



**BlueCross BlueShield
of North Carolina**

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Employer Reference Guide

*The content of this guide is intended for the use of underwritten groups only.



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Welcome to the Blue Cross and Blue Shield of North Carolina (BCBSNC) Employer Reference Guide.

This comprehensive guide is designed to give you, our Group Administrators, the information you need to oversee the insurance benefits of your company or organization.

There's a lot of information to cover, and we want to make it as simple and easy to understand as possible. To that end, we've included a Glossary of Terms at the end of this document as a reference, should you encounter words you aren't familiar with. If you have any further questions, please call your Producer.

I. Communicating With Us

Communication is essential to any relationship – this holds true for Group Administrators and BCBSNC's Group Membership area as well. We are available to answer questions that may arise or assist you in any way we can.

A. Telephone

Group Membership is a function of BCBSNC responsible for the monthly administration of your group's membership and billing transactions. Simply put, Group Membership:

- updates membership information (new adds, terminations and changes)
- reconciles your monthly billing

You may contact Group Membership's Employer Services Line toll free at (877) 237-6275. Calling this number will put you in touch with a Customer Service Specialist who can help you with any questions, concerns, issues and requests. If you feel you need to discuss your situation with a manager, talk to your BCBSNC representative who can put you in contact with the right person.

Group Membership is available to help you in any way possible. However, there may be circumstances in which another area may be better able to respond to your particular needs. The chart below will assist you in contacting the correct department for your question.

Questions about your initial rates (Fewer than 100 members)	Call your Producer or Producer Manager
Questions about your renewal rates (Fewer than 100 members)	Call your local Producer Manager or Producer
Questions about your rates (More than 100 members)	Call your Account Manager or Account Service Representative
Questions about your benefits	Call Customer Service (877) 258-3334
Questions about COBRA member information Group information COBRA enrollment status	Call Ceridian (800) 877-7994 Call Ceridian (800) 488-8757 Call Group Membership (877) 237-6275



B. Mail

You may also correspond with us through the United States Postal Service. Upon receipt at BCBSNC, the mail will be sorted and distributed to Group Membership, then processed within five to seven business days of receipt.

All correspondence should be sent to:

Post Office Box 2291, Durham, North Carolina 27702-2291

The overnight delivery address is:

5901 Old Durham-Chapel Hill Road, Durham, North Carolina 27707-0718

The payment address for invoices is:

PO Box 538660, Atlanta, GA 30353-8660

C. Fax

You can fax information to Group Membership. When submitting a fax, please use a cover sheet to detail your request. The fax number is (919) 765-1213.

D. Internet

The Employer section of our Web site at bcbsnc.com is a helpful resource where you will find useful forms, tools and resources. You may submit membership, billing address and Group Administrator changes via e-mail to: group.maintenance@bcbsnc.com.

II. Communicating With Affiliated Companies

BCBSNC contracts with third parties to handle claims and customer service for dental benefits, prescription drugs and mental health services. Use the following information to help you and your employees contact the appropriate company. You can also find this information in your Member Guide.

A. Dental Services

BCBSNC contracts with ACS Benefit Services, Inc. (ACS) to fully administer our Dental Blue® business.

ACS Contact Information	
Member Inquiries: <ul style="list-style-type: none">Toll Free Phone NumberE-mailWeb site	<ul style="list-style-type: none">1-800-305-6638dental_blue@acsbenefitservices.comwww.acsbenefitservicesinc.com
Location of Customer Service Center	Winston-Salem, NC
Hours of Operation	8:00 am – 6:00 pm EST
Mail Member Dental Claim Forms and Written Correspondence to:	Blue Cross Blue Shield of NC Claims Unit, PO Box 2100 Winston-Salem, NC 27102-2100
Electronically Submit Dental Claim Forms to:	ACS Dental Envoy Payor #61473



B. Prescription Drug Services

BCBSNC contracts with Medco Health, Inc. (Medco) to manage pharmacy benefits. Medco handles electronic claims, adjudication, real-time and retrospective drug utilization review, provides clinical support for the Pharmacy and Therapeutics (P&T) Committee and assists with physician and pharmacist education initiatives. When members obtain a prescription, they should present their BCBSNC ID card at the pharmacy. The pharmacy then submits the claim electronically to Medco with the member's ID number, name, date of birth and information about the drug being dispensed. Medco processes the claim based on the member's eligibility and benefits and returns information to the pharmacist regarding what copay or deductible to collect.

