Group Administrator Manual

BlueCross BlueShield Kansas

bcbsks.com/gam

Welcome!

We're glad you're a part of the Blue Cross family.

At Blue Cross and Blue Shield of Kansas, we're committed to the health of your business. And are here to help provide information when administering your company's health plan.

This manual is designed to:

- Provide useful information when you need it.
- Help you and your employees navigate important life events.
- Make sense of rules and regulations about health care, including employer requirements as mandated by the Affordable Care Act (ACA).

The information you need to administer your Blue Cross health plan is summarized within the manual. There's also a contact us section on page 2, if you have questions.

Thank you for placing your trust and confidence in us.

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Resources

How to contact us

Your sales representative is here to help. For questions about applications, change forms, benefit and renewal information or eligibility issues, call or email your sales representative.

General inquiries

Our customer service phone lines are open between 8:00 a.m. and 4:30 p.m.

Topeka 785-291-4013
Toll-free 800-432-3990
Hearing impaired: 800-766-3777

By mail:
1133 SW Topeka Boulevard
Topeka, KS 66629-0001

Enrollment

When sending enrollment information, email or fax our membership team. Include your company name and group number within the subject line.

Email: membership@bcbsks.com
Please include your group name and number in the subject line.

Fax: 785-290-0770

Pre-admission certification*

The patient's doctor (or the patient, if services are received from a non-contracting provider) is required to obtain prior approval for all planned inpatient admissions. If approval is not obtained, payment for any resulting medically unnecessary services will be denied.

Topeka 785-291-4180
Toll-free 800-782-4437

* Pre-admission certification is not required for emergency or obstetrical admissions.

Claims denied for other party liability

(duplicate coverage, workers' compensation or automobile accidents)

Topeka 785-291-4013
Toll-free 800-432-0216, ext. 4013

Anti-fraud hot line

Fraud adds unnecessary expense to the health care for you and for us. If you or one of your employees suspect medical fraud, please contact the Blue Cross Anti-Fraud Unit.

Blue Cross would like to assist you in making sure that your group is paying only for those individuals who are eligible for coverage under your contract. If you suspect your group is paying for someone (i.e., ex-spouse, married child, grandchild or other person) who is not entitled, let our special investigations unit investigate your concern.

(Callers may identify themselves or remain anonymous.)

Topeka 785-291-6400
Toll-free 800-432-0213, ext. 6400

Email: suspected.fraud@bcbsks.com

Online resources

BlueAccess®

Our secure online portal for easy and convenient viewing of your employees' account information.

For employees

- View benefits, including eligibility and deductible/coinsurance information
- Check claims
- View, download and monitor medical expenses through Explanation of Benefits (EOBs)
- Change mailing address

Employees may go online to register:

1. Go to bcbsks.com/welcome
2. Click *Sign up for BlueAccess*
3. Have ID card handy and follow the step-by-step instructions

BlueAccess for you

- Verify benefits, including eligibility and deductible/coinsurance information
- Employee search for details of member coverage
- Electronic payment with eBilling
- Online enrollment through BluesEnroll

Contact your sales representative to obtain a password and user ID if you don't already have a BlueAccess employer account.

Online tools for you

Forms & Manuals

eBilling – online billing

BluesEnroll SM – online enrollment

- Less paperwork
- Central database
- Updates, corrections and reports completed online

To sign up for BluesEnroll contact your sales representative.

Online tools for all

Email access for customer service

Find a doctor/provider network

HealthyOptions SM – discount partners and wellness programs

Glossary of health care terms

Enrollment

Initial opportunity

Initial opportunity is the first opportunity an employee is eligible to enroll in health benefits following completion of the Company Imposed Waiting Period (CIWP).

CIWP is a period of time set by the employer when the employee and their dependents aren't eligible for benefits under the health insurance program. Standard waiting periods are typically 0, 15, 30, 45 or 60 days.

Waiving a company-imposed waiting period may be done. We must receive written notification requesting to waive the entire CIWP prior to the 60th day following the employee's full-time first day of work or rehire date.

If the written request is received on or after the 60th day, the entire waiting period will apply.

