL form number 20551). The employee must submit the completed affidavit along with their application for membership.

### **Dependent Coverage Begins**

Coverage begins on the date of marriage, birth, adoption or court order for dependents not covered on the original effective date of the plan, or upon becoming a full-time student (as long as enrollment occurs within 31 days of the qualifying event).

### **Dependent Coverage Ends**

When a dependent child reaches the limiting age, both PPO and HMO coverage end on the last day of the month in which the dependent child reaches the limiting age.

If BCBSIL provides insurance for your group health plan, both PPO and HMO coverage end on the last day of the month in which the dependent child reaches the limiting age.

If BCBSIL provides third-party administrative services for your group health plan, dependent coverage ends as specified in your Benefit Program Application (BPA).

### **- Student Certificate status**

Student certification is no longer required for fully insured groups sized 2-150 lives due to the Dependent Age Expansion Requirement legislation effective June 1, 2009 (Illinois Law 215 ILCS 356z.12 / Public Act 95-0958). Students, like other eligible dependents are covered to the dependent limiting age of 26, or up to age 30 for military veteran dependents.

### **- Military Veteran status**

Dependents who have served in the U.S. Armed Forces must provide a release form certifying his/her honorable release from service when enrolling for coverage. For more information on how to obtain a copy of the release form, contact the Illinois Department of Veterans' Affairs at (800) 437-9824 or the U.S. department of Veterans' Affairs at (800) 827-1000.

### **- Replacement of Discontinued Group Coverage**

Totally disabled employees are entitled to all benefits described in the group policy.

In the event an employer terminates a group health policy and replaces it with a health policy offered by another insurer, Illinois State law governs under what circumstances each policy will be liable to cover disabled individuals.

The succeeding insurer is liable for disabled persons at takeover with these exceptions:

- the disabled person did not have sufficient creditable coverage to waive any pre-existing waiting period;
- there is no benefit under the succeeding insurer's plan for the person's disabling condition; or
- the disabled person has not yet satisfied his/her pre-existing condition waiting period.

*In these instances only, the previous carrier is liable under the Illinois statute.*

### **Retiree Eligibility**

At the election of the group and under the terms of their group policy, a retiree is eligible when covered prior to the original effective date of the plan, or when retirement occurs after the effective date of the plan, and the retiree has met the retiree definition as defined by the group. The retiree definition can be no less than 55 years of age and 10 years of service.

### **When there is Medicare coverage**

You may have employees or covered spouses and dependents that, because of age, disability or End-Stage Renal Disease, are covered by Medicare. In those cases, you must know the Medicare Secondary Payer (MSP) statutes — federal laws that govern employers and how they structure their benefit programs.

### **Medicare Secondary Payer (MSP) Rules**

The federal Medicare Secondary Payer (MSP) statute is essentially a coordination of benefits statute. The MSP rules determine when the group health plan will be the primary payer and Medicare will be the secondary payer, or vice versa, if an individual is entitled to coverage under both the group health plan and Medicare.

Working Aged, Disability and ESRD are the three MSP rules that determine this order of payment. When *all* criteria in at least one of the following MSP rules are met, the group health plan will be the primary payer and Medicare will be the secondary payer:

1. The **Working Aged Rule** applies to individuals who:
  - A. are age 65 and over and are covered under a Group Health Plan;
  - B. have current employment status (or have a spouse of any age with current employment status); and
  - C. are working (or have a spouse who is working) for an employer that employed 20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year.

The Working Aged Rule also applies to aged spouses who are not working, but are covered by working individuals.

The Working Aged Rule also applies to opposite-sex domestic partners, but **does not** apply to same-sex domestic partners.

2. The **Disability Rule** applies to disabled individuals who:
  - A. are under age 65 and are covered under a Group Health Plan;
  - B. have current employment status (or have a family member with current employment status); and
  - C. are working (or have a family member who is working) for an employer that employed 100 or more full-time and/or part-time employees on 50 percent or more of the employer's business days during the previous calendar year. These business days do not have to be consecutive.

The Disability Rule also applies to both opposite-sex and same-sex domestic partners.

3. The **End-Stage Renal Disease Rule** (ESRD) applies to individuals (with a current or former employer of any size) who:
  - A. have End-Stage Renal Disease and are covered under a Group Health Plan;
  - B. are still within the 30-month coordination period from the date of Medicare entitlement (due to ESRD); and

- C. are covered under a Group Health Plan based on either current or former employment status.

The ESRD Rule also applies to both opposite-sex and same-sex domestic partners.

### **Current Employment Status**

For MSP purposes, an employee does not necessarily have to be actively-at-work to have current employment status (e.g., an employee on short-term disability). If the employee is receiving compensation that is subject to employment tax, such as FICA, current employment status usually applies.

### **Dual Entitlement**

When a covered member is entitled to Medicare under more than one of these rules (dual entitlement), the rules become more complicated. General guidelines:

- where ESRD comes first, the ESRD rule takes precedence;
- where ESRD does not come first, the party who had been appropriately paying primary prior to the ESRD will continue to pay primary during the 30-month coordination period; and
- in general, age takes precedence over disability.

Consult your legal counsel or contact your BCBSIL account representative for further details.

### **MSP Information Available**

Authoritative MSP information can be found in the “Medicare Secondary Payer Manual,” maintained by the Centers for Medicare & Medicaid Services (CMS), the federal agency which administers the Medicare program.

To access the MSP Manual please click [here](#).

### **Impact on Benefits and Payments**

The covered individual must follow the rules of his or her Group Health Plan to obtain the highest level of benefits. Otherwise, Medicare will carve out what the Group Health Plan would have normally paid, and will pay the secondary payer amount only.

*For example:*

- An employee’s PPO is the primary payer and Medicare is the secondary payer. The PPO pays 80 percent of eligible claims and Medicare pays 20 percent. If the employee does not follow PPO rules, such as precertifying an elective hospital admission, the PPO will reduce benefits. Medicare will pay its usual 20 percent and the employee will be responsible for paying any unpaid balance.
- An employee with HMO coverage as the primary payer and Medicare as the secondary payer goes out of network for a physician office visit. Since the HMO will reject the claim for out-of-network care, Medicare will also reject the claim because the member did not follow the HMO’s rules.

### **When Medicare Is the Primary Payer**

Conversely, Medicare is the primary payer for

- individuals who do not meet the criteria shown above for MSP Working-aged Rule, Disability Rule or ESRD Rule;
- individuals covered by the Consolidated Omnibus Reconciliation Act (COBRA), except in some ESRD cases;
- retired individuals age 65 and over, aged spouses of retired individuals, retired disabled individuals and disabled family members of retired individuals.

*If employees or covered dependents in the above categories are eligible for Medicare but have not enrolled, BCBSIL estimates the amount Medicare would have paid and deducts that from the payable benefits. This applies to both Medicare Part A and Part B. Individuals should understand this policy when considering signing up for Medicare.*

### **Employer Size Determines Both Primary and Secondary Payer Status**

Employer size, not group size (enrollment), is crucial to determining Medicare primary or secondary payer status for the MSP Working Aged and Disability Rules. Under federal law, it is the employer's responsibility to inform its insurer or third-party administrator of proper employer size. If the employer does not do so, CMS requires that the employer's group health plan be considered **primary to Medicare**.

In order to provide the required employer size information, your company must submit a "BCBSIL Annual Medicare Secondary Payer Employer Acknowledgement Form" (EAF) at sale and, in some cases, at each renewal. If required, the EAF will be included in your annual renewal packet. This form and its instructions are available under the "Forms" section on BlueAccess for Employers.

Completing the EAF allows BCBSIL to determine benefits correctly the first time, reduces costly claim adjustments and Medicare recoveries, and helps reduce your cost for insurance or third party administration. If your employer size is miscalculated and claims are paid incorrectly as a result, you – the employer – face consequences, such as Medicare demand letters for reimbursement and possible penalties. Correcting claim errors can be time-consuming and costly — or might even be impossible due to limitations on timely filing.

**When the government demands reimbursement on Medicare claims**

Should your group receive any claim-related correspondence from the government pertaining to members who are covered by Medicare and enrolled in Blue Cross coverage, please forward that information to Blue Cross and Blue Shield of Illinois as soon as possible so timely response can be made to the government:

Labor Accounts MSP Unit  
Blue Cross Blue Shield of IL  
PO Box 804064  
Chicago, IL 60680-4064

If your company receives a questionnaire from the government about your group health plans and covered members, you are responsible for completing this questionnaire. The government can apply penalties if the form is not completed. The questions pertain to all of the group's health plans during a specific time period, along with employment and enrollment history of its employees. Blue Cross does not have this data. Medicare uses this information to identify primary payments made in error and to request repayment of the funds.

Information about other insurance coverage in effect for your employees, their spouses, or any of their covered dependents, whether private insurance or Medicare, is important for proper claims processing by all parties.

*Please provide the requested information regarding Medicare for all members, and the information in Section 3 of the Employee Application Form. Attach additional sheets if necessary. Changes in this information should be communicated to Blue Cross and Blue Shield of Illinois via the Enrollment Change Request Form as soon as you become aware of them.*

## **Enrollment Process**

### **Types of Enrollment:**

#### **Timely Enrollment**

- A timely enrollment is coverage for single and/or family members enrolled within 31 days after initial eligibility or a special enrollment qualifying event. A new hire waiting period may need to be fulfilled before initial eligibility.
- A new hire waiting period is the time between the date of hire and coverage start date.  
(Please check the appropriate box on the Application Form to indicate “timely enrollment.”)

#### **Waiting Period**

Your waiting period is established according to the terms that are set within your group policy and cannot be waived for any reason.

#### **Special Enrollment**

Coverage must be available for eligible employees and dependents during a special enrollment period. Special enrollment qualifying events include:

- Birth
- Adoption or placement for adoption
- Marriage
- Loss of eligibility for other coverage

Eligible employees and dependents may apply within 31 days of the qualifying event. (Please check the appropriate box on the Application Form to indicate “special enrollment.”) For Fort Dearborn Life coverage, this provision is only applicable to Dependent Life coverage.