To file a paper claim, prescription drug reimbursement forms can be found at bcbsnc.com. The completed forms should be mailed to:

Medco Health Solutions, Inc.
P.O. Box 14711
Lexington, KY 40512

C. Mental Health and Substance Abuse Services

BCBSNC contracts with Magellan Behavioral Health, the nation's leading behavioral health disease management and employee-assistance company to manage our mental health and substance abuse services, as well as a variety of additional services. Magellan Behavioral Health's duties vary by product, as described below.

1. Blue Care®

BCBSNC contracts with Magellan Behavioral Health for mental health and substance abuse services for Blue Care members whose coverage includes mental health and substance abuse services. Magellan maintains an extensive network of practitioners (including psychiatrists, psychologists and social workers) throughout North Carolina. Magellan manages all credentialing, claims processing, Utilization Management, Quality Management, first level appeals and member services.

If you have questions regarding the provider network, Quality Management, Utilization Management (UM) programs, claims inquiries, customer service, first level appeals for UM, member eligibility or benefit verification, please contact Magellan at (800) 359-2422. All providers must submit claims directly to Magellan. BCBSNC administers all second level appeals.

2. Blue OptionsSM and Classic Blue®

BCBSNC administers the provider network, Quality Management, customer service, claims inquiries, first level appeals for claims, member eligibility or benefit verification. Magellan administers the Utilization Management programs and first level appeals. If you have questions regarding UM, please contact Magellan at (800) 359-2422. All providers must submit claims directly to BCBSNC. BCBSNC administers all second level appeals.

Note: If your members have questions regarding the appeals process, including contact information and addresses, please refer them to their benefit booklet for detailed information about the appeals process.

III. Membership Maintenance Updates

In this section, you will find information on membership maintenance as well as eligibility guidelines and definitions.

There are three categories for membership maintenance, (often referred to as correspondence), that you will use to manage your group benefits.



- Additions – adding a member onto a new or existing group health plan and re-enrollments
- Changes – changing name, address, marital status and coverage type
- Terminations – removing ineligible members from the group health plan
 - Member Eligibility - please refer to the plan benefit booklet for more information
 - Add or Remove - please refer to the plan benefit booklet for more information

A. Late Enrollments

All late enrollments are processed for a first-of-the-month effective date. Please refer to the plan benefit booklet for more information.

B. Submitting Member Maintenance

As Group Administrator, you should submit membership changes on a daily basis and prior to the bill cycle run date. Mail these membership change requests in the salmon colored envelope inserted with your invoice. If you prefer, these documents may also be faxed or e-mailed. Section I, “Communicate with Us” has further information. Change requests will be processed within 5-7 business days of receipt. BCBSNC will update your group’s membership and reconcile your invoice according to the maintenance submitted.

Timely enrollments are processed in agreement with your group’s probationary period, if applicable. Your group contract will have specific information concerning the probationary period. If your group has a 90-day probationary period, coverage must be effective as of the 91st day of employment.

All late enrollments are processed for a first-of-the-month effective date. If the employee or dependent is enrolling due to loss of coverage, coverage can be made effective as of the last date of coverage. In order to process the enrollment correctly, loss of coverage must be properly indicated on the application when submitted, including periods of any prior coverage. Doing so could reduce the length of the pre-existing condition waiting period.

To ensure your membership is processed in a timely manner, use this checklist before submitting your maintenance:

- ✓ Did the member fill out the enrollment application completely?
- ✓ Did the member sign and date the application in all appropriate places? The application signature date must be current (not more than 30 days past).
 - Maintenance should not be submitted on a copy of the original application, if the original signature is more than 30 days in age. If the application is not signed and received within 30 days of eligibility, members will be made effective as a late add and will be subject to pre-existing conditions procedures. Late adds will not be made effective prior to the signature date.
- ✓ Is there an effective date listed on the application?
 - The effective date must be consistent with the group contract. For instance, if your group contract specifies that the applicant should be effective on the date of a qualifying event, then the applicant should be made effective only on that date. If your contract stipulates that the member should be covered effective at the end of the month, then he/she should not have their coverage effective at any other time.
- ✓ Is the group or account number listed?
- ✓ Did the member include hire date, birth date and dependent information?



- ✓ Is the product request indicated?
- ✓ Is the tier (i.e. single, employee-child) request indicated?
- ✓ Is all prior coverage and dual coverage information for all eligible persons, including names and beginning and ending dates, on the Enrollment And Change Application?
 - This information is especially important to ensure that your members are given appropriate credit for prior coverage.

All maintenance, with the exception of continuation, is subject to a 30-day retroactive policy. This policy is based on the date the request is received.