Qualifying events

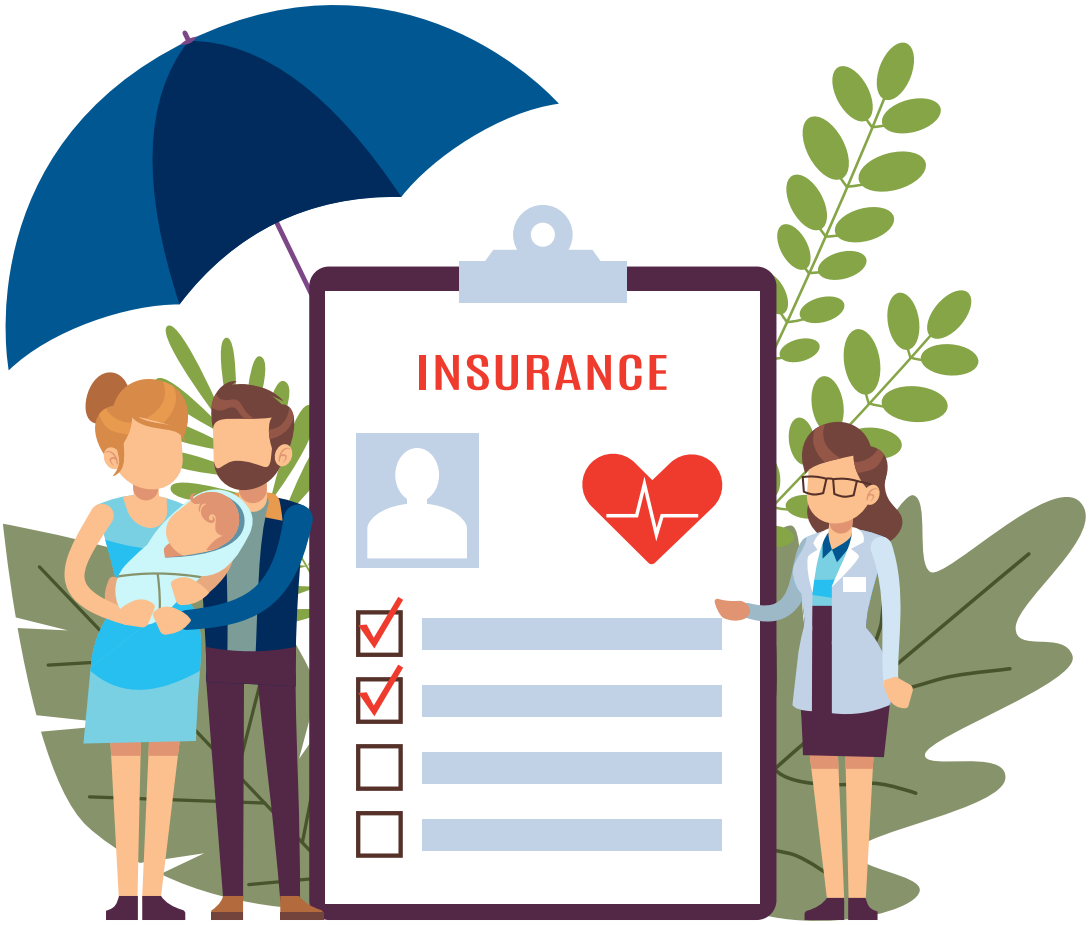
A qualifying event is a change in an employee's situation like getting married, having a baby or losing health coverage. A life event allows an employee and their dependents* to enroll in health insurance or change the status of his or her enrollment.

Health coverage will be effective the first of the month following a qualifying event when the application/change is received by Blue Cross prior to the 60th day following the qualifying event.

For the birth of a child, adoption or discharge from the military are all events that will start coverage the date the event occurred.

Refer to our qualifying events chart on page 5 for additional information.

*Voluntarily quitting other health coverage or being terminated for not paying your premiums are not considered loss of coverage. Losing coverage that is not minimum essential coverage is also not considered loss of coverage. However, choosing to not renew an existing policy at the end of the plan year is considered loss of coverage.



Qualifying events	Qualifying event for enrollment	Qualifying event for status change	Loss of coverage required to be a qualified event
Divorce/annulment	✓ employee/spouse	✓ if dependent under limiting age	✓
Death of a spouse	✓	✓	✓
Spouse's loss of employment	✓	✓	✓
Spouse's employer no longer offers coverage	✓	✓	✓
Dependent reaches limiting age of parent's contract or is no longer eligible for student coverage		✓	✓
Dependent marries		✓	✓
Affidavit dependent no longer meets qualification to be considered an affidavit dependent		✓	✓
Dependent loses eligibility under TriCare		✓	✓
Expiration of COBRA or State Continuation	✓	✓	✓
Complete cessation of employer contribution	✓	✓	✓
Discharge from the military (employee/spouse)	✓	✓	✓
Individual becomes ineligible for Medicaid/Healthwave	✓	✓	✓
Individual becomes ineligible for Medicare	✓	✓	✓
Birth of a child	✓	✓	
Marriage	✓	✓	
Adoption	✓	✓	
Upon return from FMLA	✓	✓	
Loss of group coverage at another plan's open enrollment	✓	✓	✓
Victim of domestic abuse or spousal abandonment	✓	✓	

Enrollment *(continued)*

Changes to existing coverage

When your employees need to make changes to their existing coverage, either for adding or removing dependents, please submit a Change Form to Blue Cross.