#### **Late Enrollment (not permitted for medical and dental plans)**

#### **Life and Disability Plans**

Late enrollees must furnish acceptable evidence of insurability if the employer contributes less than 100 percent. If the employer contributes 100 percent, such person’s effective date will be a date mutually agreed to by the insurance company and the employer.

### **When to Enroll – Employee**

Eligible employees may join the Group Health Plan at one of these times:

- when the employer group initially is enrolled;
- when the employee is newly hired, or at the completion of probationary period, if a probationary period is required by the employer; or
- during the employer group’s annual open enrollment period
- following a special enrollment event, as explained above.

**The annual open enrollment period is usually held prior to the renewal date.**

### **Enrolling**

Use the Employee Application Form (and Medical Questionnaire for groups of 2-50 enrolled employees) to:

- Enroll new hires and their dependents
- Enroll COBRA or State of Illinois continuation coverage applicants

### **Special Reminders on the Employee Application**

- The application should be completed in black ink or typed. The cover sheet of the application form provides directions for completion.
- Be sure to indicate the type of enrollment at the top of the application.
- It is important that all bolded Medicare questions are answered and all relevant dates supplied.

### **Submitting Applications**

#### **Open Enrollment:**

- Complete online via Blue Access for Employers (Note: Print a confirmation of enrollment online and keep a copy for your records. If requested, fax MHI to the appropriate Member Services office on the “Important Contacts” list included at the front of this guide)
- Submit to membership directly
- Send the Application Form to your Blue Cross and Blue Shield account representative at the completion of the open enrollment period. Keep a copy for your files.

#### **New Hires:**

- Send the white and yellow copies of the Application Form to the appropriate Member Services office on the “Important Contacts” list included at the front of this guide. Keep the pink copy for your files.

*Certificate of Creditable Coverage (COCC) will not be required of new enrollees. However, a certificate will be required if a claim is filed for an apparent pre-existing condition. (See Legislation Section for details on the COCC).*

Generally, if Application Forms are received by Blue Cross and Blue Shield prior to the 1<sup>st</sup> of the month, the membership information will appear on the next month's bill. However, there are occasions when it may take an additional month for this information to appear.

**Reminder:**

During Open Enrollment, all Application Forms should be sent to your Blue Cross and Blue Shield account representative.

After Open Enrollment, Application Forms should be sent to the applicable Member Services Office. Check the Important Contacts list.

## **Selecting and Changing Medical Group, Primary Care Physician (PCP), Woman's Principal Health Care Provider (WPHCP)**

***\*HMO Members Only\****

### **Selecting a Medical Group**

The HMOs of Blue Cross and Blue Shield of Illinois have contracted with established medical providers in the Chicago metropolitan, surrounding suburban and statewide areas. Although we use the term "Medical Group" to describe all the physician groups, there are three types of contracting medical providers in the HMO.

- Medical Groups: physicians practice out of the medical facility.
- Individual Practice Associations (IPA): physicians practice out of their individual offices.
- Physician Hospital Organization (PHO): physicians' practices are affiliated with or employed by a particular hospital corporation.

Members must select a contracting Medical Group for themselves and all covered dependents during enrollment. Each family member may choose a different Medical Group, if desired.

### **Changing a Medical Group**

A member may change from one contracting Medical Group to another at any time by calling the HMO Member Services Office at (800) 892-2803.

*If the change request is received on or before the 15th of the month, it will be effective on the first of the following month. The member will receive a new ID card with the new Medical Group name. Members in their third trimester of pregnancy or in the midst of an inpatient hospitalization cannot change Medical Groups.*

### **Selecting a Primary Care Physician (PCP)**

Each member (employee and covered dependents) must select a Primary Care Physician (PCP) who is affiliated with the member's Medical Group and should notify the Medical Group of the selection. The member is responsible for having all their medical care (with the exception of chemical dependency treatment, eye exams, and emergency care) performed or coordinated by their PCP. To receive benefits for treatment from another physician or provider, the member must be referred to that provider by his or her PCP.

### **Changing a Primary Care Physician**

The member may change from one PCP to another same Medical Group at any time by calling the Medical Group at the telephone number that appears on the member ID card.

**Selecting A Woman's Principal Health Care Provider (OB/GYN)**

Female members may also choose a Woman's Principal Health Care Provider (WPHCP), a doctor specializing in obstetrics and gynecology (OB/GYN). A WPHCP may be seen for care without referrals from the PCP; however, the PCP and WPHCP must have a referral arrangement with one another.

*The HMOs of Blue Cross contract with Medical Groups, not individual doctors. Doctors in the network are not employees or agents of the HMO. They have contracts with the Medical Group or are shareholders or employees of the Medical Group.*

## **After Enrollment – Identification Cards**

The Blue Cross and Blue Shield of Illinois Identification (ID) Card serves as a member's source document for identification, claims submission and correspondence. The Blue Cross and Blue Shield identification card is accepted throughout the United States and internationally. Once the Employee Application Form is signed and processed:

- BCBSIL will mail PPO members ID cards to the members and will mail Certificate/benefit booklets to the Group Administrator.
- HMO members will receive an ID card, a Certificate and a member handbook.

*Employees who enroll for family coverage will receive additional ID cards.*

### **Identification Cards**

An identification card is issued when an Application Form is submitted to Blue Cross and Blue Shield for:

- newly enrolled members
- a widowed or divorced spouse, or an over-age dependent under COBRA or State of Illinois Continuation coverage
- an employee who converts to a Direct-Pay Plan
- an employee who changes coverage (single to family or family to single)
- all employees if an employer changes copayment amounts

*Identification cards are not issued annually.*

## **Coverage Changes**

The Enrollment Change Request Form is used to make **status changes**, such as:

- address change
- addition or deletion of dependents
- name change
- eligibility for COBRA
- marriage
- death
- Birth or adoption of child.
- beneficiary changes
- medicare changes

*All changes must be received before the 1<sup>st</sup> of the month in order to appear on the next month's group billing. There are occasions when the change will not appear until the second billing cycle after the change is made.*

PLEASE REVIEW YOUR MEMBERSHIP LISTING REGULARLY TO ENSURE ALL CHANGES ARE ACCURATE.

**Changes from Single to Family Coverage**

A subscriber may change from single to family coverage after a qualifying event. A qualifying event is:

- marriage
- the birth of a child
- adoption or legal custody of a child, or a child placed in the home, pending adoption (must be documented by a social worker or attorney).

*A subscriber must complete and submit the Enrollment Change Request Form within 31 days of the event. Family coverage will be effective on the date of the event.*

**Changes from Family to Single Coverage**

A subscriber may change at any time from family to single coverage. This change will be effective on the first billing date following the request for change.

If the change is due to divorce or the death of a spouse, the change from family to single coverage will be effective on the date of the event. The Enrollment Change Request Form must be submitted within 31 days of the event.

### **Adding Dependents**

To add dependents, an employee with family coverage must complete an Enrollment Change Request Form within 31 days of the child's date of birth or date of adoption, or the date of marriage.

If the child being added is adopted and will retain the name of his or her birth parents, the child's last name should be entered in the Family Coverage Information section of the Enrollment Change Request Form.

If the child being added is adopted and will have the employee's last name, the child's last name does not have to be entered on the Enrollment Change Request Form.

*Dependents that are already covered under a family membership should not be listed again.*

### **Children Reaching Specified Age Limits**

A child is no longer covered when he or she reaches the age limit specified in your group policy. It is the employee's responsibility to notify the employer when their child reaches the limiting age specified on the group contract. The employer must notify Blue Cross of the change.

Student Certificate status allows an employee to continue coverage for a dependent who is over the group's dependent age limit, but who is enrolled as a full-time student (12 credit hours), up to the student age limit.

Health benefits can be continued in one of two ways:

- The employee must notify the Group Administrator within 60 days of loss of coverage if COBRA Continuation or State of Illinois Continuation is elected, or
- The employee must advise the Group Administrator within 31 days of the child's birthday if the child chooses direct-pay conversion.

*HIPAA rights are lost if a conversion policy is purchased. The purchase of COBRA Continuation benefits or State of Illinois Continuation benefits protects the employee's HIPAA rights. (See Legislative Section for more details on HIPAA.)*

### **Marriage of a Dependent Child**

If a child marries, he or she is no longer covered as of the date of marriage. He/she may apply for coverage by following the same continuation procedures described for a child reaching the age limit. The dependent should be dropped from family membership by completing the Family Coverage Information section of the Enrollment Change Request Form.

### **Children with Disabilities**

A child with developmental or physical disabilities is eligible for coverage under an employee's family coverage beyond the limiting age if the child:

- is incapable of self-support and is dependent on the employee for support and maintenance, or
- was covered before he/she reached the limiting age.

If the child is an over-age covered dependent, it will be necessary to complete a Disabled Dependent Certification Form.

- The first part of this three-part form is completed by the employee. The second part is completed by the child's attending physician, and the third part is completed by the employer.

The employer should send the completed form to the appropriate Member Services office (Rockford for HMO members, Quincy for PPO members).

## **Member Cancellations, Section Changes and COBRA**

### **Member Cancellations**

Member cancellations for the following reasons can be submitted to Blue Cross and Blue Shield using either the Enrollment Change Request Form or the Group Administrator's Member Transactions Form:

- left employment
- by request of the employee
- military service
- member deceased
- transfer out of state
- divorce

*HMO member cancellations should be submitted to the Rockford Member Services Office. PPO member cancellations should be submitted to the Quincy Member Services Office.*

### **Dental Cancellations**

- Submit dental cancellations for BlueCare Dental Traditional and BlueCare Dental Preferred Choice (Dental PPO) to your Blue Cross and Blue Shield of Illinois Member Services Office. Use either the Dental Application and Policy Change Form (EB4142) or the Group Administrator's Member Transaction Form (EB2251)
- For Dental HMO, use the Dental Application and Policy Change Form (EB4142), the Group Administrator's Member Transaction Form (EB2251) or the Dental HMO Program Membership Change Report (DNoA 90) included with your monthly billing statement. Submit the form to Dental Network of America at: Two TransAm Plaza Dr., Suite 500, Oakbrook Terrace, IL 60181.

