

# Benefits Administrator Guide

## Administering Your Regence Health Plan

This guide will help you administer your group's Regence coverage. We've included information regarding eligibility notifications and resources. If you can't find the answers to your questions in this guide or in your contract, please give your membership administrator or sales team a call. We're here to help!

You'll find a lot of useful information in your contract(s), such as your group number(s), renewal date, participation and contribution requirements, waiting period requirements and any additional benefits or riders you have purchased, such as:

- Medical
- Dental
- Vision
- Prescription
- Life (Long Term Disability, Short Term Disability etc.)
- Voluntary Dental
- Critical Illness Protection
- COBRA Administration

### Content

Eligibility.....	1
Premium.....	2
Enrolling Employees .....	2
Special Enrollment.....	3
Enrolling Dependents.....	3
Member Cards .....	4
When Group Coverage Ends.....	4
Leave of Absence.....	5
Returns from Layoffs .....	5
Certificate of Coverage .....	5
Continuation of Coverage.....	5
Plan Options for Individuals.....	6
Other Helpful Information.....	6
Making Changes .....	6
Fraud and Abuse.....	7
Employer Notification Requirements .....	7
Medicare Secondary Payer.....	9
Important Resources .....	11
Members-Only Advice, Navigation and Rewards .....	11
Member Satisfaction.....	12
The Role of Your Agent.....	12
Step by Step through Your Premium Invoice.....	13

### Eligibility

#### Employees

An employee regularly working the required hours per week is eligible for enrollment after satisfying your group's eligibility waiting period. The employee's coverage will begin on the first of the month following completion of the eligibility waiting period, unless otherwise specified in your group contract.

*This benefits administrators guide is not a replacement of the terms of your contract.*

**Please note:** Any employee hired as a temporary or seasonal employee cannot be offered coverage. (Please refer to the *Eligible Employee* provision in your contract for further details.) Employees whose hours increase and who become eligible to enroll must satisfy the eligibility waiting period, which begins on the date the hours were increased.

#### Dependents

The following qualify as eligible dependents of the enrolled employee:

- Legal spouse or Oregon certified same sex domestic partner
- Qualifying non-certified domestic partner (if applicable)
- Unmarried children under age 23 in Oregon or 25 in Washington, if they are dependent on the employee for support (the age may vary depending upon the group contract.) Eligible children include a natural child, an adopted child, a child placed for adoption, a stepchild living in the employee's home or a nonresident stepchild with a qualified medical support order, and a child related to the employee by blood or marriage if the employee or qualified domestic partner is the legal guardian.
- Children over age 23 in Oregon or 25 in Washington, if incapable of self-support because of a mental or physical disability. The incapacitation must have occurred before the child's 23rd or 25th birthday and be approved by us.



## Non-certified Domestic Partners (if contract is modified to include)

The non-certified domestic partner of an enrolled employee is eligible for coverage if the domestic partnership meets qualifying conditions. The qualified domestic partner and their eligible dependents can be added by completing an Employee Enrollment Form and an Affidavit of Domestic Partnership.

## Premium

We will charge premium based on an employee's or dependent's enrollment date. If an employee or dependent begins coverage on a date other than the first of the month, the premium will be prorated unless otherwise stated in your contract.

## Enrolling Employees

### Notify Employee of Eligibility

We urge you to discuss benefits with each new-hire and give them a packet containing enrollment forms, benefit summaries and related materials. Give the employee a due date for the completed forms so that you can get them back to us in a timely manner.

### Determining the Effective Date

After serving the eligibility waiting period, eligible employees and dependents must enroll within 30 days of their eligibility.

The following example will help you determine the effective date.

*Your group has a 30-day eligibility waiting period, and Joe Smith is hired on April 20. Joe's eligibility waiting period ends on May 20, so his effective date is June 1. To have coverage effective June 1, we need to receive Joe's Employee Enrollment Form in May.*

### New Employees

Timely submission of the Employee Enrollment Form is very important. We must receive completed forms within 30 days of an employee's eligibility date. When we receive late forms, we will have to return them to you. As a result, the employee and any dependents will not be eligible for coverage until your group's next open enrollment date.

If you include completed Employee Enrollment Forms along with your premium payment, please submit only the amount shown on your current premium invoice. Your premium invoice for the following month will show the appropriate payment due for any eligibility changes made the previous month.

## Newly Eligible Employees

If you have an employee who becomes newly eligible (for example, recently increased hours make them eligible for coverage), the eligibility waiting period will begin on the date the hours were increased.

For Example:

*Company XYZ has a 60-day eligibility waiting period and employees must work 30 hours each week to be eligible for coverage. Tina had been working 25 hours each week, but beginning May 17 she's working 30 hours (the minimum required). Tina's eligibility waiting period ends on July 17 (60 days from the date her hours increased) and her coverage effective date will be August 1.*

## How to Complete an Employee Enrollment Form

The form can be used for new enrollment, to add or delete dependents, or to tell us about a name change, address change or benefit changes at open enrollment. Be sure to have the employee provide all pertinent information and sign and date the form.

**Please note:** There are times when additional information may be needed, as described later in this guide. Additional information should be submitted with the enrollment form.

## When an Employee Waives Coverage

Your contract requires that a certain percentage of employees enroll in the plan. Supervision of the participation level is your responsibility. If an employee waives coverage, you must obtain and retain a signed form. You do not need to return these forms to us.

## Dental Eligibility

- **Freestanding**—Your dental plan is freestanding when medical and dental membership are not required to match.
- **Integrated**—Your dental plan is integrated when medical and dental membership are required to match.
- **Voluntary**—Your dental plan is voluntary when membership has specific enrollment rules (refer to the "Enrolling Employees" section). Medical and dental membership are not required to match. (Available only to groups of 51 or more eligible employees.)