IV. Reconciling the Monthly Invoice

A. The Invoice

BCBSNC produces your group's invoice. Your monthly invoice is mailed 20 calendar days prior to the due date and is made up of several components that break down the total monthly charges for your group. The first component lists each member and any applicable charges. The second component consists of a reconciliation and remittance statement.

- Following a complete member listing on the detail page(s), you are provided with a summary sheet. This sheet gives a total summary of each account tied to your group, and is followed by a summary of the total group information.
- The final page of the invoice is a reconciliation and remittance statement. Return this reconciliation statement **ONLY** if submitting any membership changes such as new adds, changes and/or terminations, or if your payment is different from the Total Amount Due listed on the invoice.

B. Reviewing Your Monthly Invoice

To ensure continued accuracy of your membership data, you should review your invoice monthly. Here are a few helpful hints on what you should verify:

- Eligible employees are listed
- Rates
- Tiers
- Paid-through dates
- Balance forwards

If your group does not receive a regularly scheduled invoice, call the Employer Services Line toll-free immediately at (877) 237-6275.

C. Paying Your Monthly Invoice

- Pay as billed. Your "billed" amount is firm. Deviating from the total amount will result in a balance forward on your next statement and may also result in claims suspension and group delinquency. Please note that as you send in your changes, additions and terminations, a group-specific journal will be systematically maintained and any necessary adjustments will be made and reflected on your next month's invoice. If you discover a discrepancy in your invoice, contact the Employer Services Line immediately. Once the discrepancy has been validated, the necessary adjustments will be made and reflected on the next month's invoice.
- One check for multiple groups. If you pay for more than one group but use only one check, please list each group/account number along with the allocated dollar amount per group/account.



- Submit your payment in the green colored windowed envelope included with your invoice.

D. Group Reinstatement

BCBSNC does not allow reinstatements for groups terminated due to non-payment of premiums.

V. Continuation Coverage

Consolidated Omnibus Budget Reconciliation Act (COBRA)

Federal COBRA Continuation Law applies to employer groups covering 20 or more employees. This law generally allows eligible enrollees the right to continue coverage under the employer group health plan for up to 18 months after they are no longer employed by your group. Special circumstances may extend coverage up to 36 months. Stiff penalties may be imposed on groups that do not comply with this legislation. COBRA Continuation Law applies to both fully insured (Underwritten) and self-funded (ASO) plans. However, it does not apply to certain church-related plans, plans covering less than 20 employees (see NC State Continuation), student groups and plans covering federal employees.

BCBSNC has chosen Ceridian Benefits Services to assist groups in providing COBRA compliance services. If your group chooses not to utilize the services of Ceridian, your benefit administrator is responsible for tracking COBRA membership and collecting fees from members. Neither Ceridian nor BCBSNC assume any responsibility for your group's COBRA administration if an administrator other than Ceridian is chosen.

In order for a member to be eligible for COBRA, the following three elements must be met:

A. Plan Coverage

The member must be enrolled on a group health plan provided by an employer with 20 or more employees who are employed on more than 50 percent of its typical business days in the previous calendar year.

B. Qualified Beneficiaries

The member must be a "qualified beneficiary," which generally means an individual covered by a group health plan on the day before a qualifying event. This person is an employee, the employee's spouse, or an employee's dependent child. In certain cases, disabled or retired employees and their spouses and dependent children may qualify as beneficiaries. In addition, any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary. Agents, independent contractors, and directors who participate in the group health plan may also be qualified beneficiaries.

C. Qualifying Events

The member must experience a "qualifying event," which are occurrences that cause an individual to lose health coverage. The type of qualifying event determines who the qualified beneficiaries are and the amount of time health coverage must be available to them under COBRA.

1. Qualifying Events for Employees

- a. Voluntary or involuntary termination of employment for reasons other than gross misconduct
- b. Reduction in the number of hours of employment
- c. Employee is laid off

2. Qualifying Events for Spouses and Dependents



- a. Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct
- b. Reduction in the hours worked by the covered employee
- c. Covered employee becomes entitled to Medicare (if applicable)
- d. Divorce
- e. Death of the covered employee
- f. Loss of "dependent child" status under plan rules

To learn more about your responsibilities as an employer, please refer to your underwritten Insurance Agreement.

D. Renewing Ceridian Rates

You should receive a Rate Expiration Report from Ceridian 60 days in advance of your contract expiration date. Complete the report form and return it to Ceridian. If you do not reply to the Rate Expiration Report, your services will remain in place. However, Ceridian will continue to bill your continuants at the old rate until the new rate is provided. Our contract with Ceridian requires that renewal rates be received by them 30 days in advance of the renewal.

If your group number changes for any reason at the renewal period, BCBSNC notifies Ceridian of the new group number and rates associated with the new number.