*You may request section changes and cancellations on the same form. However, HMO and PPO section changes and cancellations must be submitted on separate Group Administrator Member Transactions Forms and submitted to the applicable Member Services offices as indicated above.*

### **Member Cancellations—Issuing Certificates of Creditable Coverage (COCCs)**

Blue Cross and Blue Shield of Illinois issues certificates of creditable coverage (COCCs) to members who terminate coverage.

- The COCC includes the number of days the member was covered by Blue Cross and Blue Shield of Illinois.
- The number of days can be used to reduce a pre-existing conditions exclusion period imposed by a new employer, or to determine the member's eligibility for HIPAA CHIP (the State of Illinois individual coverage).
- BCBSIL automatically issues a COCC to the subscriber and each of the dependents upon termination of coverage. ASO clients that do not want BCBSIL to issue these certificates should notify their BCBSIL representative or broker.

### **COBRA for Employee**

If the employer is required to offer COBRA continuation and the employee elects COBRA coverage at the time of termination, he/she must complete an Enrollment Change Request form, signed within 60 days of the termination date and received within 90 days of the termination date. If the employee does not elect COBRA at the time of termination but uses the group health plan benefits, the termination date will be the first of the month following the last claim incurred date. Any claim expenses incurred will remain the employer's responsibility.

- Cancel as an active employee under the current group/section number.
- The employee must complete the Enrollment Change Request Form, checking off the COBRA box on the application
- Submit all paperwork to the appropriate Member Services Office
- BCBSIL will enter the employee as a COBRA member as part of the new section.

### **COBRA for Dependents**

If the employer is required to offer COBRA continuation, a spouse or dependent child who loses group health coverage may elect COBRA continuation.

- Using an Enrollment Change Request Form, cancel the dependent under the employee's current group/section number.
- Have the dependent complete a separate Enrollment Change Request Form. Make sure the COBRA box is checked on the application.
- BCBSIL will enter the dependent as a COBRA member as part of the new section and issue a new identification card, with coverage effective on the date of termination.

### **Waiting to Elect COBRA**

If at the time of termination or loss of coverage, an employee or dependent chooses to wait before making a decision about electing COBRA:

- Cancel the employee or dependent under the current group or section.
- Advise the employee or dependent that he or she is ineligible for coverage in the interim.
- If the employee or dependent elects within the time period allowed under the federal COBRA statute, he or she must complete a new Enrollment Change Request Form. Make sure the COBRA selection box is checked.
- Submit all paperwork to the appropriate Member Services Office.
- BCBSIL will enter the employee or dependent as a COBRA member as part of the new section

## **Conversion**

Conversion privileges are available to group employees and dependents as long as the dependent has been enrolled in the current health plan for at least three months. In addition, the employer group must not have cancelled its BCBSIL coverage and replaced it with other coverage. Conversion is available in these situations:

- when group eligibility requirements are no longer met
- upon termination of employment
- upon the loss of COBRA continuation
- when a dependent reaches the group limiting age
- when a dependent marries
- when a spouse loses coverage as a result of a divorce
- for most other reasons an employee may no longer qualify for group coverage

Conversion privileges and information should be offered to each employee or dependent who loses coverage. A member may convert to a Direct Pay Plan (Metro and State versions are available).

Direct pay conversion coverage does not duplicate the group benefits and is described in the literature that accompanies the direct-pay conversion application. Credit for all waiting periods satisfied under the group coverage is transferred to the direct-pay conversion membership.

To establish a direct-pay conversion membership, the employee must complete an application and return it to Blue Cross and Blue Shield of Illinois within 31 days of his/her termination of coverage under the group's policy. The member is then billed directly – usually every two months. (For HMO groups, this occurs monthly.)

Cancel the terminated employee from the group by following the guidelines in the “Cancellations” section of this guide.

*The conversion privilege applies to health coverage only. There is no conversion privilege for dental, vision, hearing or life products.*

**Caution:** HIPAA rights are lost if the employee purchases a conversion policy. The purchase of COBRA continuation or State of Illinois continuation protects the employee's HIPAA rights.

**Medicare Eligible Employees**

Employees who are eligible for Medicare may convert to a Group Conversion Medicare Supplement Plan.

**Family to Single Conversion**

An employee with family coverage may convert to a direct-pay conversion single contract; however, an employee with single coverage may **not** convert to a direct pay conversion family contract.

**Marriage or Limiting Age Conversion**

A dependent who converts to a direct-pay policy as a result of marriage or reaching the limiting age may convert **only** to a single contract.

**Effective Date**

The conversion policy effective date will be the day following the termination of the group contract coverage.

## **Reinstatement**

To reinstate a group member, a written request must be sent to the appropriate Member Services office. The request should state the reason for reinstatement and the effective date of the reinstatement. Include with the request:

- a copy of the original Application Form, or
- a completed new Application Form.

*Reinstatements must be requested within 90 days of the group coverage cancellation date.*

## **Military Service**

### **Active Duty**

If a member enters military service, the member's coverage must be canceled until he or she returns to civilian status. COBRA coverage is available in cases where the member's family decides to retain coverage.

To reinstate coverage after military service, the member must complete an Application Form within 90 days of his or her discharge from military service. A copy of the discharge papers must accompany the reinstatement application. The reinstatement date will be effective the same date the member returned to civilian status.

### **Reservists Called to Active Duty**

After Operation Desert Storm, the Uniform Services Employment and Reemployment Act of 1994 (USERRA) was amended to clarify the rights of individuals (and their dependents) who are called to active duty to continued health care coverage under their employer's health care programs. The law is complex, so while the following summary provides guidance to HCSC staff, employer groups should explore the issues with their own legal counsel.

Specifically under USERRA, employers are required to offer up to 24 months of continued coverage to covered employees and their covered dependents who are called to active duty and would otherwise lose coverage.

For the first 31 days of such service, the individual and dependents cannot be required to pay more than what other employees pay for such coverage (i.e., they pay the employee rate). After 31 days, the employer can charge 102 percent, just like COBRA.

USERRA coverage is deemed to be "alternative coverage" for COBRA purposes and therefore, automatically runs concurrently with COBRA.

### **Additional Information:**

USERRA applies to all employers, regardless of the number of employees. Unlike COBRA, there are no timeframes for notices and elections. In the past, the IRS has implied that adherence to COBRA standards is "good faith" compliance.

For groups that have covered individuals who are called to active duty, HCSC will treat these individuals the same as HCSC treats individuals (and their dependents) that are on COBRA. The group must inform HCSC of the affected individuals and their dependents and HCSC will maintain coverage. Unless the group also has an administrative service agreement with HCSC to provide COBRA services, HCSC will not provide notices and election forms.

Groups that have additional questions about their obligations under USERRA can visit [www.dol.gov/elaws/userra](http://www.dol.gov/elaws/userra) or the Web site of the National Committee for Employer Support of the Guard and Reserve at [www.esgr.org](http://www.esgr.org). Please note that this USERRA information is not meant to replace independent legal counsel.

# **How to Use Your Health Plan**

- Prescription Drug Coverage
- Filing an HMO Claim
- Filing a PPO Claim
- Prior Deductible Credit and Carry-Over Credit Policies for PPO Plans
- Coordination of Benefits (COB)
- Reimbursement Provision
- Complaints and Appeals (HMO)
- PPO Claim Review Process
- Transition of Care – HMO
- Away From Home Care Coverage for the HMO Member
- BlueCard PPO
- BlueExtras
- Vision Care

## **Prescription Drug Coverage**

### **Medical/Prescription Drug Card**

#### **Using an In-Network Pharmacy:**

- the member presents the prescription along with the ID card
- the pharmacist dispenses up to a maximum 34-day supply of the prescribed medication.
- the member pays the copayment and the pharmacist bills Blue Cross and Blue Shield of Illinois for the prescription amount minus the copayment.

*All in-network pharmacies have real-time claims adjudication, which allows immediate review and verification of eligibility, drug coverage, copayment and any additional information specific to the group.*

*BCBSIL has over 59,000 contracting pharmacies nationwide and over 2,000 in Illinois alone. To locate a pharmacy, visit the BCBSIL Web site at [www.bcbsil.com](http://www.bcbsil.com).*

#### **Using a Non-Network Pharmacy:**

- the member must pay the full amount of the prescription at the time it is filled
- the member completes a Prescription Drug Card Claim form, attaches the original itemized pharmacy receipt and mails them to the address on the back of the claim form. We encourage members to keep copies of their pharmacy receipts and claim forms.
- BCBSIL will reimburse the member 75 percent off the discounted rate they would have paid the in-network pharmacy minus the copayment for each prescription submitted.

#### **Non-HMO**

The Prescription Drug Mail Service program can save you both time and money. Under this program, maintenance medications are conveniently delivered to your home or selected place of choice. You can receive up to a 90-day supply for each prescription you order. According to your specific benefit plan, whether your medication is generic, formulary brand or non-formulary brand, will determine the amount you pay. However, using a generic or formulary brand medication will save you money. You can purchase maintenance medication by following the instruction listed below:

- ask your doctor for a new prescription for each medication you want to order through the program.
- ask for two prescriptions: one for up to a 34-day supply to fill immediately at a retail pharmacy and a second for up to a 90-day supply, with three refills, to be filled through the mail service pharmacy.
- send the prescription(s), the mail service order form and the full amount you own to the address on the order form.

- for your convenience, the mail service order form and physician fax form are available at [www.bcbsil.com](http://www.bcbsil.com)

For additional information about the mail service benefit program, contact the Pharmacy program at the number on the back of your ID card.

