



Highmark Group Administrator Manual

Membership and Billing

You should contact Membership and Billing for assistance with:

- Changes in employee information or coverage
- Requests for duplicate membership identification (ID) cards
- Adding or terminating employees and/or dependents
- Explanation of billing activity
- Requesting forms
- Resolution of outstanding premiums
- Request for a duplicate invoice

Please contact your Membership and Billing Administrator between the hours of 7:30 AM and 4:30 PM at the appropriate number or email address listed below:

If you purchased your coverage through a(n):	ASSOCIATION	PRODUCER	OTHERS
	1-866-763-9469 WRSCAssoc@highmark.com FAX 412-544-6802	1-866-763-9469 WRSCSmall@highmark.com FAX 412-544-8196	1-877-807-0714 WRSCMid@highmark.com Fax 412-544-4366

Sales and Marketing

You should contact your Sales Representative for assistance with:

- Premium rates
- Renewal information
- Open enrollment
- Changes to account data

Member Service

To contact us directly, your employees and their dependents can contact Member Service by calling the toll-free phone number on the back of their ID card or by sending us an e-mail using the Secured Message Center on www.highmarkbcbs.com.

Your employees should contact Member Service for assistance with:

- Benefit interpretation
- Claims submission

We have also established a dedicated unit of Customer Service Representatives to assist Group Administrators with benefit and claims related issues. The toll-free Group Administrator phone number is 1-866-228-9475.

Welcome to Highmark! You are among the thousands who have made Highmark their health benefits partner. Your business is important to us. We know that the quality of our products must match our service to you and your employees.

As the Group Administrator, you serve as your employees' primary contact for information about their health care benefits. To assist you in the daily administration of your benefits program, we are pleased to provide you with this manual. Among other things, your Group Administrator Manual outlines procedures to enroll new hires, make status changes, and when necessary, terminate coverage.

Our mission is to provide you with unsurpassed service. We thank you for giving us the opportunity to serve you.

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WHO IS ELIGIBLE?

Eligible Employees

An eligible employee is defined as “an individual who is actively employed by the group (in an employee/employer relationship) and who meets all of the following requirements:

- Works a minimum of 20 hours per week
- Works at least nine months per year
- Receives a verifiable regular wage or income (appears on the payroll)
- Has satisfied the group’s probationary requirements”

Owners are eligible by virtue of ownership unless deemed otherwise by Highmark.

Eligible Dependents

To be eligible for coverage a dependent must meet at least one of the following requirements:

- Spouse (Domestic partners may also be eligible for coverage provided you make the election know to Highmark prior to your initial enrollment or at renewal.)
- Unmarried child under a specified age, usually 19 (including those living with adoptive parents during periods of probation)
- Child as specified in your contract, for whom the employee is legal guardian
- Student dependent to the age specified in your contract. Unmarried children over the regular dependent age are also considered eligible dependents provided they are enrolled as full-time students in an accredited school, college or university and are primarily dependent upon the employee for support.
- An unmarried disabled dependent child over a specified age, usually 19. Disabled dependents are eligible for coverage if they are medically certified by a physician to be incapable of self-support by reasons of physical or mental disability and approved by Highmark Medical Review.

Grandchildren, sisters, brothers, nephews, etc., are only eligible under your group program if the employee is the legal guardian.

Individuals who do not meet the requirements for eligible employee or dependent are not eligible for enrollment in your group’s coverage. They may apply for direct pay coverage by calling Highmark Member Service, applying at www.highmarkbcbs.com or visiting a Highmark Direct retail store.

Domestic Partners

If you offer domestic partner coverage, you are responsible for verifying eligibility. To be eligible, the dependent must provide three or more documents that demonstrate financial interdependence with the employee (e.g., joint mortgage or lease, title to automobile, joint bank/credit account, etc.).

We reserve the right to validate domestic partner eligibility by requesting that you provide copies of the dependent’s financial documents. You should contact your Sales Executive or Producer for additional information.

Who is eligible?

Children

A dependent child is defined as “a newborn, a child legally adopted or placed for adoption, a stepchild, a child awarded coverage pursuant to a court order or a child of a legal guardian who has assumed financial responsibility for him or her.”