Your contract will indicate if this provision applies to your group. If an employee and or dependents declines coverage when first offered, they can't enroll on the dental plan at a later date. Voluntary termination from the dental plan disqualifies the employee from future enrollment.

## Special Enrollment

Employees or family members who did not enroll when originally eligible may apply for enrollment at your group's yearly open enrollment. The date for your open enrollment is listed on the first page of your contract.

Enrollment outside open enrollment is called "special enrollment," and is allowed under the three circumstances described below:

### Involuntary Loss of Coverage

If an employee and/or their dependents are covered by Individual or other group coverage, the involuntary loss of that coverage qualifies them for enrollment under your plan at the time of that coverage loss. The Employee Enrollment Form must be submitted within 31 days of the loss of coverage, along with a Certificate of Coverage (COC) from the prior carrier. If the COC isn't available, the Employee Enrollment Form still needs to be submitted within 31 days of the loss of coverage.

#### Here's an example of involuntary loss of coverage:

*Bob was enrolled on his wife's group plan, but she lost her job. Her health insurance will end on August 31. We must receive Bob's application for coverage by September 30 for a September 1 effective date.*

#### Here's an example of voluntary loss of coverage:

*Bob was enrolled on his wife's group plan, but her payroll deduction increased and now your group's coverage is less expensive for them. Discontinuing other insurance because of a premium increase isn't considered an involuntary loss of coverage. Bob wouldn't be eligible to enroll for your group's coverage until your next open enrollment.*

### Other Loss of Coverage

An employee becomes eligible to apply for coverage under the circumstances listed below. Eligibility begins on the date the other plan ends. We must receive the Employee Enrollment Form within 31 days of the event.

- Legal separation
- Divorce
- Death
- Termination of employment
- Reduction in hours
- Termination of employer contributions
- Involuntary loss of coverage under Medicaid, Medicare, CHAMPUS/Tricare, Indian Health Service, or a publicly sponsored or subsidized health plan such as Oregon Health Plan.

## Life Events

Even though the employee originally declined coverage when first eligible, they may enroll if:

- He or she marries or becomes an Oregon-certified domestic partner. The employee, their new spouse or Oregon-certified domestic partner and any eligible dependent children become eligible on the date of marriage or certification for an effective date of the first day of the month following the date of marriage or certification.
- He or she acquires a new dependent child by birth, adoption, or placement for adoption. The employee, their new spouse or Oregon-certified domestic partner, newly acquired child(ren), and any eligible dependent child(ren) become eligible for coverage effective the date of the birth, adoption, or placement for adoption.
- A court issues an order that the employee provide coverage for dependent child(ren). In this case, the child(ren) become eligible on the date of the order.

Additionally, only the employee (if not currently enrolled) and the child dependents named in the court order QMCSO may be added to coverage. A spouse and children who are not named in the order are not eligible as this is not a qualifying event.

We must receive the Employee Enrollment Form within 31 days of the event.

**Please note:** The life events listed above don't apply to freestanding or voluntary dental plans.

## Enrolling Dependents

### Adding Newly Acquired Dependents to an Enrolled Employee's Coverage

When an employee who already has coverage and wants to add a new dependent as a result of a life event (marriage; newly qualified domestic partner, if applicable; birth of a baby; legal guardianship; or adoption or placement for adoption), an Employee Enrollment Form must be submitted within 31 days of the event.

### New Spouse and Stepchildren

When a new spouse or Oregon-certified domestic partner and his or her children are added, an Employee Enrollment Form must be submitted within 31 days of the marriage or certification. Refer to the "Who Can Apply" section of your contract for a list of eligible dependents. We may ask you to obtain and submit a completed Certificate of Marriage and/or Certificate of Dependency. Coverage will be effective the first of the month following the date of marriage or certification.

## Newly Qualified Non-certified Domestic Partner (if applicable to your contract)

A newly eligible qualified non-certified domestic partner (see the “Who Can Apply” section of your contract for details) becomes eligible to enroll for coverage on the first of the month following the eligibility event. Please be sure to include the completed Affidavit of Domestic Partnership along with the Employee Enrollment Form. Coverage for the newly eligible qualified domestic partner will be effective the first of the month following receipt and acceptance of the forms.

## Newborn Children

An eligible newborn child will be covered as long as an Employee Enrollment Form is signed and submitted within 31 days of birth in Oregon and 60 days of birth in Washington. Coverage will be effective on the newborn child’s date of birth. If additional premium is required, it will be prorated back to the date of birth on your next premium invoice.

## Newborn Grandchildren

An employee’s newborn grandchild is eligible for coverage only if the grandchild meets the plan’s eligibility requirements. A grandchild will be considered a dependent only when the grandparent gains legal guardianship and submits the required enrollment documentation and applicable premium. Documentation of legal guardianship will be required to add a newborn grandchild to the plan.

**Please note:** In Washington, if the mother is receiving maternity benefits under the subscriber’s contract, the baby will be covered under the subscriber’s contract for 31 days regardless of eligibility.

## Adopted Children

A newly adopted child will be covered as long as an Employee Enrollment Form and any required legal documents are submitted within 31 days of placement for Oregon-based contracts and in 60 days for Washington-based contracts. Coverage will be effective on the date of placement. If additional premium is required, it will be reflected back to the date of placement on your next premium invoice.

## Member Cards

New enrollees will receive member cards in the mail. If additional member cards are needed, you or your employee can use our Web site to order cards. You can also contact a customer service specialist. Employees and dependents should present their member cards at the time care is received. Information on the card gives providers essential data about the employee’s benefits, and helps the provider file claims directly with us.