**Purchasing Maintenance Medication at a Retail Pharmacy**

- ask your doctor for a new prescription for each medication you want to purchase through the program.
- bring your prescription to a 90-day supply contracting retail pharmacy.

**Purchasing Maintenance Medication through a Mail Service Pharmacy**

- ask your doctor for a new prescription for each medication you want to order through the program.
- ask for two prescriptions: one for up to a 34-day supply to fill immediately at a retail pharmacy, and a second for up to a 90-day supply, with three refills, to be filled through a mail service pharmacy.
- send the prescription(s), the applicable mail service order form and the full amount you owe to the address on the order form. You can
- for your convenience, the mail service order form and physician fax form are available at [www.bcbsil.com](http://www.bcbsil.com)

Please visit [www.bcbsil.com](http://www.bcbsil.com) for the most recent up-to-date listing of contracting 90-day supply retail and mail service pharmacies.

**BlueSCRIPT**

BlueSCRIPT is an electronic claims processing service for members whose outpatient prescription drug benefits are not covered under a drug card, but are covered under Major Medical health plan benefits. BlueSCRIPT eliminates the need for the member to submit paper drug claims for reimbursement. Here's how it works:

- member uses an in-network pharmacy
- member presents his/her Medical ID card with the prescription to the pharmacist
- pharmacist verifies member's eligibility and current address
- member pays for the prescription (at a discounted amount when using a Blue Cross and Blue Shield of Illinois in-network pharmacy)
- claim is processed automatically by the pharmacy to Blue Cross and Blue Shield.
- member is reimbursed for the prescription, minus any deductible or coinsurance.
- Member receives an Explanation of Benefits (EOB) that provides description of services, the amount billed, the benefit level and the amount the member saved by using the BlueSCRIPT claim service.

If the member is not able to take advantage of BlueSCRIPT processing, he/she should:

- pay the full amount of the prescription at the time it is filled
- complete a Prescription Drug Card Claim form, attach the original itemized pharmacy receipt and mail them to the address on the back of the claim form and keep copies

*If the member uses a non-network pharmacy, he or she will be reimbursed at 75 percent of the amount that would have been paid had the member obtained the prescription from an in-network pharmacy, minus any deductible due.*

### **Mail Service Prescription Drug Program**

As a member of Blue Cross and Blue Shield of Illinois, the mail service prescription drug program is available to you or a dependent if you are on a maintenance medication. By enrolling in the program, this benefit saves you time and money, allowing you to take advantage of our discount arrangement with the mail service pharmacy, purchasing maintenance medication every 90 days rather than monthly, and enjoying the convenience of mail service.

Determined by your specific health care benefits plan, you will pay either:

- A fixed dollar copayment depending on whether your medication is generic, formulary brand or non-formulary brand,
- A coinsurance amount that is lowest for generic medications, the same or slightly higher coinsurance for formulary brands and the highest for non-formulary brands or
- A combination of fixed dollar amounts and coinsurance.

For specific information on your prescription drug plan, contact customer service at the toll-free number on the back of your Blue Cross and Blue Shield of Illinois ID card.

## **Claims Filing - HMO**

Generally, when a member receives care from his/her PCP or from another provider and presents the Blue Cross HMO Identification Card, the provider will submit a claim to Blue Cross.

Occasionally, a member may receive a bill and should follow these steps.

- Obtain an itemized bill from the hospital, physician or other provider, which includes:
  - The itemized bill should include:
  - the provider's name and address
  - the patient's name
  - the diagnosis
  - the date of service
  - a description of the service
  - the billed amount
- Complete claim form or include the following information with the itemized bill:
  - member's name, and the group and identification number
  - patient's name, age and sex
  - any additional relevant information
- Mail the information to:  
Blue Cross Blue Shield of Illinois HMO Claims  
P.O. Box 805107  
Chicago, IL 60680-4112

### **Timely Filing of Claims**

Claims should be filed with Blue Cross and Blue Shield of Illinois on or before December 31<sup>st</sup> of the calendar year following the year in which the member's covered services were rendered. Claims not filed within the required time period will not be eligible for payment.

*To determine the status of an HMO claim, please contact the Member Services office at (800) 892-2803.*

## **Claims Filing – PPO**

### **Claims Filed by an in-network Contracting Provider**

Generally, when a member shows his/her Blue Cross and Blue Shield ID card to the hospital or physician (or other provider) providing the service, the provider will file the claim with Blue Cross and Blue Shield for the member. Blue Cross and Blue Shield will process the claim and send the benefit payment directly to the hospital or physician. The member will receive an Explanation of Benefits (EOB) explaining how the claim was adjudicated via online by logging onto [BlueAccess for Members](#) or by mail.

*In some cases, Blue Cross and Blue Shield will send the payment directly to the member or, if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on Blue Cross and Blue Shield's records.*

### **Claims Filed by the Member**

In certain situations, the member will have to file his or her own claim. This is primarily when services or supplies are received from non-contracted providers. To file a claim, the member should:

- Complete a Health Insurance claim form.
- Attach copies of all bills to be considered for benefits. These bills must include the Provider's name and address, the patient's name, the diagnosis, the date of service and a description of the service and the claim charge.

Mail the claim form with attachments to:

Blue Cross and Blue Shield of Illinois  
P.O. Box 805107  
Chicago, Illinois 60680-4112

### **Timely Filing of Claims**

Claims should be filed with Blue Cross and Blue Shield of Illinois **on or before December 31<sup>st</sup> of the calendar year following the year in which the member's covered service was rendered.** (A covered service furnished in the *last* month of a particular calendar year will be considered part of the *succeeding* calendar year.) Claims not filed within the required time period will not be eligible for payment.

## **Prior Deductible Credit and Carry-Over Credit Policies**

- **Prior Deductible Credit** - Expenses incurred under the prior group policy, either the prior carrier's policy or a prior Blue Cross policy, can be applied toward satisfying the deductible for initial enrollees.
- **Carry-Over-Credit** - Expenses incurred for covered services in the last three months of a benefit period that were (or could have been) applied to that benefit period's deductible will be applied to the deductible of the next benefit period.

### **PPO Plans**

- ✓ Prior deductible credit applies
- ✓ OPX is not applied
- ✓ Carry-over credit applies (4<sup>th</sup> Quarter)

### **HSA/HCA Plans**

- ✓ Prior deductible credit applies
- ✓ OPX is not applied
- ✓ Carry-over credit does not apply (4<sup>th</sup> Quarter)

## **Coordination of Benefits**

Coordination of Benefits (COB) is a system to determine the insurance carrier that has primary responsibility for payment of medical treatment when there is more than one insurance carrier involved. It prevents duplicate payment and ensures that the total benefits under dual coverage do not exceed 100 percent of the patient's expenses. Because COB saves money for your group, accurate COB information is important.

### **General Rule**

- **The primary plan pays first** without considering the benefits of the other plan.
- **The secondary plan pays second.** The payment may be reduced because of benefits paid by the primary plan.

### **Order of Benefit Determination**

- **Employee or employee's dependent:** the plan covering the person as an employee pays benefits first. The plan covering the person as a dependent pays benefits second.
- **Dependent children of parents not separated or divorced – birthday rule:**
  - The plan covering the parent whose birthdate (month/date) occurs earliest in the calendar year pays first.
  - If the parents have the same birthdate, the plan covering the parent for the longer time pays first.
  - If the other coverage does not have this "birthday" type of COB provision and, as a result, both coverages would be considered either

primary or secondary, then the provisions of the other coverage will determine which coverage is primary.

- **Dependent children of separated or divorced parents:** If there is a court decree that establishes financial responsibility for medical, dental or other health care expenses of the child, benefits are determined in agreement with the court decree. Otherwise, the plan of the parent with custody pays first, the plan of the spouse of the parent with custody pays second and the plan of the parent without custody pays third.
- **Longer/Shorter Length of Coverage:** If none of the above rules determines the order of benefits, the plan covering the person longer pays first.

#### **Other Information**

- Any plan that does not contain a Coordination of Benefits provision is automatically primary.
- For a BCBSIL HMO to pay as secondary payer, the employee must coordinate care through his/her PCP.
- When Medicare is the secondary payer, Medicare will not pay as if it were primary if the rules of the primary plan were not followed. If HMO is primary and the PCP does not direct care, Medicare will not pay in full. It will only pay what would have been paid if the primary plan rules were followed.

## **Reimbursement Provision**

The Reimbursement Provision is an addendum to provide for claim payment recoveries for services that are also payable by another party as a result of an auto accident, personal injury, and malpractice or product liability settlement.

- If a covered person is injured through the act of omission of another person and benefits are provided under this group plan, with the Reimbursement Provision, there is an agreement to reimburse the plan for damages collected to the extent of the benefits provided.
- This recovery is done through a lien process against the proceeds of any settlement provided to the injured party.
- Each accident claim submitted is investigated to determine if reimbursement procedures are applicable. If so, a reimbursement questionnaire is sent to the insured to determine the name of the other carrier(s) involved and the circumstances of the injury.
- If circumstances warrant, a claim for a lien is filed with the responsible party's insurance company, and the lien amount is negotiated between the concerned parties. If collection is made, the group is credited with the recovery minus the administrative fees.

## **Complaints and Appeals — HMO**

### **Complaints**

If a member is not satisfied with the service he/she receives, the member is entitled to file a complaint with Member Services. The complaint may relate to quality of care, service or a decision made by the health plan. These complaints may be directed to the Member Services area either by phone or in writing to:

Blue Cross and Blue Shield of Illinois  
Member Services  
P.O. Box 805107  
Chicago, IL 60680-4112  
(800) 892-2803

### **Appeals**

When a member is not satisfied with the way the complaint is resolved, he/she may request an appeal. A member, designee or guardian, primary care physician or other health care provider may file an appeal. The member will not be responsible for any expenses incurred in the appeal process. The appeal process does not imply that HMO Illinois is required to pay for health care services not covered under the member's certificate of coverage.