Students

If a dependent is enrolled as a full-time student in an accredited school, college, university or licensed technical or specialty school and is primarily dependent on the employee for support, he or she may be eligible to continue coverage to an age specified by your group contract. A student must meet all of the following requirements to be eligible for dependent coverage:

- Does not exceed the age limit stated in your group contract
- Is not married
- Is enrolled full-time in an accredited university, college, high school or licensed technical or specialty school

For most groups, dependent children are automatically removed from their parent's contract at the time they reach their maximum age of eligibility.

Disabled

An eligible dependent child can be covered until the age limit stated in your contract. If a child is medically certified by a physician as unable to work to support themselves due to a disability, the dependent's eligibility will be continued past the limiting age. Highmark Medical Review must certify eligibility before a dependent is enrolled as a disabled dependent.

Eligible Retirees

An eligible retiree is “one who is no longer actively employed by the group and who qualifies for the employer's **formal** retirement benefits program (such as a pension program, 401(K) or 403(B) plan).” To qualify as a “formal retirement program,” the program must be applied uniformly to ALL employees that meet your group's years of service and age requirements; and, the retiree must have been covered as an active employee at the time of retirement. Health care benefits alone do not qualify as a formal retirement program.

You must complete and notarize an Affidavit of Retirement form for each retiree enrolling in your group. Retirees have a 30-day window from the date of retirement to elect coverage. Retirees who do not elect to continue coverage within the 30-day time-frame or who continue coverage and later leave the plan will not be eligible to enroll at a later date.

Ineligible Dependents

Dependent children, who reach the maximum age limit, marry prior to reaching the maximum age limit or are no longer full-time students, are no longer eligible under your group's coverage. The dependent's cancellation date is usually the first of the month following the month he or she reached the maximum age, married or lost full-time student status. Under most programs, the

Who is eligible?

deletion age for a regular dependent is 19; however, depending on your group's contract, your group's age limit may be higher .

Highmark will mail a conversion notice to the member/dependent 45 days prior to their cancellation date. The conversion notice includes an offer to purchase direct pay or COBRA coverage.

ENROLLMENT

Enrolling Employees and Dependents

New employees are effective based on the date you provide, as long as they fall within Highmark's retroactive policy. Current employees and their eligible dependents become eligible on the same date your group's coverage becomes effective.

New Employees

All employees enrolling for new coverage must complete an Enrollment Application. Form JD-7 is used for non-managed care (PPO, Indemnity) coverage. Form Enroll-1 is used for managed care (HMO) coverage.

Employees Returning to Work

To keep both your and our records current, employees returning to work after a layoff or leave of absence must always complete an Enrollment Application (JD-7 or Enroll-1). Even though the employee being rehired may have been previously enrolled in your group's program, they must reapply for coverage. You must include the new effective date on the enrollment form.

Student Dependents

The employee must contact you to have the dependent certified as a student. You must then submit a Member Change form (ENR-010) to Highmark's Membership department as written notification.

You may choose to perform your own student verification or have Highmark perform it for you. We conduct our verifications on one of the following schedules:

1. annually each August
2. semi-annually in February and August

If your group performs its own student verification, we reserve the right to request information to confirm student eligibility.

Disabled Dependents

When you request coverage for an overage disabled dependent, please contact your Membership and Billing Administrator. We will mail the employee a Disabled Dependent Certification form to be completed by the employee, employer, and the family physician and returned to Highmark for review and approval. We will notify the employee of our decision. If the disabled dependent qualifies for coverage, they will automatically be added to the employee's policy.

Terminated Employees

Upon termination of employer provided coverage, Highmark will provide the terminated employee with information on direct pay coverage. If the terminated employee does not enroll in

a Highmark direct pay product within the conversion time frame, they will lose any conversion advantages.

If an employee or an enrolled dependent is receiving hospitalization for benefits on the date coverage would otherwise terminate, those benefits will continue to be provided until the end of that particular hospital stay, or until benefits are exhausted, whichever occurs first.

A cancelled spouse and/or dependent child will be given the opportunity to apply for their own Highmark direct pay coverage. If the spouse and/or dependent are employed where a Highmark program is in effect, he or she may be eligible to enroll in that group's health plan.

Waiving Coverage

Employees that decline coverage for themselves or their dependents must complete Waiver of Insurance Coverage forms (6202). You should both send copies of the forms to Highmark, and include them in the employees' permanent record.