Note: If an employee participates in a Flexible Benefits/ Premium Conversion Plan, the employee will need to confirm the change is allowed as an IRS status change.

Terminating coverage

Whenever an employee or dependent loses eligibility, notify Blue Cross as soon as possible.

Please submit these changes to Blue Cross no later than the month in which the changes occurred. The coverage will be effective through the last day of the month following receipt of notification.

You may cancel an employee or dependent by completing one of the following:

- Crossing the employee and/or dependents off the group bill and noting the termination date
- Submitting a completed change form
- Sending an email of the termination to membership@bcbsks.com. This should include your group name and number, the member name and ID number and date of termination.

If notification is received after the month in which the changes occurred, the coverage can be canceled for the first of the month notification was received, if requested. If no such request is made, coverage will be canceled the first of the month following receipt of notification. Any adjustment in premiums will be made by Blue Cross.

A retroactive cancellation is any request to set a cancellation date prior to the date specified by the standard cancellation policy. No retroactive cancellations will be allowed.

In certain situations, (i.e., death, divorce, child reaching the age limit of the contract, etc.) continuation of benefits may apply. For more detailed information, refer to the Continuation of Coverage section.

Military Policy — Please contact Blue Cross before an employee or dependent enters into active military service.

Change in name/address

When an employee has a name or address change, they need to notify us as soon as possible. Changes can be made within their BlueAccess account or by calling customer service.

Open enrollment

Open enrollment is the month before your company's health plan anniversary date. This is for those who did not enroll at their first opportunity or a qualifying event. If completed applicable forms (applications, change forms, benefit selection forms) are not received by Blue Cross by the last day of the open enrollment month, the employee will not be eligible until the next open enrollment period or occurrence of a qualifying event.

Use our enrollment date calculator to check an employee's eligibility.

Membership ID cards

All new members will receive a membership ID card after they enroll. Renewing members will only receive a new

ID card if there are cost share changes, like a change to copay amount, or if other information that is printed on the cards has changed.

If your card is lost or damaged, you can request a new ID card through BlueAccess®.

Billing

Billing statement

You will receive a billing statement, which is a listing of all enrolled employees in your group and their current premiums plus any unpaid premiums (unless you're on the automatic payment option).

Payment

When is your payment due?
Your Blue Cross coverage is a prepaid health plan. Therefore, payment is due no later than the first of the month. Premiums must be submitted before claims will be paid for that period of time. Please make sure your remittance check or money order reflects your group number.

Two options for electronic bill payment

eBilling
Through the online convenience of eBilling, you are able to view bills and payment activity 24 hours a day, seven days a week. You may also:

- Pay bills
- Make adjustments to bills
- Print and export bills
- Create customized reports
- Go paperless by turning off paper bill

To sign up for eBilling contact Blue Cross at 800-432-3990 or talk with your sales representative.

Automatic payment option
Complete the Automatic Payment Option Form and your employees' premium will automatically be deducted from that account on your next premium payment due date.

Delinquent payments

If the premium payment is not received by the end of the 10-day grace period, a delinquent letter will be sent. If premium payment is not received 10 days after the delinquent letter, your group will be canceled.

Late payments

Late payment of premiums will result in claims being delayed in processing.

Included with each billing are two Group Billing Summary pages and one Group Billing Notice. It is important to include one of the original summary pages with your payment. Please do not send a photocopy or detach the lower portion of the page when sending your payment to us.

General information and questions

If you have questions regarding your billing statement contact your financial auditor at the telephone number shown on the statement.

Billing *(continued)*

When you pay for more than one group plan

Include the Group Billing notice and/or the original Group Billing Summary page for each group, indicating the amount paid for each group. Please indicate all changes on the appropriate Group Billing Notice or Billing Worksheet.

When you receive billings for multiple months

If you are not paying all billed months together, destroy the bills for the months not paid. A new bill will be issued when your payment is processed. Example: You are billed for March and April. However, you are only paying for March. You will need to destroy the April bill.