**Clinical Appeal** - an oral or written request that concerns a decision about medical treatments or services that are covered benefits in the Certificate of Health Care Benefits or could be considered as covered depending on the circumstances. Examples include appeals filed for services denied on the basis of medical necessity; services that may or may not be considered experimental, investigational or cosmetic; or access to out-of-network providers. The two levels of Clinical Appeal are:

- Non-Urgent – no immediate risk to a member's health
- Urgent/Expedited – might jeopardize the life or health of the member, or concerns a admission or continued stay, or when the member has received emergency services but has not been discharged from a facility

### **Non-Urgent Clinical Appeal Process**

1. The process begins by contacting Member Services by telephone or in writing with a request to appeal a decision.
2. The HMO will request additional information needed to evaluate the appeal within three business days of receiving the request.
3. The HMO Level One Appeal Committee will make a decision about the appeal within 15 business days of receiving the requested information.
4. A verbal notification will be made to the party filing the appeal, the member, the PCP and any health care provider who recommended the health care service.
5. A written notification will be sent to the same parties within five business days of the determination.

If the Level One Committee maintains the denial, the member is notified that the case is being referred to the Level Two Appeal Committee and informed of the right (or the right of someone acting on behalf of the member) to appear in person, via conference call or using other appropriate technology.

The Level Two Appeal Process:

1. The HMO will notify the parties in writing at least five business days prior to the date the Level Two Appeal Committee is meeting to review the case.
2. A verbal notification of the decision will be made to all parties.
3. A written notification will be sent within five business days of the Committee meeting and within 30 days of the date the Level Two Appeals process began.

### **Urgent/Expedited Clinical Appeal Process**

1. The process begins by contacting Member Services by telephone or in writing, indicating a request to pursue an Urgent/Expedited Appeal.
2. The HMO will request any additional information needed to evaluate the appeal within 24 hours of receiving the request.
3. The HMO Level One Appeal Committee will make a decision about the appeal within 24 hours or no later than 3 calendar days of receiving the requested information.
4. A verbal notification will be made to the party filing the appeal, the member, the PCP and any health care provider who recommended the health care service.
5. A written notification will be sent to the same parties within two business days of the appeals determination.

If the Level One determination agrees with the original decision, we will notify all parties that the case is being referred to the Level Two Appeal Committee.

If the Level One determination is *different* from the original decision and the outcome is still not satisfactory, a Level Two Appeal can be requested verbally or in writing.

The Level Two Appeal Process:

1. The HMO will notify all parties as soon as possible – within 24 hours – of all the information needed to evaluate the appeal.
2. A decision will be made within 24 hours of receiving all the required information and within three calendar days of receiving the appeal.
3. A verbal notification will be made to the party filing the appeal, the member, the PCP and any health care provider who recommended the health care service.
4. A written notification will be sent to the same parties within two business days of the appeal determination.

### **External Independent Review for Clinical Appeal**

If the Level One or Level Two determination is not satisfactory, any involved party may request an external independent review. This request may be made directly to an Independent Review Organization (IRO). The independent reviewer is a clinical peer who has no direct financial interest in the case. The HMO pays all expenses incurred for the independent reviewer.

The two levels of External Independent Review include:

- Normal Process – no immediate risk to member’s health
- Expedited – when a delay would significantly increase the risk to a member’s health, or extended health care services for a member undergoing treatment are at issue

### **Normal Process**

1. The HMO must receive the written request for an external independent review within 180 days of an adverse decision.
2. Within 30 days of receiving the written request, the HMO will select an external independent reviewer who is acceptable to the member and/or the member’s PCP or other health care provider. All relevant medical records and documentation will be provided to the independent reviewer; the identity of the member is not.
3. The independent reviewer will make a decision within five business days of receiving all the information.
4. The HMO will inform the member in writing of the IRO decision, unless the IRO has already notified the member directly. If the IRO reverses the HMO’s decision, the HMO will inform the member in writing of the time and procedure for claim payment or approval of service.

### **Expedited Process**

1. A request for an expedited appeal may be submitted to Member Services verbally or in writing.
2. The HMO will request any additional information needed for the expedited appeal from the Medical Group or other provider. The Medical Group or other provider will be asked to respond within 24 hours.
3. The IRO will determine if the appeal is eligible for IRO review.
4. The IRO will make a final decision as promptly as possible – within 24 hours of receiving all necessary information.
5. The member will be notified immediately of the decision by telephone with a follow up notification in writing.

**Non-Clinical Appeal** - an oral or written request that concerns an adverse decision of a previous injury, complaint or action by the HMO, its employees or its independent contractors that has not been resolved to the member’s satisfaction. A non-clinical appeal relates to administrative health care services that include (but are not limited to) membership, access, claim payment, denial of benefits, extension of benefits, out-of-area benefits and coordination of benefits with another health carrier.

**Non Clinical Appeal Process:**

1. The process begins by contacting Member Services by telephone or in writing, indicating a request to appeal a decision.
2. The HMO will send a written confirmation within five business days of receiving the appeal request. If the appeal can be resolved with existing information, a decision will be made. If additional information is needed, we will request that it be provided within five business days.
3. The appeal decision will be made within 30 business days of receiving the initial request. In cases when the decision cannot be made within 30 business days (due to circumstances beyond the HMO's control), the member will be informed of the delay before the 30<sup>th</sup> business day. A decision will be made on or before the 45<sup>th</sup> business day of receiving the appeal.

If the Level One Committee maintains the denial, the member is notified that the case is being referred to the Level Two Appeal Committee. The member is also informed of the right (or the right of someone acting on behalf of the member) to appear in person, via conference call or using other appropriate technology.

**The Level Two Appeal Process:**

1. The HMO will notify the parties in writing at least five business days prior to the date the Level Two Appeal Committee is meeting to review the case.
2. A verbal notification of the decision will be made to all parties.
3. A written notification will be sent with five business days of the Committee meeting and within 30 days of the date the Level Two Appeal process began.

**Additional Information:**

- If the member, designee or guardian is not satisfied with the way HMO Illinois is handling a clinical or an administrative appeal at any step of the process, they may contact the State of Illinois Department of Insurance at (877) 527-9431.
- No person reviewing the appeal may have had any involvement in the initial determination that is the subject of the appeal.
- In at least one internal level of a clinical appeal, a clinical peer will participate in the process.
- The HMO, at its discretion, may bypass the first level and go directly to the second level of appeal without the member's permission. The HMO may also refer an appeal (bypassing one or move levels of internal review) to the IRO with the member's permission. Upon receipt of a Level Two denial, the member may appeal directly to the IRO. The member may also appeal to the Department of Insurance at any level of appeal.
- Written notifications of determination will include: clear and detailed reasons for the decision, medical and clinical criteria used in the determination and the procedures for requesting an external independent review in the case of an adverse determination.

## **PPO Claims Review Process**

Blue Cross and Blue Shield will process claims no later than 90 days after receiving them. (In some cases, after all necessary information has been received; an additional 90 days may be needed. The member will be notified of this during the first 90 day period.)

- If a claim is denied, the member will receive a written explanation of the denial.
- If a claim is denied, or if 180 days have elapsed since it was filed and the member has not received a written decision, the member may have the claim reviewed.
- A review must be requested no later than 60 days after the denial, or after the end of the 180 day period. The request for review should be sent to:

Claim Review Section  
Health Care Service Corporation  
P. O. Box 2401  
Chicago, Illinois 60690

- Once the review is requested, the member may submit additional information and comments on the claim to Blue Cross and Blue Shield as long as it is done within 30 days of the date the member asked for the review.
- During this 30 day period, the member may review any pertinent documents held by Blue Cross and Blue Shield by making an appointment in writing to the above address.
- Within 60 days of receiving the request for review, Blue Cross and Blue Shield will send the member its decision on the claim. (In unusual situations, an additional 60 days may be needed for the review. The member will be notified of this during the first 60 day period. By law, no more than 120 days can be taken for a review, even at the member's request.)
- The member may have someone else represent him/her in the review procedure as long as the member informs Blue Cross and Blue Shield, in writing to the address above, the name of the person who will be the representative.

## **Transition of Care - HMO**

HMO members can request transition of care benefit when the member is receiving services from a physician who leaves the network or when an employee/dependent is considering joining HMO and his/her current doctor is not in the network. To qualify, a member must be receiving an ongoing course of evaluation and/or medical treatment or be in the second or third trimester of pregnancy.

Benefits for transitional services may be authorized for a period up to 90 days from the date of the physician's termination from the network or the member's original effective date (for new members). Authorization of services is dependent on the physician's agreement to comply with contractual requirements and submit a detailed treatment plan, including reimbursement at specified rates and adherence to HMO quality assurance requirements and HMO's policies and procedures. All care must be transitioned to the member's new PCP/Medical Group after the transition period has expired.

*"Ongoing course of treatment" means the treatment of a condition or disease that requires repeated health care services pursuant to a plan of treatment by a physician because of the potential for changes in a therapeutic regimen.*

### **How to Request Transitional Care**

- If an existing member receives notification that his or her medical group and/or PCP is leaving the network, the member must submit a request in writing within 30 days of receiving the notification. If a new member's current physician does not participate in the plan network, the member must submit a request in writing within 15 days after the eligibility effective date. Requests should include the subscriber's name, group and member identification number, patient name, treating physician name, and a detailed reason for the request. Submit the request to:

Blue Cross and Blue Shield of Illinois  
Transition of Care Unit  
300 East Randolph Street, 25<sup>th</sup> floor  
Chicago, IL 60601

- HMO will contact the member's physician to obtain a treatment plan and a signed contract stating the physician will adhere to all contractual requirements.
- Within 15 days of our receiving the transition of care request, we will provide the member with written notification of our decision. If the request has been denied, the reason will be given. The notification will outline the services that have been approved and the timeframes for the transition of care benefits.