Changes to Enrollment

Change in Family Status

An employee's benefit selection, including waiver of coverage, will remain in effect for the contract year unless he or she experiences what the Internal Revenue Service (IRS) defines as a "change in family status." If an employee has a change in family status, they can change certain benefit selections without having to wait until the next annual enrollment.

A change in family status occurs when:

- The employee gets married, divorced or legally separated
- The employee has a child or adopts a child
- A spouse or child dies
- A child is no longer eligible for dependent coverage
- A spouse loses coverage under another benefit plan, or that coverage is significantly changed (For example, a spouse is laid off or changes from full-time to part-time employment)
- The employee moves into or out of a POS plan network area
- The employee loses coverage by transferring to an ineligible employment status (For example, the employee goes from full-time to part-time and works less than 20 hours per week.)

In addition, if an employee waives health care coverage for themselves and their dependents because they have other health care coverage and they lose that coverage during the year, they may be able to enroll with Highmark prior to the next annual enrollment.

Enrollment

An employee may be eligible for this special enrollment if one of the following occurs:

- The employee and/or dependents are no longer eligible for their other health care coverage — for reasons other than non-payment of premiums
- An employee's COBRA coverage ends — for reasons other than non-payment of premiums
- A spouse's employer-provided coverage becomes fully contributory

Note: Employees and dependents will not be offered conversion privileges if your company cancels its Highmark coverage.

Adding a Spouse or Dependent

To add a spouse or dependent to their agreement, an employee must complete a Member Change form (ENR-010) within 31 days of the date of marriage or birth, or the date the child is adopted or added through marriage. (Refer to page one for specific details.) Current employees and their eligible dependents become eligible on the same date your group's coverage becomes effective.

NOTE: Newborn children are entitled to coverage for the first 31 days following birth, regardless of the employee's marital status, dependent coverage or eligibility for maternity benefits. Under Pennsylvania's Act 81, this coverage is mandatory and extends to medically necessary treatments provided to a newborn during those 31 days. To continue coverage beyond the 31 days, the employee must add the newborn to their policy by completing a Member Change form (ENR-010).

Newborn grandchildren are also entitled to coverage for the first 31 days following birth, provided that the child's mother or father is currently enrolled as an eligible dependent under the employee's coverage. An employee cannot add a grandchild to their policy after the first 31 days unless the grandchild satisfies the eligibility requirements of an eligible dependent.

REPORTING YOUR GROUP'S ENROLLMENT

- If you are an **ePlatform client**, you **must** submit your enrollment **electronically**.
- If you submit your enrollment via paper, you must complete Enrollment Applications (JD-7 or Enroll-1) and/or Member Change forms (ENR-010).

We have electronic enrollment alternatives. If you are not currently submitting your enrollment electronically, please contact your Sales Representative for more information.

Whether you report your enrollment electronically or via paper, we encourage you to submit your updates as changes occur throughout the month.

You can report enrollment activity by using one or more of the following multi-part forms:

Enrollment Application Form JD-7

Form JD-7 is used for non-managed care — PPO, Indemnity and Comprehensive — enrollment. You and/or the employee must complete all fields on the form. After the application has been verified and signed by you and the employee, have the employee keep the last copy for their records.

Enrollment Application Form Enroll-1

Form Enroll-1 is used for enrolling your employees in KeystoneBlue HMO. You and/or the employee must complete all fields on the form. After the application has been verified and signed by you and the employee, have the employee keep the last copy for their records.

Member Change Form ENR-010

When an employee with active coverage needs to change his or her status — change coverage, add or delete a spouse or dependent, change an address, etc — they must complete a Member Change form. The employee must include their Group and Agreement Numbers and fill out any other fields that need to be completed. If adding or removing a spouse or other dependent, the employee must provide the reason. The form must be signed by you prior to being submitted to Highmark.

Report of Enrollment Activity Form COD-SH-297 S

You may include a Report of Enrollment Activity form that summarizes the enrollment additions and changes that you submitted. You must include the number of new and reinstated employees in the “Additions” section of the form. You must include all active members that are changing coverage, in the “Changes” section. If you are terminating employees’ coverage, list the members’ names, Agreement Numbers, termination codes, and the effective dates of termination in the “Terminations” section.

General Form Instructions

You may request additional copies of enrollment forms by calling or sending an email to the number/address listed on the Quick Reference page at the beginning of this manual. You can expect to receive your forms within 10 business days. For your convenience, each form includes an instruction sheet.