**Please note:** Employees may receive their member cards before coverage begins. The “issue date” printed on the card most often isn’t the coverage effective date. It is simply the date the card was printed. You should inform your employees of their actual coverage effective date.

## When Group Coverage Ends

### Termination of Employment

When employment terminates, you’ll want to end the employee’s coverage effective on the last day of the month in which the termination occurred. On your next billing invoice, under the section entitled “Terms,” list the employee’s name, member number and the last day worked. We’ll cancel coverage on the last date of the month the employee stopped working. **NOTE:** Please refer to your contract. Alternate termination rules may apply if you have amended your contract to stipulate different termination provisions.

### For example:

*Sam’s last day worked is September 2. So, his last day of coverage is September 30. Depending on your group’s size, your employees may be eligible for COBRA continuation or state continuation. Refer to the “Continuation of Group Coverage” brochure for more details.*

### Employee’s Child Becomes Ineligible for Coverage

Coverage for a child normally ends at the end of the premium payment period during which the child turns 23 in Oregon or 25 in Washington (the age may vary depending on the group contract), marries, or is no longer dependent on his or her parent for support. The child may then be eligible to continue their group coverage through COBRA continuation. Any dependent losing eligibility may also apply for Individual coverage with Regence. They can call customer service or see *Need Coverage* at [www.or.regence.com](http://www.or.regence.com).



## Divorce

The spouse or Oregon-certified domestic partner may remain on coverage until the divorce decree is final or if termination of domestic partnership occurs. An Employee Enrollment Form must be completed; the spouse or Oregon-certified domestic partner will be deleted from coverage on the first of the month following the date the divorce is final or on the date of termination of the domestic partnership. The spouse or Oregon-certified domestic partner may be eligible to continue coverage through COBRA continuation or state continuation (Oregon or Washington).

**Please note:** If you have an employee who wants to remove his or her spouse or Oregon-certified domestic partner before the divorce decree or termination of domestic partnership is final, we suggest you advise the employee to consult an attorney before ending the spouse or Oregon-certified domestic partner's coverage.

## Death

Coverage for the employee's spouse or Oregon-certified domestic partner and covered children ends at the end of the premium payment period in which the employee dies. Please delete the employee on your next premium invoice. Covered family members may be eligible to continue their group medical coverage through COBRA continuation or state continuation. Upon the death of a dependent, an Employee Enrollment Form should be completed to reflect the change to enrollment.

## Any Member Losing Group Coverage

Any member losing eligibility may also apply for Individual coverage with Regence. They can call customer service or see *Need Coverage* at [www.or.regence.com](http://www.or.regence.com).

## Leave of Absence

A leave of absence can be approved for up to three months for Oregon-based groups and up to six months for Washington-based groups. The same applies to leave of absence due to Workers' Comp. The employee must still be considered employed and be expected to return to work. If employee doesn't return within the expected time frame, the employee can be terminated and any applicable continuation can be offered.

## Leave of Absence Under the Family and Medical Leave Act (FMLA) of 1993

FMLA applies to groups with 50 or more employees. Indicate on the monthly premium invoice that the employee is on an approved FMLA leave of absence. Continue to send in the necessary premium each

month. By law, you are required to continue coverage for up to 12 weeks. Employees must continue to submit premium to maintain coverage for eligible dependents during the leave.

If the employee and/or dependents elect not to remain covered during the leave, they can re-enroll with no new eligibility waiting periods when the employee returns to work. The employee must submit a new Employee Enrollment Form within 60 days of the return to work. Credit is applied for all eligibility waiting periods served prior to the FMLA leave.

## Returns from Layoffs

When an employee returns to work within 6 months after being laid off, send a completed New Employee Enrollment Form for that employee with your next monthly premium. Indicate the rehire date on the premium invoice and the form. The retroactive premium will be billed on the next month's invoice.

If your group has fewer than 20 employees and is subject to Oregon Continuation coverage, the returning employee will get credit for any eligibility period they already met if they return to work within six months after the layoff. (This provision does not apply to groups with Washington Continuation).

If your group has 20 or more employees, the employee will get credit for any previously satisfied eligibility waiting period only if he or she had COBRA or Oregon Continuation coverage while laid off or begins coverage the day they return. If the employee chose not to continue coverage through COBRA or Oregon Continuation, he or she will be treated as a new hire and will need to satisfy your group's eligibility waiting period.

## Certificate of Coverage

A Certificate of Coverage (COC) form will be mailed to each member who has terminated coverage with us. The COC will show the member's effective date and termination date. This form can be used as proof of coverage when the member applies for coverage with another carrier to help reduce any pre-existing condition limitation period.

## Continuation of Coverage

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) eligibility applies to employers who have 20 or more employees on 50% or more of the employer's typical business days in the preceding calendar year, whether they are enrolled in your health care plan or not.

If your group doesn't meet this qualification and you're an Oregon-based company, then your continuation of coverage provision is based on state continuation. An employee must have been enrolled on the group health coverage for a minimum of three months to be eligible for Oregon State Continuation.

Washington-based employers have Washington Continuation if elected and made part of their contract. An employee or dependent must be covered by the group health plan on the day before a qualifying event.

It's important to let us know if your continuation status has changed (your total employee count has increased or decreased). The best time to notify us is in December so we can ensure that your group contract reflects the correct continuation option for the new year.

## Plan Options for Individuals

When an employee loses group coverage for whatever reason, they have several options for continuing their coverage. Some may be eligible for Medicare or a Medicare supplement plan; others may elect COBRA, state continuation coverage or choose to enroll on a portability plan. Some former plan members may choose to apply for a Regence Individual plan.

For more information about options and help choosing the Individual plan that is best for them, they can visit us at [www.or.regence.com/needCoverage](http://www.or.regence.com/needCoverage) or call us at 1-888-REGENCE (1-888-734-3623).