*Approved transitional care benefits apply to services related to the ongoing course of treatment. All other care must be approved or coordinated through the HMO Medical Group and/or PCP.*

## **Away From Home Care - HMO**

The Away From Home Care (AFHC) program provides HMO employees or their eligible dependents with benefits when they are traveling or temporarily living out of state. Members or dependents receive benefits through a national network of affiliated Blue Cross and Blue Shield HMOs. This two-part program consists of Urgent Care and Guest Membership benefits.

### **Urgent Care**

Under the AFHC Care program an urgent care emergency is defined as an unexpected illness or injury that is not life-threatening but that cannot reasonably be postponed until a member or dependent returns to his or her home service area. Examples of an urgent care illness or injury are an ear infection or a sprain. Urgent Care claims are administered through the BlueCard® program. The BlueCard program is a national network of participating Blue Cross and Blue Shield providers that gives members easy access to participating providers for urgent care services.

### **To Access Care**

The member or dependent should search our website at [www.bcbsil.com](http://www.bcbsil.com) or call (800) 810-BLUE (2583) to locate a provider in the area he/she is visiting. The provider will file all claim forms and all the member or dependent may be required to pay is the office visit copay.

### **Guest Membership**

Any time a member or eligible dependent is away from home for at least 90 days, he/she can become a Guest Member at an affiliated Blue Cross and Blue Shield HMO near his/her destination. This benefit is particularly valuable for out-of-state college students. The member or dependent will receive the same health care coverage he/she has at home.

### **To Participate as a Guest Member**

- The member or dependent should contact Member Services and explain that he/she will be living *temporarily* away from home. The coordinator will determine if there is a participating Blue Cross and Blue Shield HMO near the travel destination. If so, the coordinator will assist the member or dependent in applying for Guest Membership.
- The Host (Destination) HMO AFHC coordinator will contact the member or dependent with information about the Host Blue Cross and Blue Shield HMO. The information will include a list of physicians and benefits that the member or dependent will be entitled to as a Guest Member.

*If the member or dependent is moving out of state or using COBRA benefits, they are not eligible for Away From Home Care Guest Membership Coverage.*

## **Out of State Benefits for the PPO Member**

The BlueCard® Program is designed to give Blue Cross and Blue Shield of Illinois member's easy access to participating doctors and hospitals across the country and around the world. The BlueCard PPO Program is a PPO network that allows any Blue Cross and Blue Shield member to receive in-network PPO services while traveling or living outside their normal Blue Cross service area.

### **Identification Cards**

The BlueCard Program is indicated by a “suitcase” logo on the ID card. This logo helps Blue Cross and Blue Shield providers recognize a BlueCard member. The ID card also shows a three-letter alpha prefix (e.g. XOF) to alert providers to file your employees' claims with the local Blue Cross and Blue Shield Plan. It is important that your employees present their ID card when they receive care to ensure that their records are updated and that the claim is filed correctly.

### **How To Locate a Blue Cross and Blue Shield Provider**

When your employees receive care outside the Blue Cross and Blue Shield of Illinois provider contracting boundaries, they simply present their ID card with the suitcase logo to a participating Blue Cross and Blue Shield Plan provider. Participating providers include more than 85 percent of all hospitals and physicians across the United States that contract with independent Blue Cross and Blue Shield Plans. Members can easily find information about a BlueCard PPO doctor or hospital by calling the toll-free customer service number on the back of the ID card, BlueCard Access at (800) 810-BLUE (2583) or using the Provider Finder on our Web site at [www.bcbsil.com](http://www.bcbsil.com).

### **How It Works**

- Your employees and their covered dependents should always carry their most current ID card.
- Your employees are responsible for calling BCBSIL to satisfy any precertification or prior authorization requirements, when using the BlueCard PPO Program.
- When your employees or their covered dependents arrive at the doctor's office or hospital, they should present their ID card and the doctor or hospital will verify membership and coverage information with Blue Cross and Blue Shield of Illinois.
- The provider will file your employee's claim to the local Blue Cross and Blue Shield Plan.
- The local Plan will transmit the claim electronically to Blue Cross and Blue Shield of Illinois for benefit adjudication.
- The local Plan pays the provider and Blue Cross and Blue Shield of Illinois mails an Explanation of Benefits to the member. Members are responsible only for out-of-pocket expenses such as non-covered services, deductible, copayment or coinsurance.

### **BlueCard Worldwide®**

BlueCard Worldwide is an international hospital network for employees who travel or live outside of the United States and require inpatient hospital care. This network includes hospitals in Western Europe, Africa, Asia, Australia, South America and other regions.

If the member requires hospital care, he or she can call Blue Cross and Blue Shield of Illinois to identify BlueCard Worldwide participating hospitals in their area or visit the BlueCard Web site at *www.bcbs.com*. The member may also call (800) 810-BLUE (2583) or call collect to (804) 673-1177 for information on international hospitals, clinics and physicians.

### **Inpatient Services Abroad**

For care at a BlueCard Worldwide participating hospital, members should present their Blue Cross and Blue Shield ID card at the time of admission. The member should also call (800) 810-BLUE (2583) and alert staff to the admission. This ensures that the Worldwide Service Center can work with BCBSIL to coordinate eligibility, coverage and secure access with the foreign provider.

### **Outpatient and Professional Services Abroad**

If the member receives outpatient or professional services, he or she should pay for the services and request an itemized bill. The member should complete an international claim form (available from customer service or on our Web site) and submit it to the Worldwide Service Center (the address is on the form). The member can call the customer service number on their ID card if they have questions.

*The member must call BlueCare Connection (BCC) for inpatient precertification when using the BlueCard PPO program. The telephone number located on the back of member ID cards. BluePrint PPO and BAE PPO members are not responsible for calling (BCC) when they use Illinois in-network PPO providers.*

## **BlueExtras**

Through the BlueExtras discount program, Blue Cross and Blue Shield of Illinois (BCBSIL) members are eligible to save money on value-added health care products and services that help support healthy lifestyles. These discounts are for health care products and services not usually covered by your health benefits plan. There are no claims to file, no referrals and no pre-authorizations. And there is no additional fee to participate - it's just one more benefit of being a BCBSIL member!

**If you are already a BCBSIL member, log on to [Blue Access® for Members](#) for details about your coverage and benefits, including specific BlueExtras discount amounts.**

### **Vision Discount Program**

- **Davis Vision**  
Save on laser vision correction surgery and disposable contact lenses through Davis Vision. To learn more about laser vision correction surgery discounts, call Davis Vision customer service at (866) 484-2020. Or, for information about Davis Vision's Lens 1 2 3® Mail Order Contact Lens Replacement Program, call (800) LENS-123.

### **Hearing Discount Program**

- **TruHearing**  
Save on digital hearing aids through TruHearing. Have your hearing tested for free when performed for the purpose of fitting a hearing instrument by a licensed hearing specialist. And enjoy a five-day money back guarantee, a two-year warranty and a selection of hearing aid styles at various price levels. To learn more, or to take advantage of the savings available through the TruHearing discount program, call TruHearing at (866) 687-2020 and identify yourself as a BCBSIL member.

### **Weight Management Discount Programs**

- **Jenny Craig**  
Jenny Craig is a long-term food/body/mind solution that can help manage your weight by teaching you how to create a healthy relationship with food, build an active lifestyle and develop a balanced approach to living. To find the nearest Jenny Craig Centre, or to enroll in Jenny Direct—the at-home program—call (800) 597-Jenny (800-597-5366) or visit the Jenny Craig Web site at [www.jennycraig.com](http://www.jennycraig.com).
- **Curves**  
Curves offers a 30-minute workout that combines strength training and sustained cardiovascular activity through safe and effective resistance equipment. Curves has made exercise available to more than four million women, many of whom are in the gym for the first time. For more information about Curves and to find the

locations nearest you, visit the Curves Web site at [www.curves.com](http://www.curves.com) or call **(800) CURVES-30/(800-287-8373)**.

**Complementary Alternative Medicine Discount Programs**

Complementary Alternative Medicine (CAM) includes a variety of therapies that may help to increase wellness, prevent illness and address existing symptoms and conditions. Through BlueExtras, you're automatically eligible to receive discounts from a network of more than 35,000 practitioners, spas and wellness and fitness centers. You're also eligible to receive discounts on vitamins, herbal supplements and health-related magazines. **Note that your plan may provide benefits for chiropractic, physical, occupational and other therapies, as well as certain registered dietitian services.**

## **Premium Billing**

- The current billing statement includes a recap of the previous bill. This lets you see details used in determining the starting figure of the current bill.
- All payments are shown as of the date they were received by Blue Cross and Blue Shield of Illinois.
- The subscriber list is provided for your verification.
- Member changes should be submitted as soon as they occur on the forms provided. Changes received before the date the bill is prepared will be shown on the current bill. Changes received after the bill is issued are shown as retroactive changes on the next bill statement. Changes for future periods will appear on the bill on which they become effective.
- A remittance payment card is included with your bill. The remittance payment card should be returned to us with your payment. Simply fill in the dollar amount of your payment and return the card along with your payment in the envelope provided. This will enable us to credit your account promptly.

On each page of your bill you will find your account number, bill profile detail, bill date and bill period information located in the top right corner.

The account number is unique to your account. Subscribers are assigned to specific group/sections within your account. The group/section should always be included when submitting member changes.

The bill profile identifies the format in which the bill is summarized. Your bill may be formatted in various ways depending on your specific account needs. Billing formats are determined during your account's set up. You may have all products and employee classes combined on a single bill – or multiple bills can be produced based on product, employee class – or both. In addition, you have the ability to sort subscribers in a variety of ways within a bill. To change an existing format, contact your account representative.

The bill date and the bill period information indicates the date the bill was produced and the period the bill applies to.

The **Bill Summary** section begins with the amount due from the previous bill. All activities such as payments and adjustments are individually listed. Charges included in the bill period are summarized by Current Subscriber Fees, which represent the fees calculated for the current bill period. Subscriber Fee Adjustments represent adjustments occurring since the last bill. The last line of the summary indicates the total amount due.