- You and your employees must always sign their Enrollment Applications (JD-7).
- You must always either sign your employees’ forms or attach a disclosure statement informing Highmark that you’ve reviewed them.
- You may photocopy or fax your enrollment forms as long as the information is readable and the signature(s) are visible. (If you fax an enrollment form, you do not need to submit the original.)

Once the Membership and Billing department receives your enrollment changes, they will generally process them within four to seven business days. If we receive your enrollment changes up to seven business days prior to printing your invoice, your changes will be reflected

Enrollment

on the invoice. If we receive your enrollment changes after we've printed your invoice, your changes will appear as retroactive adjustments on the next invoice.

NOTE: Do not send enrollment forms or correspondence with your invoice. Send them to the address listed on the enrollment form.

Enrollment and Effective Date of Coverage

Current employees and their eligible dependents become eligible on the same date your group's coverage becomes effective.

New employees are effective based on the date you provide, as long as they fall within Highmark's retroactive policy. An employee's coverage typically begins or ends on the first of the month. If you're not sure what effective date to use, please call your Membership and Billing Administrator.

HIPAA Hire Date

According to HIPAA guidelines, you must include the hire dates' month, day and year.

Death of a Member

You must notify Highmark in the event of an employee's death. The surviving spouse and eligible dependent(s) may be eligible to continue group coverage as COBRA continuants, provided you have 20 or more employees as defined by COBRA law. Otherwise, Highmark will offer the surviving spouse and eligible dependents a conversion to direct pay coverage. We will send a notice describing this option to the surviving spouse and/or dependents. They can also call Member Service or visit a Highmark Direct retail store for more information.

Address Changes

If an employee changes their address, please notify us by submitting a Member Change form (ENR-010). We must have the correct address on file so your employees receive any benefit information, ID cards or literature that we send. You must also notify us if your company changes its location or mailing address.

Retroactive Enrollment Changes

Highmark and your company must mutually agree upon regulations governing delayed employee enrollment.

Retroactive additions, changes and terminations are only permitted for a period of 90 days from the last invoice date. Follow the retroactivity chart when calculating how far back to add/cancel an employee and/or a dependent.

Our retroactivity policy with regard to additions, terminations and changes to enrollment allows you to make retroactive transactions for the *current* month and two additional months. Any retroactive enrollment that falls outside of the guidelines listed below will be adjusted to comply with the chart, unless otherwise approved by Highmark.

Receipt/Entered Date	Max Retro	COBRA Max Retro
January	November 1	August 1
February	December 1	September 1
March	January 1	October 1
April	February 1	November 1
May	March 1	December 1
June	April 1	January 1
July	May 1	February 1
August	June 1	March 1
September	July 1	April 1
October	August 1	May 1
November	September 1	June 1
December	October 1	July 1

NOTE: ASO/ASC claims billed groups have unlimited retroactivity.

Enrollment Roster

You can receive an Ending Member Listing of covered employees each month along with your invoice. You can request a more detailed roster that includes address and dependent information by calling your Membership and Billing Administrator. Please allow seven business days for your request to be processed.

Termination of Your Group Enrollment

All requests to terminate your group's coverage must be made in writing by an authorized representative of your group. This request must be forwarded to your Sales Executive or Producer. Cancellation requests are subject to limitations and requirements as stated in your contract.

IDENTIFICATION CARDS

Your employees should always carry their most recent Identification (ID) Card, and should present it whenever they seek medical services. The card identifies them as Plan members and eligible for covered services.

ID cards are sent directly to your employees. They should receive their cards within ten business days of our receipt of Enrollment Applications (JD-7 or Enroll-1) or Member Change forms (ENR-010).

Employees will receive an ID card for themselves and each covered dependent. The card includes the member's name, Agreement Number, Group Number, copayments required for medical care (if applicable), etc. If your group has prescription drug benefits, an R_x group number will print on the front of the card. If your group has vision benefits, a separate ID card will be issued, unless otherwise indicated.

Please advise your employees to call Member Service if any of the information on the ID cards is incorrect or if a duplicate is needed. They can also request additional cards by logging onto www.highmarkbcbs.com.

If an employee loses his or her ID card, or believes it was stolen, they should notify Member Service immediately. We may need to issue a new Unique Member Identifier (UMI) to protect the member's medical file.