## Other Helpful Information

### Changing Terms of the Group Contract

We'll change the terms of the contract upon written request on the first of the month following receipt of the change. Some changes require underwriting approval.

### Changing Your Eligibility Waiting Period (probationary period)

You can change your group's eligibility waiting period at any time. However, implementation of the new waiting period will apply only to new employees.

For example:

*You want to change your eligibility waiting period effective May 1. Employees hired before May 1 will follow the prior eligibility waiting period. Employees hired on or after May 1 will follow the new eligibility waiting period.*

### Changing the Eligibility Hours

Contact your sales team if you want to change the number of hours employees need to work in order to

be eligible for coverage. It may be necessary to re-rate your group premiums if several employees will be added or deleted because of the change.

### Changing the Employer Contribution

Contact your sales team if you want to change how much of the premium your group contributes. It may be necessary to re-rate your group premiums if several employees will be added or deleted because of the change.

### Changing Medical Plans

If you offer a choice of medical plans, employees can elect to change to another available program only at your group's open enrollment date.

### Changing Dental Plans

If your group offers a choice of dental plans, employees can change from one plan to the other at your group's open enrollment date. If the employee has Dentacare dental coverage and moves out of the service area but continues to be an active employee, he or she can switch at that time to the standard dental program by submitting an Employee Enrollment Form within 31 days of moving.

### Annual Group Size Verification/Census

Groups with fewer than 99 employees: Oregon regulation requires that we provide periodic reports regarding the eligibility and enrollment of individuals. In order to comply with this rule, each year we will mail you a form to complete that provides us with an updated profile of your group.

Washington-based companies with 2 to 50 employees will receive an annual census questionnaire. The completed census must be returned by the due date in order for us to issue a renewal proposal. If the questionnaire is not returned, we will be unable to renew your group's health plan.

## Making Changes

### Name Changes

Have the employee complete an Employee Enrollment Form. Submit it with your regular monthly premium invoice. We'll send new member cards directly to the address that we have on file for the member.

### Address Changes

Your employee may change their address on our Web site or fill out an Employee Enrollment Form. If your employee chooses to fill out the form, please forward it to us at the earliest possible date so that future documents, such as Explanation of Benefits forms, are mailed to the right address.

## Fraud and Abuse

To help control the cost of health coverage, our Fraud and Abuse Department works to identify fraudulent claims and ineligible employees or dependents who have enrolled. This team works diligently to recover thousands of dollars each year helping to keep your premium increases to a minimum.

## Employer Notification Requirements

Employers who provide group health benefit plans to their employees have notification requirements they must comply with. The following is a summary list of notifications that you are required to provide, the federal law citation relating to that notification requirement, and where information on the required notifications can be found:

Notification Requirement	Disclosure Responsibility		Documentation Location/Resources
	Regence	Group/Employer	
<b>Consolidated Budget Reconciliation Act of 1985 (COBRA) - 26 CFR Part 54</b>			
Initial COBRA notice	x	x	Information is included in the benefit booklet.
COBRA Election notice		x	See <a href="http://www.dol.gov/ebsa">www.dol.gov/ebsa</a> for model documents and compliance assistance for employers.
COBRA Unavailability notice		x	
Termination of COBRA notice		x	
<b>DOL Claims Regulations - DOL Reg. §2560.503-1</b>			
Notice of benefit determination	x	x	Regence provides an Explanation of Benefits (EOB) for each claim processed for each plan participant.
Claim procedure notification & appeals	x	x	Included in benefit booklet as well as on each claim EOB.
Pre-service claims (pre-authorization) notification	x	x	Outlined in benefit booklet.
<b>ERISA - Employee Retirement Income Security Act of 1974</b>			
ERISA rights & protections	x	x	See <a href="http://www.dol.gov/ebsa">www.dol.gov/ebsa</a> for model documents and compliance assistance. Regence includes a brief summary in the benefit booklet.
Summary of Material Modifications	x	x	See <a href="http://www.dol.gov/ebsa">www.dol.gov/ebsa</a> for compliance assistance.
Summary Annual Report	x	x	See <a href="http://www.dol.gov/ebsa">www.dol.gov/ebsa</a> for compliance assistance.
Summary Plan Description		x	Regence benefit booklet may be a significant part of an SPD, but does not satisfy the law entirely.
Written request for documents by participant		x	Must provide within 30 days of request.
<b>FMLA – Family Medical Leave Act – 29 CFR Part 825</b>			
Posting Disclosure		x	Regence includes a summary in the benefit booklet.
<b>GLB – Graham Leach Bliley Act – 15 USC §- 6810 and 6821 - 6827</b>			
Initial Notice		x	Regence will provide the employer with this notice when the relationship is established.
Annual Notice		x	This notice is combined with other annual notices that we will send to you to distribute to your plan participants.