The **Subscriber Fee** section of your bill identifies each of your subscribers along with the appropriate category, product, rate tier, and rate for each subscriber. In addition, an explanation is provided for any adjustments to the subscriber fee.

The category (CAT) column identifies a specific group of subscribers combined for billing purposes. You may have several categories created for your account, if necessary, or just one that combines all of your subscribers.

The product and tier columns display the health and/or dental products for each subscriber and the family status selected for each product (e.g., SUB+ indicates a subscriber and 1 or more dependents are covered). A tier identifier is located at the bottom left hand side of the page. This identifier further defines the Medicare status within the family (e.g., SUB-M indicates a single subscriber who is Medicare primary). A description of each of the applicable tier values can be found in the Rate Table section of your bill.

Subscriber changes are identified in the change reason column. The change reason will be displayed along with the date the change is effective. Any associated fee adjustments will be recorded in the retro fee adjustment column next to the change reason. Current charges are the subscriber charges applicable to the current bill. Total charges include current fees and any retroactive adjustments for a subscriber.

In the **Rate and Exposure Tables** section, the rate table identifies charged rates for the latest billing period by product and rate structure. A benefit agreement represents a specific product or benefit plan design. For each benefit agreement, the Medicare and Non-Medicare rates for each rate structure are displayed.

The exposure table shows the number of subscribers by product and rate class.

A split subscriber is a subscriber that may be Medicare primary with a covered spouse/dependent that is Non-Medicare or vice versa.

Your bill will include a Remittance Card. Fill in the amount paid and send it along with your payment. **Note that the remittance goes to a dedicated post office box, which speeds up processing times. Credit for payments sent to other addresses may be delayed.**

## **Legislative Information**

- COBRA/Continuation
- State of Illinois Continuation
- Health Insurance Portability and Accountability Act (HIPAA)
- Mental Health Parity Act
- Newborn' and Mothers' Health Protection Act
- Women's Health and Cancer Rights Act

## **COBRA/Continuation**

The information provided herein is intended to help you administer your insurance policies. The information should not be construed as legal advice or as a legal opinion on any specific facts or circumstances, and is not intended to replace independent legal counsel. You are urged to consult a lawyer concerning your own situation and any specific legal questions you may have.

### **Introduction**

This COBRA/Continuation section has been created as an overview of some continuation of coverage provisions in federal and State of Illinois insurance law. Employees or dependents losing group health plan coverage may be eligible to continue their group health plan coverage for a specified time under one or more of these provisions. Of course, federal and State of Illinois law does not make every individual eligible under every law—eligibility depends on the size of the employer group (for example, groups that employed 20 or more employees during a typical business day during the prior year are required to offer federal COBRA continuation); type of group health plan (for example, insured vs. self-insured); type of health product (for example, indemnity vs. HMO), and other factors.

If your group health plan is subject to both COBRA and the Illinois statutes, you are not required to offer every continuation option—you are only required to offer the most generous of the available continuation options. For example, if an employee terminates employment and is eligible for both COBRA and Illinois continuation, COBRA would be the more generous option (18 months of COBRA continuation versus nine months of Illinois continuation).

The Illinois continuation statutes apply to all eligible employees and dependents regardless of which state they are living or working in, unless the state has an extraterritorial restriction.

The eligible individual may make only a single election of continuation coverage at the time of the loss of group health coverage. For example, the individual may not elect COBRA coverage and, when COBRA ends, continue group coverage under Illinois continuation.

Some Illinois public servants such as police officers, firefighters, deputies and municipal employees may be eligible for continuation through special State of Illinois ‘public service’ continuation laws, which are not addressed in this guide.

When an employee or dependent is switching from active membership to continuation, please make sure you indicate the type of continuation involved—COBRA or Illinois continuation. Refer to your group’s certificate of insurance for more detailed information or to your group’s attorney for legal interpretation.

Additional information is available at:

- COBRA —The U.S. Department of Labor for COBRA
  - COBRA hotline at (866) 444-3272
  - website at [www.dol.gov/dol/topic/health-plans/cobra.htm](http://www.dol.gov/dol/topic/health-plans/cobra.htm)
- Illinois continuation statutes — The Illinois Department of Financial and Professional Regulations
  - IDPFR hotline at (312) 814-2427
  - website at [www.idfpr.com](http://www.idfpr.com)

### **Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)**

COBRA, a federal law, was enacted on April 7, 1986. As outlined in the chart below, COBRA enables a qualified beneficiary to continue coverage under the group health plan for a specified period of time after coverage is lost due to one of the qualifying events shown. See the headings following this chart for additional information.

<b>Qualifying Event</b>	<b>Qualified Beneficiary</b>	<b>Required Coverage Period</b>
Termination or reduction in covered employee's hours of employment	<ul style="list-style-type: none"> <li>▪ Covered employee</li> <li>▪ Spouse</li> <li>▪ Dependent children, including newborn and adopted children</li> </ul>	18 months
Termination or reduction in covered employee's hours of employment with Social Security disability determination	<ul style="list-style-type: none"> <li>▪ Covered employee</li> <li>▪ Spouse</li> <li>▪ Dependent children, including newborn and adopted children</li> </ul>	29 months
Covered employee becomes entitled to Medicare <b>before</b> a COBRA qualifying event which is a termination or reduction in hours of employment	<ul style="list-style-type: none"> <li>▪ Spouse</li> <li>▪ Dependent children, including newborn and adopted children</li> </ul>	The <b>longer</b> of <ul style="list-style-type: none"> <li>▪ 36 months from the earlier date of Medicare entitlement, or</li> <li>▪ 18 months from the later termination or reduction in hours of employment</li> </ul>
Covered employee becomes entitled to Medicare <b>after</b> the COBRA qualifying event	<ul style="list-style-type: none"> <li>▪ Spouse</li> <li>▪ Dependent children, including newborn and adopted children</li> </ul>	36 months from the earlier date of termination or reduction in hours, but <b>only</b> if the Medicare entitlement would have resulted in a loss of coverage had it occurred before the first

		qualifying event.
Divorce or legal separation*	<ul style="list-style-type: none"> <li>▪ Spouse</li> <li>▪ Dependent children, including newborn and adopted children</li> </ul>	36 months
Death of covered employee*	<ul style="list-style-type: none"> <li>▪ Spouse</li> <li>▪ Dependent children, including newborn and adopted children</li> </ul>	36 months
Loss of dependent status*	<ul style="list-style-type: none"> <li>▪ Dependent child</li> </ul>	36 months
Bankruptcy proceedings	<ul style="list-style-type: none"> <li>▪ Covered retiree</li> <li>▪ Surviving spouse of a deceased retiree</li> </ul>	Lifetime
	<ul style="list-style-type: none"> <li>▪ Spouse of a covered retiree</li> <li>▪ Dependent children of a covered retiree</li> </ul>	Until covered retiree's death + 36 months
<p>* If divorce or legal separation, death of the covered employee, or loss of dependent child status takes place during a period of COBRA continuation, the additional qualifying event extends the continuation period from 18 to 36 months from the date of the first qualifying event, but <b>only</b> if the additional qualifying event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.</p>		

## **Groups That Must Comply**

Effective July 1, 1986, COBRA applies to all employers

- that sponsor group health plans subject to ERISA, including ASO and insured plans,
- and that employed 20 or more employees (including part-time employees) on a typical business day during the previous calendar year.

## **Qualifying Event**

A qualifying event is any of the events listed below that occurs while a group health plan is subject to COBRA and that causes a covered employee (or the spouse or dependent child of a covered employee) to lose coverage under the plan. Qualifying events include:

- termination of employment or reduction in work hours, which can include
  - voluntary termination
  - strike
  - lockout
  - layoff
  - Involuntary discharge.
- death
- divorce or legal separation
- entitlement to Social Security
- a dependent child no longer meeting the groups health plan's definition of dependent
- bankruptcy

## **Multiple Qualifying Events**

A "multiple qualifying event" is an additional qualifying event, occurring during the initial COBRA continuation period that entitles the qualified beneficiary to an extended period of COBRA continuation coverage.

- Disability determination extends coverage for all qualified beneficiaries in the family unit (e.g., a covered employee, the employee's spouse and dependents) from 18 to 29 months from the date of first qualifying event.
- Divorce or legal separation, death of the covered employee, loss of dependent child status and the covered employee's entitlement to Medicare extend the continuation period from 18 to 36 months from the date of the first qualifying event.

The extension of COBRA continuation due to the multiple qualifying event rule only applies to individuals who were covered under the group health plan as qualified beneficiaries 1) as of the first qualifying event; and 2) at the time of the second qualifying event.

### **Qualified Beneficiaries**

Qualified beneficiaries under COBRA are:

- individuals covered under a group health plan on the day before a qualifying event (e.g., the employee, the employee's spouse and dependent children), or
- children born to, or adopted, or placed for adoption with a covered employee during a period of COBRA continuation, or
- spouses and dependents of certain retirees of employers that commence bankruptcy proceedings.

Qualified beneficiaries may elect COBRA independent of the covered employee's election and independent of whether the covered employee's COBRA coverage is terminated.

- For example, a dependent who is a qualified beneficiary may elect COBRA even if the employee does not elect COBRA.
- Another example is a spouse who elects COBRA even though COBRA continuation is terminated for the employee who becomes Medicare entitled.

### **Spouse's Right to COBRA Continuation Coverage**

A spouse of an employee covered by the group health plan has the right to elect COBRA continuation coverage if coverage is lost due to any of the following qualifying events:

- the employee's reduction in hours or termination of employment (other than for gross misconduct);
- divorce or legal separation;
- employee's entitlement to Medicare; or
- employee's death.

### **Dependent's Right to COBRA Continuation Coverage**

A dependent covered by the group health plan may elect coverage:

- following the same qualifying events for which a spouse may elect COBRA continuation coverage, or
- when the dependent no longer meets the group health plan's definition of a "dependent child."