The employee will receive only the initial ID card during the contract period unless information on the card changes or they add a dependent to their contract.

BILLING INFORMATION

Billing Policy

Please pay the Total Amount Due on your invoice by the due date indicated. We cannot accept partial payments of premium.

Past Due Payment

We will aggressively pursue past due premiums. You jeopardize your employees' benefits with non-payment of the total premium amount due. According to the terms outlined in your contract, your group is responsible for any accrued premiums in the case of utilization of services by an employee.

In the event of non-payment of premium, you can expect to receive a Past Due Notice advising you that we have not received your scheduled premium payment. If we do not receive payment shortly thereafter, you will receive a Cancellation of Coverage Notice. This is the final warning you will receive prior to the actual cancellation of your group coverage for non-payment of premium.

We recognize that occasionally situations arise that may result in a late payment. When a situation arises, please contact your Membership and Billing Administrator immediately.

Our billing system automatically adjusts amounts due for retroactive enrollment changes processed during the billing period. If enrollment changes are processed after the invoice is prepared, they will appear as adjustments on your next invoice, and the Total Amount Due will be credited/debited accordingly. Generally, for enrollment changes to be reflected on your current invoice, we must receive them seven business days prior to the invoice preparation date.

If you feel your invoice is incorrect, please call your Membership and Billing Administrator immediately.

NOTE: Do not send enrollment forms with your invoice. Send them to the address listed on the enrollment form.

e-Bill

After you receive your first invoice, you can sign up for e-Bill, a secure way to view your bills electronically. You can also pay your bills through Automatic Clearinghouse (ACH) from the first time you make a connection. Electronic payments eliminate mailing delays and ensure prompt posting to your account.

With e-Bill you receive your bills as they are produced – no mail delays and no paper copies to file. Download or print any reports or information you want to keep on file.

Even if you have both Premium and Claims billed groups, you can receive one consolidated bill via e-Bill.

Billing Information

Important Payment Instructions: If you are an e-Bill customer and you submit payment by check, you **must** send your payment and a copy of the Invoice Remittance Stub to the “Remit to Address.” Sending your payment to any other address or not including the remittance stub will delay processing your payment.

Other Payment Options

We can also accept wire transfers of funds in lieu of a check. If you wish to establish a wire transfer process, please contact your Membership and Billing Administrator for more information.

Invoices

Premium

If you are billed based on a fixed dollar premium per eligible employee, you will receive a Premium invoice. Your Premium invoice is typically generated 20 days prior to your payment due date. Highmark must receive payment on or before the due date. Your invoice will typically have three parts: an Invoice Summary, a Premium Summary, and a Member Activity Report. In addition, when your account activity warrants, you will receive a Retroactive Rate Change Summary and/or an Additional Items Report. For more detailed information concerning your premium billed documentation, please refer to your Administrative Billing Guide.

If you are an **ePlatform client**, you **must** receive your invoice via **e-Bill**.

Claims Billed

If you are invoiced based on claims utilization and a retention fee, you will receive a Claims Billed invoice on either a weekly or monthly basis. The frequency of the invoice will depend on the financial arrangements that have been agreed to with Highmark and your Sales Representative.

If you receive a Claims Billed Invoice, you will have a separate Billing Representative assigned to assist you with your invoice related questions. The name of the Billing Representative and their phone number is listed on the front page of the invoice. Membership related questions should be directed to your Membership and Billing Administrator.

We fax weekly invoices every Wednesday. We must receive a wire transfer payment within 24 hours of your receipt of the invoice.

We fax monthly invoices on or around the 15th of each month. The payment due date is stated on the invoice. We must receive payment on or before the due date, by wire transfer or other agreed upon arrangement.

Billing Information

Supporting invoice reports are mailed, or they can be accessed online through an Internet connection. If you wish to view your reports online, please call your Billing Representative at the number listed on your invoice.

FEDERAL LEGISLATION

COBRA

Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) health insurance provisions in 1986. The law amended the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that might otherwise be terminated.

COBRA contains provisions giving certain former employees, spouses and dependent children the right to temporary continuation of health care coverage at the group rate. This coverage, however, is only available in specific circumstances.