Notification Requirement	Disclosure Responsibility		Documentation Location/Resources
	Regence	Group/Employer	
<b>HIPAA – Health Insurance Portability &amp; Accountability Act</b>			
Certificate of Creditable Coverage (COC)	x		Regence generates a COC at plan termination that is sent to the member's last known address.
Notice of Pre-Existing Condition (PEC) Provision	x		Benefit booklets include a provision about the plan pre-existing condition waiting period and how proof of prior creditable coverage may reduce that time. Regence will generate an individual PEC notice for each member who presents evidence of prior creditable coverage that reduces, but does not eliminate, the pre-existing limitation period
Special Enrollment Provisions (SEP) Notification		x	Employer provides this notice to all new hires to ensure that those who elect to waive the group health plan receive the information.
Notice of Privacy Practices (NPP) <ul style="list-style-type: none"> <li>• Initial Notice</li> <li>• Tri-Annual Notice</li> <li>• Notice of Change</li> </ul>	x		Regence provides a Notice of Privacy Practices to each new enrollee, a reminder every three years of the availability of the notice, and notice any time a material change is made.
<b>Newborns &amp; Mothers Health Protection Act – DOL Regulation §2590.711, 731, 732</b>			
Initial Notice	x	x	Information is included in the benefit booklet.
<b>Qualified Medical Support Order – 29 CFR Part 2590 and 45 CFR Part 303.32</b>			
QMSO Notification	x	x	Outlined in benefit booklet, upon receipt of QMSO, employer/plan sponsor must determine if the order is 'qualified' and respond to the issuing agency.
<b>Uniformed Services Employment and Reemployment Rights Act (USERRA) 20 DDFR Part 1002</b>			
Notice of Rights and Obligations	x	x	Regence can include this information in benefit booklets upon request.
<b>Women's Health and Cancer Rights Act (WHCRA) – DOL Reg. §2590.731, 732</b>			
Initial Notice	x	x	Included in benefit booklet.
Annual Notice	x	x	Regence will include WHCRA notice with other annual notices sent to you for distribution to your plan participants.
<b>OREGON Notification Requirements (Oregon-Based Plans)</b>			
Patient Protection Act			Included in benefit booklet.
Delinquency Notification			Regence provides to employer for delinquent premium no less than 10 days prior to the end of the premium payment grace period.
Group Cancellation			Included in delinquency notification.
Notice of Right to File Complaint with Oregon Insurance Division			Included in benefit booklet.
Coordination of Benefits (COB) Notice			Included in benefit booklet.
Portability			Provision outlined in benefit booklet. Notice is provided automatically at member cancellation. Notification includes plan description as well as rates and forms for enrollment. They are mailed to the participant's last known address.

*Subject to change*

Notification Requirement	Disclosure Responsibility		Documentation Location/Resources
	Regence	Group/Employer	
<b>WASHINGTON Notification Requirements (Washington-Based Plans)</b>			
Patient bill of rights (PBR) Pre-sale notification		<b>x</b>	Included in plan descriptions and quote materials.
PBR Post-sale notification		<b>x</b>	Included in benefit booklet.
PBR Annual Notice		<b>x</b>	Included in benefit booklet, posted on Regence public Web site and available upon request.
Notice of Conversion Rights		<b>x</b>	Regence mails to the last known address a notice to the plan participant who has lost group coverage
Appeals Notice		<b>x</b>	Outlined in benefit booklet and included on each Explanation of Benefits form.
Appeals Annual Notice		<b>x</b>	Included with other annual notification documentation for distribution to your plan participants.
Coordination of Benefits (COB) Notice		<b>x</b>	Included in benefit booklet.
Regence Disclosure: Agent Compensation Notification	<b>x</b>		Regence outlines standard agent compensation provisions for all business in all Regence states.

## Medicare Secondary Payer

### What Is Secondary Payer?

Many people are covered by both Medicare and an employer plan, either as an employee or a dependent. In those cases, Regence and the federal government work hard to make sure that, when services are covered by both Medicare and the group plan, benefits are paid correctly.

There is, in fact, a series of federal regulations called “Medicare Secondary Payer (MSP) statutes.” These statutes create a system under which the federal government expects claims to be paid. The system provides guidelines for claims processing when a person has both Medicare and private health plan (group or Individual) coverage.



### Your Role in Sharing Information

As part of a contract agreement with the Centers for Medicare & Medicaid Services (CMS), Regence participates in a data exchange program regarding member eligibility. Medicare uses the information to validate coordination of benefits efforts. By exchanging this information with Medicare, we are helping employers and members comply with the MSP statutes. We want members to avoid penalties and delays in Medicare eligibility. We also want to help reduce claims experience, help control escalating premium costs, and assure that our employer groups are receiving the maximum benefits of federal funds for claims for Medicare-eligible members.

One of our sources for information on Medicare or other coverage eligibility is the Enrollment Application. That’s why it is so important that requested information be provided for each employee and dependent on the Enrollment Application. Also, when a member or dependent becomes eligible for Medicare, it is important that we be advised so we can update our records to assure accurate and compliant claims processing. Our goal is to provide Medicare with the information they need while providing you with the service and support you deserve.

## The Special Case for Those With Part A Only

Medicare has several “Parts,” each of which covers a different category of health care services. Part A covers hospital care (no premium is charged); Part B covers doctors’ care and outpatient services (and charges a monthly premium that is usually deducted from the individual’s monthly Social Security payment); Part D addresses prescription drug needs (and may require an additional premium cost). People entitled to Medicare can elect not to take all parts of Medicare, but must actively decline the coverage when doing so. When someone with both Medicare and group coverage elects not to take Part B, they may think that Medicare will cover their hospital bills while their group plan will cover everything else.

That’s not necessarily the case.

If that person is covered by a small group (with fewer than 20 employees), Regence benefits are designed to coordinate with Medicare as if that person had both

Medicare Parts A and B. That means your benefit will be reduced by the amount Medicare would have paid for a doctor’s care and outpatient services than they would if they were to enroll in both Parts A and B. This decreases group experience, which can translate into premium savings in the future. It is important to maximize the federal government’s coverage of health claims for those members who are entitled to that coverage.

Enrollment in Part B is optional. However, Regence urges all members to consider enrollment in Part B when they are first eligible because doing so helps them maximize their health benefits and avoid unnecessary penalties. You play a big role in your employees’ decisions about coverage; we want you to be aware of our benefit provision regarding Part A-only coverage so that you are prepared to answer questions from any employees or dependents in this situation. Furthermore, you can help them remember that changes in employment status can trigger special enrollment periods with Medicare.