E. State Continuation Coverage

North Carolina State Continuation allows terminated employees and members of a fully insured (underwritten) group that employs less than 20 workers to continue coverage under their employer's group health plan when they terminate employment or lose their eligibility under the group health plan. Upon termination or other loss of eligible status, employees and their dependents have the option to continue group coverage for 18 months from the date they cease to be eligible for coverage under the group health plan. Employees are not eligible for continuation under state law if:

- The employee's insurance is terminated because he/she failed to make the appropriate contribution
- The employee or his/her dependents requesting continuation are eligible for another group health benefit plan
- The employee was covered less than three consecutive months prior to termination

The member must notify the group of his/her intention to continue coverage and pay any applicable fees within 60 days following termination of eligibility. Upon receiving the notice of continuation and any applicable fees, BCBSNC will reinstate coverage back to the date eligibility ended. The state law continuation benefits run concurrently and not in addition to any applicable federal continuation rights.

State Continuation coverage will end after 18 months, or earlier, if:

- The employer ceases to provide a health benefit plan to employees
- The continuing person fails to pay the monthly fee
- The continuing person obtains similar coverage under another group plan

If an employee elects State Continuation, you should:

- Submit an Enrollment and Change form, or
- Record the request on your Reconciliation Sheet under the CHANGES section. Please note member name, social security number, termination date, and code for



NC State Continuation. (See bottom of reconciliation sheet for list of codes). Please keep a copy for your files.

If a dependent elects State Continuation:

- Submit a signed Enrollment and Change form designating the dependent as the policyholder (employee).

VI. Glossary of Terms

The following is a glossary of terms that may be helpful in working with employee benefits. While these terms are not comprehensive or universally accepted definitions, they are meant to assist you in understanding concepts, services and information related to BCBSNC. Please refer to your Member Guide for additional health care definitions

Account Manager	Person responsible for your contractual agreement, supply requests and service management.
Account Number	Number assigned to your group; made up of six numbers and an alpha character.
Account Service Representative	Works with the account manager to service the account.
Adjudication	Process of determining the reimbursement applicable for a particular claim.
Allowable Charge/Amount	Maximum amount to be reimbursed to a provider as negotiated.
Appeal	Request for review for non-certification of services, which have not been received (i.e., a denial of a request for services).
Balance Forward	Amount not paid from the previous billing cycle.
Benefit Package	(Ben. Pkg.); The product in which the group/member is enrolled.
Benefits	The amounts payable by a health plan for the cost of various health care services.
Benefits Period	Specified period of time during which charges for covered services provided to a member must be incurred in order to be eligible for payment. Typical benefits period is a calendar year.
Benefits Booklet	Document containing a general explanation of the member's benefits; also known as member handbook.
Bill Cycle	Date of the month that your bill is produced.
Billed Amount	Amount a physician, facility, pharmacy, supplier of medical equipment or other provider bills a member for a particular medical service or procedure.
Billing	Itemized account of (1) member dues owed to BCBSNC by a group or member or (2) services rendered by a physician or supplier.
Calendar Year	Period of time beginning on January 1 st and ending on December 31 st of any given year.



Certificate	Contract issued to a group or individual by a health plan or carrier that describes the scope of covered services and establishes the level of benefits payable.
Copayment	Cost-sharing arrangement in which the member pays an established charge for a specific service at the time that service is rendered.
Continuant	Someone who has elected COBRA coverage.
Credentialing	The process by which a health care organization reviews and evaluates qualifications of licensed independent practitioners to provide service to its member
Deductible	Flat amount a member pays before BCBSNC makes any benefit payments.
Effective Date	Date on which coverage begins under a certificate.
Eligible Employee	Full-time individual working 30 or more hours per week, receiving an annual W2 compensation record from the employer.
Exclusions	Specific conditions or services listed in the certificate for which benefits are not available.
Member	An individual for whom BCBSNC has a contractual obligation to provide, or arrange for the provision of, health services.
Network	Group of physicians, hospitals and other health care providers working with a health care plan to offer care at negotiated rates and at other agreed upon terms.
Plan	BCBSNC or other Blue Cross and Blue Shield organization.
Premium	Payment required to keep a policy active.
Probationary Period	Period after beginning a job that an individual must wait before becoming eligible for group coverage, also known as a waiting period.
Qualified Beneficiary	Anyone who is eligible for COBRA coverage.
Quality Management	Network quality audits performed in the field, including medical records, facility, and access to care.
Tier	Package type (i.e. single, family, etc.)
Utilization Management (UM)	The process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing any needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources.