Employee changes

Indicate all changes on the Group Billing Notice. Add or subtract any additions, changes, terminations or cancellations from the total amount of your bill and return the adjusted amount to us along with the Group Billing Notice. Please include one original Group Billing Summary page.

Best practices

Please use the below guidelines when submitting your payment:

- Return one original summary page with your payment.
- Pay the exact amount if there are no changes.
- Subtract all terminations and cancellations from the total amount billed, along with a note stating the name of the person to be canceled, the reason for the cancellation and the effective date.
- Include the employee's full name, Social Security number or identification number and amount paid when adding employees to your plan.
- Indicate the amount paid as the result of any changes made to the Group Billing Notice.
- Use only black or blue ink.
- Provide a current address for all terminated employees so we can notify them of their continuation options.

Please refrain from:

- Tearing off the lower portion of the Group Billing Summary page.
- Sending a photocopy of the Group Billing Summary page.
- Using red ink, highlighters or pencil when completing forms.
- Sending personal checks from your employee(s).
- Crossing through the identification number on the billing.
- Sending partial payments.

Eligibility

Eligible groups

Groups with 1-50 total employees – Eligible employees are employees/owners who work at least 30 hours per week. The applicant must be employed for personal financial gain and receive wages which would be forfeited if they were to leave the group. Only eligible employees/owners are permitted to enroll.

Groups with 51 or more total employees – Eligible employees are employees/owners who work at least 30 hours a week. However, a group may request eligible employees to be employees who work at least 20 hours a week. To request this change, please contact your sales representative. Applicants must be employed for personal financial gain and receive wages which would be forfeited if they were to leave the group. Only eligible employees are allowed to enroll.

Eligible employees and dependents

It is the responsibility of the contract holder/employer group's plan administrator to submit to Blue Cross only those employees and dependents who meet the eligibility criteria of the contract holder and Blue Cross for enrollment. They should also ensure and verify the continued eligibility status of covered employees and dependents. Blue Cross has the right to recover any benefit payments paid on behalf of ineligible persons.

The following are eligible under employee/dependent coverage subject to underwriting approval.

Lawful spouses
Lawful spouses may be enrolled as dependents.

Disabled dependent
If the child is eligible according to the terms of the member's contract, an Application for Coverage of dependent with disabilities must be completed. For further information, contact the customer service center at 800-432-3990.

Grandchildren and adopted children
Children not by birth, adoption or placement for adoption may be eligible. Members should contact the customer service center at 800-432-3990.

Stepchildren
Stepchildren must be under age 26 and the employee must be legally married to the stepchild(ren)'s legal guardian.

Dependent children by birth
Dependent children by birth must be under age 26.

Employees on extended leave
For questions regarding an eligible employee on extended leave, please contact your sales representative.

Who is not eligible

Employees working fewer than required number of hours

Temporary employees

Seasonal employees

Retired employees

Officers/directors/stockholders/partners
Individuals who are solely officers, directors, stockholders or partners of an organization are not eligible. To be eligible for coverage they must be an employee of the employer and meet the definition of an eligible employee.

A partner cannot be part of a group's cafeteria plan.

Contract labor/independent contractors
These individuals are considered a 1099 contractor and not an employee of the business or businesses. Instead they are considered to be self-employed.

Eligibility *(continued)*

Participation requirements

Groups must meet participation requirements. The following are based on group size and grandfather status.

Grandfathered (all size groups)
70% of adjusted eligible employees

Non-Grandfathered (2-50 size groups)
70% of adjusted eligible employees

Non-Grandfathered (51+ size groups)
No participation requirement.

Adjusted eligible employees are determined by subtracting non-eligible employees and employees enrolled through a separate group enrollment plan. Contact your sales representative for additional information on participation requirements.

Employer contribution requirements

To be eligible for group coverage with Blue Cross, the eligible group must collect premium amounts through payroll deductions and must contribute to those premiums.

Groups offering employees a single benefit choice: Employer contribution is required.

Groups offering employees two or more benefit plans to choose from: Employer contribution is required and must be at least 25% of the employee only cost of the highest deductible option.

Retirees

Companies subject to State statute 12-5040
Each local government which provides an employer-sponsored group health care benefits plan for the employees of the local government shall make coverage under such group health care benefits program available to retired former employees and their dependents, upon written application filed with the clerk or secretary thereof within 30 days following retirement of the employee.

Coverage under the employee group health care benefits plan may cease to be made available upon (1) the retired employee attaining age 65, (2) the retired employee failing to make required premium payments on a timely basis, or (3) the retired employee becoming covered or becoming eligible to be covered under a plan of another employer.