## Timeline of Medicare Enrollment Periods

<b>Initial Enrollment Period</b>	Three months before and up to seven months after the 65th birthday.
<b>General Enrollment Period</b> (if the member doesn’t enroll during their Initial Enrollment Period)	Every year in January, February and March for coverage to be effective on July 1 of that year. The member will pay a higher Medicare premium for Part B if they sign up during the General Enrollment Period.
<b>Special Enrollment Period</b>	<ul style="list-style-type: none"> <li>– Anytime you are still covered by the employer or union group health plan through your or your spouse’s (or if you are disabled, a family member’s) current or active employment, or</li> <li>– During 8 months following the month the employer or union group health plan coverage ends, or when the employment ends (whichever is first).</li> </ul>

## Medicare Part D—Employer Notification Responsibilities

Medicare offers prescription drug benefits under Part D. Employers have a responsibility to notify employees annually about the prescription drug plan offered through their group health plan and whether that coverage is considered “creditable” according to

Medicare. Creditable coverage is coverage that is as good as or better than the coverage available through Part D. When an employee has access to creditable group prescription drug coverage, they can waive enrollment on Part D. If that employee loses eligibility for creditable prescription drug coverage, they can then enroll on Part D coverage without penalty.

## Timeline for Medicare Part D Enrollment Periods

<b>Medicare Part D Enrollment (Prescription Drug plans)</b>	Each year from November 15 to December 31 for coverage to begin January 1. The member will pay a higher premium for Part D coverage if they did not sign up when they were first eligible to enroll.
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You can refer employees to your local Social Security office for advice and assistance for enrolling in Medicare, or they can call the Social Security Administration office at 1 (800) 772-1213. Also, there

are excellent resources available on the Internet at [www.medicare.gov](http://www.medicare.gov) that help clarify how Medicare affects them.

## Important Resources

### Need More Benefit Booklets, Forms or Other Supplies?

Visit our Web site at [www.or.regence.com/employer](http://www.or.regence.com/employer) or call our Portland office:  
(503) 225-4961  
toll-free 1 (800) 452-7278, x4961

### Questions About Your Group Invoice?

Call the number found on your monthly premium invoice to reach your group membership administrator. Your membership administrator can also help you with questions you may have regarding adding or deleting employees or dependents, and other eligibility situations.

### Claim or Benefit Questions?

If employees have questions about benefits or about filing a claim, please send them to their online benefits booklet. If they still have questions after referring to the booklet, advise them to call the Member Service phone number shown on the back of their member card.

### Other Questions?

If you have a question that isn't answered by this guide or your contract, please contact your sales team or call our Member Services Department.

Member Services hours are Monday through Friday, between 6 a.m. and 6 p.m. (Pacific time).

Portland	(503) 225-5336
toll-free	1 (800) 365-3155
Salem	(503) 371-3249
toll-free	1 (800) 643-4512
Medford	(541) 779-6464
toll-free	1 (800) 828-0035
Pendleton	(541) 276-5931
toll-free	1 (800) 828-0052
TTY line for people with hearing impairments	1 (800) 735-1232

Our Web site, [www.or.regence.com](http://www.or.regence.com), offers a variety of information and services:

- Search for a physician or other professional provider in our provider directories
- Order replacement member cards
- Order forms or supplies
- Email Member Services through our secure site
- Access benefits booklets online

- See our Benefits Administrator Guide
- Make employee address changes
- Find important telephone numbers and addresses

### Other Helpful Web Sites

The Department of Labor provides a great deal of information about the rules and laws that govern group health plans in the United States. Learn more at [www.dol.gov/](http://www.dol.gov/).

For information about Medicare, consult the Centers for Medicare & Medicaid Services at [www.cms.hhs.gov/](http://www.cms.hhs.gov/).

Finally, the Oregon Department of Consumer and Business Services provides a wealth of information and resources at [www.oregoninsurance.org](http://www.oregoninsurance.org).

### Members-Only Advice, Navigation and Rewards

Another valuable resource for information and answers is **myRegence.com**, powered by the Regence Engine. This members-only tool provides more value for your employees' health care costs. It offers Regence members the power to take charge of health care decisions and track progress for themselves and their families. Members can also view claims history, and create and maintain their own Personal Health Record. Our site also offers a Community section that offers members a discussion forum online to ask questions and participate in health and wellness discussions online.

When your employees seek health care advice, use the health planning tools or participate in wellness activities, they can access Regence Rewards. Points begin accumulating and can be redeemed for gift certificates to hundreds of popular stores, theaters, restaurants, and more.

When you encourage your employees to try **myRegence.com**, you're motivating them to take more accountability for their health. They can quickly and easily perform health care tasks, explore events and rewards for healthy living and plan ahead for annual health care needs.



## Member Satisfaction

### Member Grievance, Appeal and External Review

A grievance is an expression of dissatisfaction. The dissatisfaction can be with any aspect of care, including adverse claim determinations or how plan provisions impact them.

An appeal can be filed when a member wishes to dispute an adverse determination. The dispute may be with the rejection of a claim or denial of preauthorization request.

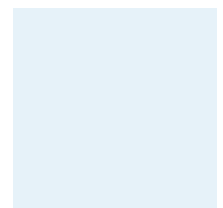
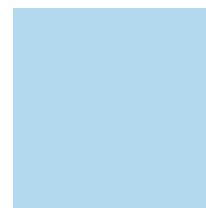
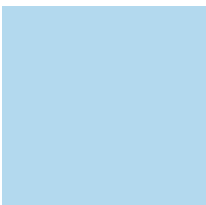
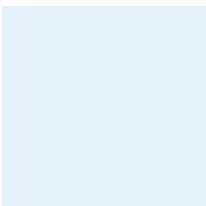
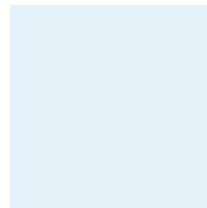
Members may also request External Review of an adverse determination. This process is governed by state regulation and is independent of Regence.