There are three elements to qualifying for COBRA benefits:

1. **Plan Coverage** — GHPs for employers with 20 or more members on more than 50 percent of the business days in the previous calendar year are subject to COBRA. The term “members” includes all full-time and part-time members as well as self-employed individuals.
2. **Beneficiary Coverage** — A qualified beneficiary generally is any individual covered by the group plan on the day before the qualifying event. A qualified beneficiary may be a member, the member’s spouse and dependent children, and in certain cases, a retired member, the retired member’s spouse and dependent children.
3. **Qualifying Events** — These are types of events that would cause, except for COBRA continuation coverage, an individual to lose health care coverage. The type of qualifying event will determine who the qualified beneficiaries are and the required amount of time that a plan must offer the health care coverage to them under COBRA. Qualifying events for members are:
 - Voluntary or involuntary termination of employment for reasons other than “gross misconduct”
 - Reduction in the number of hours of employment

Qualifying events for spouses are:

- Termination of the covered member's employment for reasons other than “gross misconduct”
- Reduction in the hours worked by the covered member
- Covered member becomes eligible for Medicare
- Divorce or legal separation of the covered member
- Death of the covered member

Qualifying events for dependent children are the same as for the spouse with one addition: loss of “dependent child” status under the plan rules.

COBRA Continuation of Coverage

The continuation of coverage provision established by COBRA is a Federal directive that increases an employer's (with 20 or more members) responsibility to terminated members and their dependents. Under COBRA, eligible members and dependents that are terminated from the group agreement by plan regulations may continue their health care coverage for an extended period of time if they qualify for benefits. Under this provision, employers must offer identical health care coverage to qualified beneficiaries at a cost no greater than the percentage allowed by the Federal government.

HIPAA

HIPAA is the Health Insurance Portability and Accountability Act of 1996, a Federal law that includes protection for working Americans and their families who have pre-existing medical conditions or might suffer discrimination in health care coverage based on a factor that relates to an individual's health. It became effective in July 1997. HIPAA does the following:

- Limits exclusions for pre-existing conditions
- Prohibits discrimination against employees and dependents based on their health status;
- Guarantees renewability and availability of health care coverage to certain employers and individuals
- Protects many workers who lose health care coverage by providing better access to individual health insurance coverage

Pre-Existing Conditions

HIPAA permits the pre-existing condition exclusion only if the exclusion relates to a condition, whether physical or mental, for which the medical advice, diagnosis, care or treatment was recommended or received within a six-month period ending on the enrollment date, regardless of the cause of condition. However, Highmark applies a look-back period of 90 days (rather than six months), ending on the enrollment date, as permitted by HIPAA. Note that not all contracts include a pre-existing condition exclusion. Refer to your contract to determine whether this applies.

Restrictions Based on Pre-existing Condition

HIPAA provides that a plan may include a pre-existing condition exclusion period, and if it does, restrict the payment of benefits for a period not to exceed 12 months for a pre-existing condition. In the case of a "late-enrollee" (i.e. an individual who enrolls later than he or she was first eligible to enroll, other than during a special enrollment period), the plan may limit benefits for a period of up to 18 months for a pre-existing condition. The period of a plan's pre-existing condition exclusion must be reduced by periods of "creditable coverage". Creditable coverage is continuous coverage under a previous health plan.

Portability

Portability allows the time an employee is enrolled under previous health insurance coverage to be credited toward the pre-existing condition exclusion of a new employer's group health plan. This time is called "creditable coverage". Credit is given for previous coverage that occurred without a break in coverage of 63 days or more. The law also guarantees that an employer's health plan must accept a new employee, regardless of health status.

Federal Legislation

Certificate of Coverage

Highmark will issue Certificates of Coverage to members once we have received notification of termination from you. The certificates prove they had health insurance coverage from Highmark. Specific cancel codes generate HIPAA Certificates after the direct pay 90-day conversion grace period. Evidence of coverage can be provided prior to our receipt of the member's termination from your group.

To receive credit from a previous carrier, you should include a Certificate of Coverage when you mail or fax the employee's Enrollment Application (JD-7 or Enroll-1). HIPAA regulations require employers and insurers to accept any form of "reasonable evidence of prior coverage" if a Certificate of Coverage is not available.

HIPAA does not impact the normal conversion products offered to members when they terminate from group coverage. However, a HIPAA individual direct pay product is available to individuals who can provide evidence of 18 months or more of prior creditable coverage.

Medicare

An employee or employee's spouse reaching the age of 65 may be eligible for health care coverage under the Federal Government's Medicare Program. In addition, certain disabled persons under the age of 65 are eligible for Medicare benefits.