Each local government shall make such coverage available to all persons who were employed by the local government for not less than 10 years and who retired from such employment after Dec. 31, 1988, and may make such coverage available to other retired employees and their dependents. Each such retired employee who elects to continue such coverage may be required to contribute to the employee group health benefits plan, including the administrative cost.

Employees subject to the above will be canceled when attaining age 65.

Blue Cross is not required to allow retirees who are subject to 12-5040 to remain enrolled once they retire. It is the group's responsibility to offer such coverage. However, Blue Cross has agreed to allow employees subject to 12-5040 to remain enrolled, provided it is mutually agreed upon by the group and Blue Cross.

Groups subject to Small Group Rate Reform*
Employees currently enrolled on their employer's retirement or disability plan are allowed to keep Blue Cross group coverage, provided the group was enrolled continually prior to small group rate reform (July 1, 1992). New employees are not eligible for the group's retirement or disability program. Groups with an effective date of July 1, 1992 or later cannot consider retired or disabled employees (working fewer than the required number of hours for a full-time employee) as eligible employees.

Groups not subject to Small Group Rate Reform*
Retired or disabled employees may be offered Blue Cross group coverage by their employer, provided it is mutually agreed upon by both the group and Blue Cross.

*Small Group Rate Reform — State legislation that applies to groups with 50 or fewer full-time employees.

Continuing coverage

COBRA

State and Federal Legislation Regarding Continuation of Coverage
Federal Law – Groups over 20 in size

Group health plans for employers with 20 or more employees on more than 50% of its typical business days in the previous calendar year are subject to COBRA. Both full- and part-time employees are counted to determine whether a plan is subject to COBRA. Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full-time.

We review your status at the anniversary of your group each year; however, your COBRA determination should be calculated on a calendar year basis – January through December – each year. Please evaluate your group's COBRA responsibility each calendar year and notify your sales representative if your status changes.

COBRA is not directly addressed to insurance companies, but is an obligation of the employer. You therefore need to make certain that you notify employees, spouses and dependents of the rights they are entitled to under COBRA. Employers must give notice of the right to continue coverage to each employee, spouse and dependent child(ren) at the time they become covered under your plan. When a spouse is added after initial enrollment of the employee in the group health plan, they are to be notified independently of their COBRA right. The Continuation Coverage Rights Under COBRA General Notice Template can be used for both. However, you should always verify with your legal advisors that the information is current.

Right to COBRA

Once employees have elected continuation of coverage and we receive the COBRA declaration form, we will bill them for the group coverage. If your group changes carriers during any COBRA continuation period, the COBRA continuation employees remain the responsibility of your group, whether the new carrier covers them or not, and Blue Cross will not provide coverage if our contract is terminated.

COBRA entitles a group health plan to bill a person exercising their continuation rights up to 102% of the "applicable premium" for active employees in the group. "Applicable premium" is generally the same premium, which applies to other similarly situated employees and dependents. For self-insured groups, there is an alternative method for calculation of "applicable premium." However, as the administrator, Blue Cross will ordinarily bill at 102% of the same premium that has been projected for current employees and dependents. For an employee with the right to an extension of continuation by reason of being disabled within 60 days of the qualifying event, the group health plan is entitled to charge up to 150% of the applicable premium for continuation of coverage months, after the 18th month.

COBRA/Medicare eligibility

The Medicare eligible member may or may not be eligible for COBRA depending on his or her situation.

- Enrollee becomes eligible for Medicare **prior to** the COBRA effective date:
  - Enrollee is eligible for COBRA. COBRA coverage always pays secondary to Medicare coverage.
- Enrollee becomes eligible for Medicare **after** the COBRA effective date:
  - Enrollee is not eligible for COBRA. If member is already on COBRA coverage, any benefit for which COBRA is elected would be terminated upon post-election Medicare entitlement.

Continuing coverage *(continued)*

- Enrollee become eligible for Medicare on the COBRA effective date:
  - If the COBRA form is signed before the Medicare eligibility date, the member is not eligible for COBRA.
  - If the COBRA form is signed on or after the Medicare eligibility date, the member is eligible for COBRA. COBRA coverage always pays secondary to Medicare coverage.

If a member is eligible for Medicare and enrolled in COBRA coverage, Medicare will be the primary insurer. If the member is eligible for but not enrolled in Medicare coverage, the patient will be responsible for any amounts that Medicare would have paid.