A complete description of the Member Appeal process is included in the benefit booklet.

Members may also file a complaint for any reason with the Oregon Insurance Division. They may contact the regulators toll free at 1 (888) 877-4894.

## The Role of Your Agent

Your agent provides a valuable service. We want you to know that Regence BlueCross BlueShield of Oregon may at times provide incentives for that service. Agents may receive bonuses, commissions, administrative service fees or other compensation, including non-cash compensation, from Regence BlueCross BlueShield of Oregon. These incentives may be based on any of several factors, including the size of group business, the products you buy, your agent's volume of business with Regence and the other services your agent provides to you. At times, these incentives may have an indirect impact on your premiums. Your agent can provide you with more information about incentives, or you can visit [www.or.regence.com](http://www.or.regence.com).



# Step By Step Through Your Premium Invoice

## This Section Walks You Through:

- Invoice generation
- Understanding your premium invoice
- How to notify us of changes to your enrollment
- What to include with your premium payment
- Steps to reconcile your premium invoice

## When Invoices Are Generated

We generate the next bill once we process payment of the current month's premium invoice. As noted in the group contract, payments are due no later than the first of the month for which coverage is being purchased. Example: June health insurance coverage is due by June 1.

The contract provides a 15-day grace period and if payment has not been received, the group health insurance plan is terminated without further notice. We may mail a letter offering one opportunity to reinstate the coverage.

Please be aware that due to Oregon legislation, if we have not processed a payment by the third day of the month, letters must be sent to any employee and their provider for claims that are pended due to the group premium payment not being received. The letter will direct the employee to check about the status of their coverage.

If you have any questions about your invoice, please call the appropriate phone number shown in the upper right corner of your invoice entitled, "For Billing Questions".

## Understanding Your Premium Invoice

### Group Billing Summary

The premium for the members listed on the roster, any amounts (debits or credits) carried forward, and adjustments to the previous invoice are displayed and totaled. The sum of these amounts is the total premium due for this billing period. We provide two summaries: one to return with your payment and one to keep for your records.

*** GROUP BILLING SUMMARY ***	
ROSTER TOTAL	\$5,543.20
CARRY FORWARD	\$20.00
ADJUSTMENTS	\$142.50-
AMOUNT DUE	\$5,420.70
*****	

*Please send a check for the Amount Due by the payment due date.*

### Eligibility Adjustments

Use this space to list any additions, cancellations, or changes to the enrollment. Record the subscriber's name, identification (ID) number, and the effective date of the change. (If your changes won't fit in this space, record the information on an eligibility adjustment form and submit with your premium payment.) Be sure that application forms are included with your payment for new enrollees or changes to existing enrollment (if you haven't already submitted them).

ELIGIBILITY ADJUSTMENTS	
ADDITIONS (NEW SUBSCRIBERS)	
CANCELLATIONS	
CHANGES TO EXISTING ENROLLMENT	

*Do you have any enrollment changes to submit? Record the name, member #, and effective date.*

## Member Roster

Each subscriber currently covered for this billing period is listed. The contract type and the lines of business are shown for each subscriber. The roster also shows the number of members enrolled, the benefit package selected, and the total premium amount.

**No Mbr:** Number of members on this employee's contract.

**Ben Pkg:** The benefit package the employee is enrolled in. (The benefit package options selected by your account are shown in the last section of your premium invoice.)

CONTRACT	***** MEMBER ROSTER *****	CONTRACT TYPES (SEE BENEFIT/RATES FOR CODES)					N M B R	B P K G	TOTAL PREMIUM	REMARKS
		MD	DN	VS	RX					
920100455	JACKSON JACK	01	01	01			01	01	188.20	
920100392	SANDERSKEN	04	04	04			04	01	539.10	
920100567	SMITH JOHN	02	02	02			02	01	391.20	

### Abbreviations used for types of coverage (lines of business):

- MD = Medical
- DN = Dental
- VS = Vision
- RX = Prescription medication

### Contract Types:

- 01 = Subscriber only
- 02 = Subscriber and spouse
- 03 = Subscriber and one child
- 04 = Subscriber, spouse, and one or more children
- 05 = Subscriber and two or more children

## Auditing Your Premium Invoice

It is important to audit your invoice to ensure the changes you requested in the previous invoice are now reflected in the new invoice. Does the new invoice reflect new employees you added previously? How about terminations or package changes? What about dependents that were added or deleted, or name changes that were made? These are examples of what you will want to audit your invoice for.

**Note:** Enrollment changes to existing coverage made on your previous invoice will be shown under the "contract types". Additions will show an increase in the number covered under the "no mbr". Deletions, showing a decrease in the number covered, will be reflected in the same area.

## Contract Type Counts

For each benefit package, the total number of contracts enrolled by contract type and lines of business are displayed.

**Benefit Package:** Any choices of benefits available to your employees are designated by a package number and description. The packages of benefit options are selected by your account. Packages may also define different employee classifications. Examples include active, retiree, COBRA, salary, hourly, management or nonmanagement. A description of each benefit package displays in this section.

*** CONTRACT TYPE COUNTS ***					
BENEFIT PACKAGE	01 BCP / DENT / VIS / RX				
CONT. TYPE	01	02	03	04	05
	SUBSCRIBER	SUBSCRIBER AND SPOUSE	SUBSCRIBER AND CHILD	FAMILY	SUBSCRIBER AND CHILDREN
MD	4	6	3	2	1
DN	4	6	3	2	1
VS	4	6	3	2	1
RX	4	6	3	2	1

Are the total contract counts correct for each benefit package?