To determine eligibility for Medicare benefits, an individual approaching age 65 should contact the nearest Social Security Administration office for information regarding Medicare enrollment requirements and coverage. It is recommended that this be done three months in advance of their 65th birthday. Those individuals under 65 receiving Social Security benefits should also inquire about Medicare eligibility information. Current Highmark members should contact Member Service for additional information.

When an employee or any of the employee's dependents becomes eligible for Medicare through Social Security Disability benefits, please submit a Member Change form (ENR-010) and indicate that the dependent is eligible for Medicare coverage. Please note that individuals who are eligible for Medicare due to a disability and who are under the age of 65 must be offered the same group health plan coverage that is offered to individuals under the age of 65 who are not disabled. Contact your Sales Executive to determine whether MedigapBlue is also available for your disabled employees. (See the Medicare Secondary Payer section below regarding coordination requirements.)

Supplementing Medicare Coverage

Employees who reach age 65 and will become retirees enrolled in Medicare may wish to supplement their Medicare Parts A and B coverage with Highmark's MedigapBlue individual program, or if offered by your group, MedigapBlue group program. These programs add important benefits to their Medicare agreements that are not available under Medicare Part A or Part B. Members should contact Member Service for additional information.

Supplemental coverage like MedigapBlue is not available to members who choose only Medicare Part A.

Medicare Part D Coverage

Medicare Part D is the newest part of Medicare. It makes prescription drug coverage available to everyone with Medicare. It was created as a result of the Medicare Modernization Act of 2003 and was effective on January 1, 2006. Medicare Part D is administered by the Highmark Senior Markets area. Questions concerning Medicare Part D should be directed to your Sales Representative.

Medicare Secondary Payer Statute

In an effort to save Medicare resources, Congress has adopted a series of amendments to the Social Security Act that affect Medicare beneficiaries who have dual health coverage. These are generally known as the Medicare Secondary Payer (MSP) statute.

The MSP statute is essentially a coordination of benefits statute. MSP does not dictate the benefits an employer or Group Health Plan (GHP) must offer, but requires, in certain instances, that a GHP make primary payment where dual coverage exists. With some exceptions, described below, the MSP statute specifically prohibits employers and GHPs from offering different benefits to Medicare beneficiaries than they offer to other active employees and spouses.

The requirements for MSP coverage vary depending on several factors, including the size of the employer sponsoring the GHP and the basis for Medicare eligibility (age or disability). In general, the following apply:

1. Medicare pays secondary to GHPs that cover individuals with end-stage renal disease during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees or whether the individual has “current employment status.”
2. Medicare pays secondary to the GHP in the case of actively employed individuals and their spouses age 65 or over, except in the case of GHPs offered by employers with fewer than 20 employees. If the employer participates in a multi-employer GHP having at least one participating employer with 20 or more employees, the MSP rules apply to all employers in the plan, even those with fewer than 20 employees (unless the plan elects the “small employer exception” under the statute). (If you select the “small employer exception,” you must have it approved by the Centers for Medicare and Medicaid Services (CMS) and then send a copy to Highmark.)

Even though the GHP is primary to Medicare in groups of 20 or more employees, an employee may decline GHP coverage. In that case, Medicare would become the employee’s primary coverage. The group may not offer, subsidize, or be involved in the arrangement of a Medicare supplement policy for over-65 employees who have declined enrollment in the GHP. An employee who waives GHP coverage must complete and submit Highmark’s Waiver of Insurance Coverage form (6202) and notify CMS that GHP coverage has been waived.

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3. Medicare also pays secondary to the GHP in the case of individuals under age 65 who are eligible for Medicare on the basis of disability, when the employer sponsoring the GHP has 100 or more employees. If the employer participates in a multi-employer GHP having at least one participating employer with 100 or more employees, the MSP rules apply even to participating employers of fewer than 100 employees. (There is no small employer exception under the statute.)

IMPORTANT! When an employee or dependent becomes eligible for Medicare, based on either age or disability, you must update their health insurance information. Failure to do so may result in claims being delayed or paid incorrectly or in liability to the Medicare program under the MSP statute.

Since some employers choose to keep retired members and spouses in the same group, it is important to determine the status of both active employees and retirees. You must notify Highmark of each individual's eligibility status to assure proper claims adjudication.