Uniformed Service Employment and Reemployment Rights Act (USERRA)

Applies to all group sizes

The Uniformed Service Employment and Reemployment Rights Act of 1994 provides certain rights to employees who are absent from work for service in the uniformed services. Under this act, the employee has the right to continue the coverage he/she has under your company medical plan if certain conditions are met.

Leave of absence and Family Medical Leave Act (FMLA)

When an employee takes a leave of absence consistent with your company's personnel policy, you do not have to take any special action regarding their health insurance with Blue Cross.

If your company requires employees to pay for their group health plan coverage during the leave period, payment must be made payable to your company and not to Blue Cross. We will continue to include the name of the employee on leave on your monthly billing statement.

If an employee is on an approved family leave and your company is subject to the federal Family Medical Leave Act of 1993, payment of the employee's dues will keep coverage in place for the periods allowed by the Act.

The length of a leave of absence is determined by your company's personnel policy. Therefore, your company's policy determines if or when the employee on leave is terminated.

State Continuation of Coverage Law

Groups with less than 20 employees

Employers who offer a group health plan for their employees and have fewer than 20 full-time employees are affected by the Health Care Reform Act of 2008. This law allows group health insurance benefits for hospital, medical and/or surgical services.

Employees and their dependents who meet certain criteria must be offered continued group benefits for a total of 18 months from their state continuation effective date. This continuation of coverage must be offered at the same premium available through the group. Although the 2008 provisions state employers will bill employees, Blue Cross will continue to process as a value-added service for groups. This includes notification of eligibility to the employee and direct billing to the employee. The 2008 law affects all groups except those on self-insurance.

If the group health insurance is replaced by similar group coverage within 31 days, the employee is not eligible for continued group benefits under State continuation and conversion laws.

If the employee and/or dependents have not been covered by your group health insurance coverage for three months prior to termination, they are not eligible for State Continuation but their loss of coverage may qualify them to enroll in an individual plan.

Medicare

Managing the transition to Medicare

Medicare is a federal health insurance program for people age 65 and over and for some disabled individuals.

The Age Discrimination in Employment Act (ADEA) requires you to counsel employees or dependent spouses nearing age 65 about Medicare benefits.

You must counsel them on:

- Eligibility requirements
- How to apply
- Medicare's relation to your group health plan

As your employees reach retirement age, contact your sales representative for information about our Medicare Supplement and Medicare Advantage options.

There are three primary parts to Medicare:

- **Hospital insurance (Part A)** — to help pay for the cost of hospitalization and related services. Nearly everyone age 65 and older is eligible to receive these benefits.
- **Medical insurance (Part B)** — for medical-surgical and outpatient services. If your employees and/or their spouses elect Medicare as primary payer of their medical expenses, they will need to enroll in both Parts A and B of Medicare. Be sure to have these employees check with their local Social Security office within the 60-day period prior to their 65th birthday for Medicare enrollment details.
- **Prescription drug insurance (Part D)** — for outpatient prescription drugs. More information on Part D can be found on the CMS website. Creditable and Non-creditable coverage forms continue to change. Please reference the CMS website for the most current examples.

Change in coverage

A change in medical coverage may be an option when an employee or the employee's dependent spouse reaches age 65. At least one of the following conditions must apply:

- Your group plan is not subject to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), and the employee or spouse has not already changed to Medicare for their primary coverage.
- The employee is retired but has not already changed to Medicare for their primary coverage.

Choosing the primary or secondary health insurer

Secondary health insurance is an insurance plan that pays for some of the costs that primary health insurance does not pay.

As an employee and/or the employee's dependent spouse approaches age 65, their primary and secondary health insurer needs to be determined. It is also possible they will remain enrolled under your Blue Cross group plan.

A member already on COBRA when they become entitled to Medicare will lose COBRA coverage, and certain retired members may lose coverage.

Coverage is determined by the employee's employment status (active or retired) and whether you are subject to:

- ADEA and the amendments enacted as part of TEFRA
- Deficit Reduction Act of 1984 (DEFRA)
- COBRA
- Omnibus Budget Reconciliation Act of 1986 (OMBRA)
- Omnibus Budget Reconciliation Act of 1993 (OBRA)

Your company's legal counsel can help you determine which laws apply.

These guidelines will help you determine when someone is eligible for Medicare primary health coverage. The guidelines will also tell you what administrative changes need to be made to coverage for the employee and/or the employee's dependent spouse.