### **Newborn and Adopted Children**

A child who is born to or placed for adoption with the covered employee during a period of COBRA continuation coverage is a qualified beneficiary.

### **COBRA Coverage**

COBRA requires that the employer offer qualified beneficiary health coverage identical to that which the beneficiary had immediately before a qualifying event.

Qualified beneficiaries must be offered the same opportunity as an active employee to elect different coverage during open or annual enrollment.

### **Notification Requirements**

The plan administrator is responsible for notifying all qualified beneficiaries of the right to elect COBRA within 14 days of the qualifying event. It is advisable to send this notice by certified or registered mail.

The covered employee, spouse or dependent is responsible for informing the plan administrator of a birth, adoption, divorce, legal separation, Medicare entitlement or a child losing dependent status under the group's health plan within 60 days of the event.

If the employer and the plan administrator are separate entities, the employer is responsible for notifying the plan administrator within 30 days of the commencement of bankruptcy proceedings or the employee's death, termination or reduction in hours.

### **Electing COBRA**

Qualified beneficiaries have 60 days from the later of: (a) the date that the notice is sent; or (b) the date coverage is lost, to elect COBRA.

### **Payment for COBRA Continuation Coverage**

The employer may charge up to 102 percent of the cost of group coverage. If a period of COBRA continuation is extended from 18 to 29 months due to disability, the employer can charge up to 150 percent of the cost of coverage for the additional 11-month period of extended COBRA continuation coverage.

COBRA can be terminated for failure to make timely payments. There is a grace period of 30 days for payment.

### **Early Termination of COBRA**

COBRA can be terminated under the following circumstances:

- Failure to pay premiums (after a 30 day grace period).
- Coverage under another group health plan after the COBRA continuation period begins, except when the new plan has an exclusion or limitation that would impact a pre-existing condition.
- The employer no longer provides group coverage for any employees.
- A qualified beneficiary becomes entitled to Medicare after the COBRA continuation period begins.

To be entitled to Medicare, an individual must 1) file an application for Medicare Part A hospital benefits or Part B professional benefits, or 2) apply to begin receiving Social Security income payments. Also, certain individuals who are under 65 and disabled are also entitled to Medicare after they receive 24 months of Social Security disability payments. As long as an individual is entitled to benefits under either Medicare Part A or Part B, the individual is considered entitled to Medicare for COBRA purposes.

The United States Supreme Court has determined in *Geissel v. Moore Medical Corp.* that an employer cannot deny COBRA when the qualified beneficiary is covered under another group health plan or is entitled to Medicare at the time he becomes eligible for COBRA.

### **Procedures for Enrolling COBRA Beneficiaries**

COBRA beneficiaries should never be continued in a group section of active employees. Instead, COBRA beneficiaries should be canceled from the active group and section so they receive their certificate of creditable coverage.

- COBRA beneficiaries must then be enrolled in a separate group section number (8888). See the enrollment section for specific form number for a section change.
- A new ID card will be issued with COBRA effective from the date of cancellation of the active coverage.

## **State of Illinois Continuation**

Several State of Illinois statutes offer continuation privileges similar to those offered by COBRA. Employers not required to offer COBRA may be required to offer the appropriate Illinois continuation option. These statutes include

- Illinois continuation
- Illinois spousal continuation
- Illinois dependent continuation
- Illinois public servant continuation options including
  - Municipal Employees Continuation Privilege
  - Firefighter's Continuation Privilege
  - Police Officer's Continuation Privilege
  - Deputy's Continuation Privilege

Authoritative information about the Illinois continuation statutes is available from the Illinois Department of Financial and Professional Regulations

- IDPFR hotline at (312) 814-2427
- website at [www.idfpr.com](http://www.idfpr.com)

## **Health Insurance Portability and Accountability Act (HIPAA)**

### **HIPAA—Overview**

This HIPAA section provides an overview of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Included in the overview are highlights of several sections of the regulations and the Blue Cross and Blue Shield of Illinois (BCBSIL) implementation approach.

### **Background**

- The federal Health Insurance Portability and Accountability Act (HIPAA) affects most group health plans except self-funded governmental entities that are allowed to opt out of specific HIPAA requirements. Both insured and self-funded plans must comply with HIPAA rules since the federal legislation amended the Employee Retirement Income Security Act of 1975 (ERISA). The legislation had a major impact on medical and mental health benefits and their administration. The benefits and administration of BCBSIL products were modified to comply with this legislation.

### **HIPAA Portability Provisions**

#### **Overview**

The intent of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is to protect the health coverage of individuals who switch jobs or leave a job without taking another. HIPAA's portability provisions do not literally require that an individual be allowed to keep identical health benefits when moving from one employer to another, or leaving the job market. Instead, these provisions make it easier for individuals changing employment to enroll in the group health plan offered by the new employer. Or, for individuals leaving the job market, HIPAA ensures availability of individual health coverage through insurers or, as in Illinois, state programs such as HIPAA-CHIP.

To achieve this goal of making health coverage more “portable,” the law limits the use of pre-existing condition exclusions, waiting periods and eligibility restrictions based on health status.

*The information regarding pre-existing waiting periods is included in this manual as a source of reference. However, HMO coverage does not include pre-existing exclusions or waiting periods.*

### **Pre-existing conditions defined**

Under HIPAA, a pre-existing condition exclusion can be imposed on a condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the enrollment date. HIPAA defines the enrollment date as the date of hire or the first day of a new hire waiting period.

### **Pre-existing condition exclusion periods limited**

HIPAA established maximum lengths of time for the pre-existing exclusion periods:

- **Timely enrollment** pre-existing exclusion periods can not exceed 12 months. Enrollment is considered timely if the individual joins when he or she is first eligible or during a special enrollment period.
- **Late enrollment** pre-existing exclusion periods can not exceed 18 months.
- **Affiliation periods** for HMOs cannot exceed two months for timely enrollment or three months for late enrollments. (This requirement will not affect HMOs at BCBSIL since affiliation periods are not included.)

### **Pre-existing condition exclusion periods—pregnancy**

Pregnancy cannot be defined as pre-existing and no pre-existing condition exclusion period may be applied to pregnancy. There is no requirement for the mother to have creditable coverage.

### **Pre-existing condition exclusion periods—newborn or adopted children**

No pre-existing condition exclusion period can be applied to newborns or children who are adopted or placed for adoption as long as they are enrolled within 31 days of the qualifying event. (Although the law indicates that the enrollment period is 30 days, BCBSIL will continue to allow 31 days.)

### **“Creditable coverage” may reduce pre-existing condition exclusion periods**

Pre-existing condition exclusion periods must be reduced by prior “creditable coverage.” Most prior health coverage can count as creditable coverage as long as there is not a gap in coverage of 63 days or more. For example, COBRA coverage is creditable coverage.

- BCBSIL will not request certificates of creditable coverage (COCCs) from incoming members unless a claim is received that appears to be for a pre-existing condition. That claim will be pended until it is determined if the member has prior creditable coverage.

- Upon receipt of a COCC, days of creditable coverage will be used to reduce any remaining pre-existing wait period. BCBSIL will notify the member in writing if any pre-existing condition exclusion period applies to them after credit is given for prior coverage.

### **BCBSIL Automatically Issues COCCs**

Blue Cross and Blue Shield of Illinois automatically issues certificates of creditable coverage (COCC) when coverage is terminated. This certificate reflects the number of days that an individual had coverage with that employer.

- COCCs are automatically issued for dependents.
- COCCs can be requested while active coverage is still in effect.
- COCCs will be issued upon request for 24 months after the termination of coverage.

## **New Hire Waiting Periods**

- New hire waiting periods are not counted as a gap in coverage.
- New hire waiting periods are not included in creditable coverage used to reduce pre-existing condition exclusion periods for future coverage. In other words, when coverage is terminated, the days of the new hire wait period are not included in the certificate of creditable coverage.
- A pre-existing exclusion period starts on the day of hire or the first day of a new hire wait period.

## **Special Enrollment**

HIPAA requires that group health plans include special enrollment periods for certain qualifying events. A special enrollment period may occur if a family member with other health coverage loses that coverage or if a person becomes a dependent through marriage, birth, adoption or placement for adoption.

### **Special Enrollment Event and Effective Date**

- **Loss of coverage** – effective date must not be later than the first day of the month after an employee requests the enrollment for himself or herself or on behalf of a dependent.
- **New dependents** – enrollment is available for the employee, spouse and/or any new dependents:
  - a) Due to marriage - the effective date is no later than the first day of the month after the request for enrollment is received.
  - b) Due to birth, adoption or placement of adoption - the effective date is the date of the birth, adoption or placement for adoption.
- **A person with a special enrollment** – qualifying event is subject to the timely enrollment rules (maximum of 12 months pre-existing condition exclusion period). An exception is that no pre-existing waiting period is applied to a newborn or child under age 18 who is adopted or placed for adoption. The effective date is the same for all family members enrolling during the qualifying event period.

## **Late Enrollment**

Late enrollees without other coverage do not have the same protection HIPAA gives to other enrollees.

- HIPAA does not require employers to allow these individuals to enroll.
- Late enrollees without other coverage could be subject to an 18-month pre-existing exclusion period.

However, if the employer allows late enrollments, the following requirements apply:

- Non-discrimination requires that all employees must be accepted.
- No more than 18 months pre-existing exclusion period can be applied.
- Health status, genetic information or prior claims coverage can not be considered to determine eligibility or to determine contribution levels.

*This information has been included for reference purposes. HMO does not allow late enrollment.*

### **Group to Individual Coverage Rules**

In Illinois, the Illinois Comprehensive Health Insurance Plan (ICHIP) is the individual program that offers protection to HIPAA-protected individuals.

To be eligible for HIPAA-CHIP, an individual leaving group coverage must have 18 months of creditable coverage and exhaust COBRA coverage.

Enrolling in a conversion policy makes an individual ineligible for the protection of HIPAA if that individual later applies for HIPAA-CHIP.