Michelle's Law (H.R. 2851)

Michelle's Law is a Federal law that becomes effective on October 9, 2009. The law affects groups that provide coverage to dependent children based on student status.

If your group provides coverage to dependent children based on student status, effective October 9, 2009 upon your group's renewal, you must continue to provide coverage to dependent students who:

- are required to take a medically necessary leave of absence from school for a period of up to one year from the first day of the medically necessary leave of absence
- change their enrollment status (such as change from full-time student to part-time due to a reduction in credits) because of a medically necessary condition

USERRA Protections for Deployed Employees' Health Care Coverage

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) is the latest in a series of laws protecting veterans' employment and health care coverage rights. USERRA became effective in December 1994, but was amended several times, with final rules effective January 2006. USERRA is intended to minimize the impact to an individual whose civilian employment is interrupted by a tour of duty in the U.S. uniformed services.

Your group should be aware that USERRA protects employees covered under a GHP in two important ways:

- *Continuation of Coverage during Deployment* The deployed employee may elect to continue his/her health care coverage during the period of deployment. Coverage may be continued for up to 24 months if the payment of premiums is made as required by the mandate. Many groups have implemented policies that impose reasonable requirements upon employees who choose to make this election to ensure a more orderly and manageable process. You should consult with your legal counsel when establishing those procedures.

- *Reinstatement of Coverage after Deployment* Once the deployment has ended, the employee has an additional right to reinstate their health care coverage when they return to their job. The coverage is reinstated without additional waiting or pre-existing condition exclusion periods (except for injuries/illnesses that were incurred during deployment or exclusions that would have applied even in the absence of the deployment).

USERRA applies to both fully-insured and self-insured groups, regardless of whether those plans are governed by ERISA or offered by church groups or state/local governments.

Continuation of Coverage during Deployment

Highmark makes a form available that your group may use to let us know when an employee who was previously cancelled from coverage makes a USERRA election to continue coverage while deployed. When you need to reinstate the deployed individual's coverage, you should follow your normal enrollment procedure and, in addition, complete and submit the USERRA Continuation of Coverage during Deployment form (ENR-096). This form will ensure that your deployed employee's health care coverage is retroactively reinstated.

Group Administrators may obtain USERRA Continuation of Coverage during Deployment form (ENR-096) from our Web site or through your Membership and Billing Administrator. The return address is indicated on the form.

To ensure the accurate processing of claims for services that were incurred during the period between the cancellation of coverage and the election to continue coverage, please instruct the employee or his/her family member to ask providers to resubmit any unpaid claims for services covered by the employee's Highmark program as soon as the employee receives his/her new identification cards. Highmark has procedures in place to ensure that the claims of USERRA-protected individuals will be processed without delay when submitted in a timely fashion.

Reinstatement of Coverage after Deployment

- *Groups that do NOT have pre-existing condition exclusion periods*
Please follow your normal enrollment process to reinstate the employee's coverage.
- *Groups with pre-existing condition exclusion periods*
If you wish to reinstate coverage for an employee returning from deployment and your group includes pre-existing condition exclusion requirements, you need to call your Membership and Billing Administrator BEFORE you submit the reenrollment information. Your Membership and Billing Administrator needs to know that the employee is subject to the protections of USERRA, the date of reinstatement of coverage and whether the employee's original pre-existing condition exclusion period has been satisfied. Once you have provided the requested information, your Membership and Billing Administrator will ask you to confirm the information in an e-mail or by fax. You do not need to complete any special forms to reinstate the employee who has returned to employment; just contact your Membership and Billing Administrator. If you do not contact Membership prior to submitting the enrollment information, Highmark will not know that the employee is entitled to the protections of USERRA and the pre-existing

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condition exclusion period may be applied to program benefits after the employee returns to work.

How USERRA Relates to COBRA

USERRA is similar to the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) with regard to an individual's right to continue group health plan coverage, but it also differs in several ways. USERRA:

- Covers *all* employer groups, regardless of number of employees
- Provides a period of up to 24 months of continuation coverage during the period of deployment

USERRA is a separate Federal mandate. Therefore, compliance with COBRA may not be sufficient to meet your obligations under USERRA.

Information about USERRA is available on the United States Department of Labor Web site (www.dol.gov/dol/faq). For specific advice about your rights and obligations under USERRA, we encourage you to consult with your group's legal counsel.