Medicare *(continued)*

Tax Equity and Fiscal Responsibility Act (TEFRA)

If your group plan is subject to TEFRA, the following rules apply to employers with 20+ eligible employees:

- Blue Cross is primary for the employee if the employee is active or if they are retired and under age 65. Medicare is primary for the employee if the employee is retired and is age 65 or older, unless the retiree has coverage under an active group plan — that is, their spouse is covering them as a dependent.
- Blue Cross is primary for the dependent if the employee is active or if they are retired and the dependent is under age 65.
- Medicare is primary for the dependent if Medicare End Stage Renal Disease (ESRD) Coordination of Benefits (COB) rules are affected by the ESRD "coordination period," and the employee is retired and the dependent is 65 years of age or older.

If your group plan is *not* subject to TEFRA, the following rules apply to employers with fewer than 20 eligible employees:

- Blue Cross is primary for the employee if the employee is under age 65.
- Medicare is primary for the employee if the employee is age 65 or older.
- Blue Cross is primary for the dependent if the dependent is under age 65.
- Medicare is primary for the dependent if the dependent is age 65 or older.

If the member is entitled to Medicare because of disability, various factors are used to determine the primary payer. These include:

- Type of disability
- Age
- Retirement status

Sometimes when a person is on Medicare because of a disability, Blue Cross is primary and Medicare secondary.

If the member has end-stage renal disease, different laws govern who is the primary payer.

Medicare Part D

Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), individuals entitled to Medicare may purchase prescription drug coverage through Medicare.

Individuals entitled to Medicare who do not enroll in Medicare Part D when first eligible will be subject to a significant late enrollment penalty unless they are covered by other creditable drug coverage.

The late enrollment penalty for Part D eligible individuals that go without creditable prescription drug coverage for any continuous period of 63 days or longer after the end of their initial enrollment period in Part D will be an increase in the premium that would otherwise apply, of at least 1% for each month without creditable coverage.

Creditable coverage

Under the MMA most companies that currently provide prescription drug coverage to Medicare Part D eligible individuals must disclose to the Centers for Medicare and Medicaid Services (CMS) and to individual members whether the coverage is creditable prescription drug coverage.

Creditable prescription drug coverage is coverage that is at least as good as the Medicare drug benefit. Blue Cross sends out an annual notification to your company letting you know if your coverage is creditable.

Notice to individuals

The disclosure must be provided to all Part D eligible employees who are covered under your prescription drug coverage. This notice must be sent annually and in the other circumstances outlined below. Consider a group sending the annual notice to all of your employees to ensure all eligible Part D individuals receive the information.

The notice must be sent at the following times:

1. Prior to the Medicare Part D Annual Coordinated Election Period – beginning November 15th through December 31st of each year
2. Prior to an individual's Initial Enrollment Period (IEP) for Part D
3. Prior to the effective date of coverage for any Medicare eligible individual that joins the plan
4. Whenever prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable
5. Upon a beneficiary's request

For sample creditable coverage notices produced by CMS and additional guidance regarding the notice, refer to the CMS website.

Notice to CMS

Groups must also disclose to CMS whether or not their prescription drug plan is creditable. Groups that contract with a Part D plan to provide qualified prescription drug coverage are exempt from this disclosure requirement. This disclosure may *only* be made online.

The notice must be sent at the following times:

1. Within 60 days of the beginning date of the plan year for which the entity is providing the disclosure to CMS
2. Within 30 days after the termination of the prescription drug plan
3. Within 30 days after any change in the creditable coverage status of the prescription drug plan

For the link to the online CMS disclosure form and additional guidance regarding this notice, refer to the CMS website.

Disabled

Groups with 100 or more active full- and part-time employees: If your company has 100 or more employees on your payroll at least 50% or more of last year, the Medicare Secondary Disability Regulation applies. This regulation requires the group health plan to provide primary health insurance benefits for active employees under age 65 who are disabled, and for an active employee's disabled family members if they are covered on the family policy. This provision applies to any employer who has 100 employees on the payroll, or any multi-employer where at least one of the employers has the 100 employees on payroll.

Groups with fewer than 100 active full- and part-time employees: If your group has fewer than 100 employees on the payroll at least 50% or more of last year, active employees, their spouses and/or dependents who are disabled for reasons other than end stage renal disease are eligible to remain on your group's coverage as secondary to Medicare. These employees (spouse and/or dependents) must be sure to sign up for Part A and B of Medicare. In this case, Medicare will be the primary payer of medical expenses and your group health care program will be the secondary payer.

End stage renal disease (ESRD)

An employee eligible for Medicare due to ESRD is encouraged to enroll in Medicare at his or her first opportunity. The employee can choose to wait and enroll in Medicare toward the end of the 30-month time period during which the group is the primary carrier.