## Benefit/Rate

For each benefit package, the premium rate by contract type and line of business and the effective date are shown.

***** BENEFIT / RATE *****					
BENEFIT PACKAGE	01	BCP / DENTAL / VISION / RX			
EFF DATE	01/01/04	CAN DATE			
CONT. TYPE	01	02	03	04	05
	SUBSCRIBER	SUBSCRIBER AND SPOUSE	SUBSCRIBER AND CHILD	FAMILY	SUBSCRIBER AND CHILDREN
MD	136.85	283.90	283.90	395.50	395.50
DN	21.90	40.90	40.90	63.50	63.50
VS	4.85	9.90	9.90	13.45	13.45
RX	24.60	56.50	56.50	66.65	66.65
TOTAL	188.20	391.20	391.20	539.10	539.10

## Understanding The Invoice Messages

The following messages may appear within or directly following the member roster:

## Remarks

If premium was prorated due to partial coverage for the billing period, an explanation appears under “remarks” within the member roster.

CONTRACT	***** MEMBER ROSTER *****	CONTRACT TYPES (SEE BENEFIT/RATES FOR CODES)								TOTAL PREMIUM	REMARKS	
		MD	DN	VS	RX							
920100455	JACKSON JACK	01	01	01	01				01	01	188.20	
920100392	SANDERSKEN	04	04	04	04				04	01	323.46	FR 05/01/04 TO 05/18/04
920100392	SANDERSKEN	02	02	02	02				02	01	152.48	FR 05/18/04 TO 06/01/04

## Employee Adjustments

New enrollments, contract cancellations, and changes that were made the previous month are listed in the employee adjustments section following the member roster. The premium amount is included in the amount due of your current invoice.

lines of business and benefit package the member is enrolled in or canceled from, the from and to dates of the adjustment period, what the adjustment is (add, cancel), and the reason code associated with the adjustment. “Member Adj Reasons” provides a definition of any reason code used in the employee adjustments section.

In addition to the subscriber’s identification number and name, this section shows contract types for the

*** EMPLOYEE ADJUSTMENTS ***														
920100215	WINTERS	MILO	L	0202	02	02	-142.50	FR	07/01/02	TO	08/01/02	CANCEL	RSN	01
*****														
*** MEMBER ADJ REASONS ***														
RSN	DESCRIPTION													
01	LEFT EMP													
*****														

*Shows types of coverage by contract type. (This individual had medical, dental, and prescription medication coverage.)*

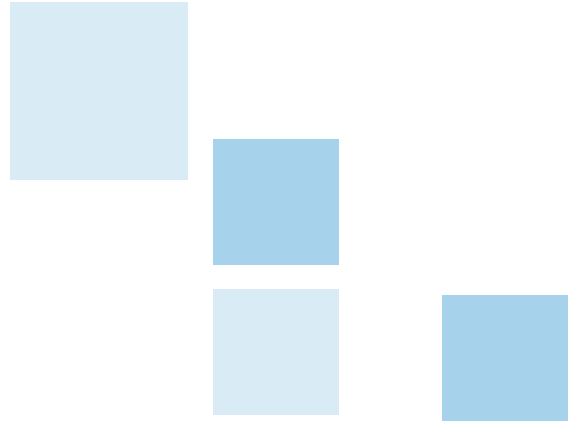
*Benefit Package*

*Refer to “Member Adj Reasons” for a definition of this code.*

## Billing Messages

If there is a carry forward amount listed in the group billing summary, this message section provides an explanation.

\*\*\*\*\* BILLING MESSAGES \*\*\*\*\*  
GROUP UNDERPAID \$20 FOR RANDEL IN JULY  
\*\*\*\*\*



## Reconciling Your Premium Invoice

To reconcile your invoice, simply review the information we show for your group and record any additions, cancellations, or changes to your enrollment.

### Six Easy Steps

- Review the **group billing summary** on page 1 of your premium invoice. Any additions and changes you made to your previous invoice are reflected in the adjustments amount on this invoice.
- Review the **member roster** which begins on page 3. Verify that each subscriber who should have coverage for the billing period is listed on the roster.
- Review the **contract type** and **benefit package** section on the member roster. Verify that all subscribers are included in the correct benefit package with the appropriate contract type.
- Read any **messages** that appear on your invoice. The messages are displayed as:
  - remarks,
  - adjustments, or
  - billing messages
- Indicate under **eligibility adjustments** on page 1 any additions, cancellations, or changes to existing enrollment. Record the subscriber's name, member number and the effective date of the change. If you have a number of changes, please record them on an eligibility adjustment form<sup>1</sup> and attach to page 1.
- Using the enclosed return envelope, send to us:
  - the first page of your invoice. (Keep all other pages of the invoice for your records.)
  - your premium payment for the amount you were billed. Please make your check payable to Regence BlueCross BlueShield of Oregon and write the group and invoice number on the check. Note: If you submitted any changes, your premium invoice next month will show the appropriate payment due or the credit applied.
  - any eligibility adjustment forms you are submitting to make enrollment changes. (Retain your copy of the form.)
  - any new enrollment applications or eligibility changes you are submitting.

If you have any questions about your invoice, please call the appropriate "For Billing Questions" phone number shown in the upper right corner of your invoice.

<sup>1</sup> If you are in need of additional eligibility adjustment forms, please don't hesitate to contact our supply desk at 1 (503) 225-4961 in Portland, or toll-free at 1 (800) 452-7790 x4961 and ask for form 2303. You may also order supplies online at [www.or.regence.com/employer](http://www.or.regence.com/employer).



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