If he or she is receiving COBRA benefits, the group will be primary until the COBRA time period ends or until the Medicare 30-month coordination period ends; whichever occurs first.

Omnibus Budget Reconciliation Act (OBRA)

If your group has more than 100 employees on the payroll at least 50% or more of last year, you are subject to OBRA. This requires employers offer current employees, or spouses of employees under age 65, entitled to Medicare due to disability, the same health benefits as other employees. Medicare will be secondary in these cases.

Frequently asked questions

When adding a newborn as a qualifying event, can other dependents also be added to the existing coverage at this time?
Yes.

Refer to the Qualifying Events and Special Enrollment Rights section on page 5 for more information.

How do I make an inquiry on behalf of an employee?
To make an inquiry on behalf of an employee, a HIPAA Designation Form must be completed by the employee. This form must be on file with Blue Cross before we can provide information to someone other than the member.

When calling, be prepared to provide the following information:

- Inquirer's name
- Inquirer's relationship to member
- Inquirer's phone number
- Member's group number
- Member's ID#/SS#
- Member's full name

What happens when there is other insurance involved in a claim such as auto or workman's compensation?
Call our other party liability department for information on how payment will be coordinated between carriers.

Topeka 785-291-4013
Toll-free 800-432-0216 ext. 4013

Can a divorced employee continue to provide coverage on an ex-spouse and/or stepchild(ren)?
The spouse and/or stepchild(ren) are no longer eligible for coverage the first of the month following the date of the divorce. Once notification of divorce is given to Blue Cross and Blue Shield of Kansas by the employer, coverage will be removed effective the last day of the month of notification.

What does an employer do when a parent (who is an employee) refuses to add a dependent from a court order to provide health care coverage?
If we receive a qualified medical support order (QMCSO) instructing a parent to add a dependent to medical coverage, the parent has no choice but to have that dependent enrolled and pay for any additional premium.

My employee received an inquiry regarding a paid medical claim from Rawlings Company LLC. Why are they getting this letter?
Rawlings and Associates is an insurance law firm contracted by Blue Cross to handle subrogation services. Subrogation is a cost containment activity which allows groups to recover claims payments where duplicate amounts are sometimes received through a lawsuit or settlement from a third party (or its insurer). When employees receive this questionnaire, they should complete it and return it in the provided envelope.

The NYHCRA filing requirements for BCBSKS, and its self-funded groups, is affected by a special agreement between the DOH and Empire. Empire acts as a conduit for payment of claims in New York through the ITS, for BCBSKS and its self-funded groups. Empire is considered payor of claim and, as payor, is obligated to remit NYPGP reports, surcharge payments and covered lives, if applicable, to the OPA in New York. Empire files the NYPGP reports and submits the surcharge under their election, and then bills BCBSKS.

Privacy compliance

HIPAA

What is HIPAA Privacy?

HIPAA stands for the Health Insurance Portability and Accountability Act. This federal act ensures the privacy and security of health information. HIPAA Privacy was designed to provide additional rights and protections to participants in health plans. Blue Cross has spent significant time examining how the HIPAA Privacy regulations affect our business relationship with our fully insured and self-insured health plans.

We take our responsibility of protecting your Protected Health Information (PHI) very seriously. We have a number of policies and procedures in place to make sure it stays safe. If you would like to review our policies, please reference these websites.

Privacy policy

- Internet use and privacy statement
- Notice of Health Insurance Portability and Accountability Act (HIPAA) Privacy Practices and Financial Privacy Information

Legal notices

- Blue Cross and Blue Shield of Kansas Inc., Service Area
- Statement of Liability
- Confidentiality of Communications

If you are concerned we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, please contact our customer service department at 800-432-3990 or the privacy officer at 785-291-7309. You may also write to us at:

Blue Cross and Blue Shield of Kansas
P.O. Box 2218
Topeka, KS 66601-2218

This group administrator manual is intended to be a brief outline of benefits available. It does not include all of the terms of coverage offered by Blue Cross and Blue Shield of Kansas or its affiliates. The entire terms are contained in the respective contract documents (the applicable certificate, policy, employer application and/or trust agreement). In the event of a conflict between this manual and the policy under which the group insurance coverage is provided, the terms of the policy will prevail. The guidelines in this manual are subject to change from time to time without prior notice.

Visit us at bcbsks.com/gam

BlueCross BlueShield Kansas

1133 SW Topeka Blvd, Topeka, KS 66629

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