North Carolina Medical Society
Employee Benefit Plan

Health Insurance Program

Group Administrator Guide

Marketed Exclusively by MMIC Agency, Inc.

Administered by Blue Cross and Blue Shield of North Carolina

AG001, 12/09

Contents

For Information Regarding: Refer to Page:

I. Membership Maintenance Updates
A. Member Eligibility....1
1. Eligible Employees....1
2. Military Leave of Absence....1
3. Medicare Eligible Employees....2
4. Eligible Partners....3
5. Eligible Dependent Children....4
a. Definition of Dependent Children....4
b. Removing a Dependent Child....4
B. Late Enrollments....5
1. Health Late Enrollments....5
2. Life Late Enrollments....5
C. Submitting Member Maintenance....5

II. Reconciling The Monthly Invoice
A. The Invoice....6
B. Reviewing Your Monthly Invoice....7
C. Paying your Monthly Invoice....7
D. Group Reinstatement....7

III. Continuation and Conversion
A. State Continuation....8
B. How to Document Election of NC State Continuation....8
C. Conversion to Individual Coverage....8
D. Adding New Employees and New Dependents to COBRA....9
E. Managing Qualifying Events....9
F. Removing Employees and Dependents....10
G. Renewing Rates with Ceridian....10

IV. How To Communicate With Us
A. Telephone....10
B. Mail....11
C. Fax....11
D. E-mail....11
E. Internet....12

V. How To Communicate With Affiliated Companies
A. Prescription Drug Services....12
B. Mental Health and Substance Abuse Services....12

VI. Continuity of Care Process
A. Eligibility for Continuity of Care....13
B. Continuity of Care Form....13
C. Sample Authorization For Release of Information Form....16

VII. Glossary of Terms....17

The North Carolina Medical Society Employee Benefit Plan is pleased to provide you with this Group Administrator Guide. If you have questions regarding this Guide, or issues not covered by this Guide, please call us at (800) 662-7917.

The North Carolina Medical Society Employee Benefit Plan (the "Plan"), sponsored by the North Carolina Medical Society, is marketed exclusively by MMIC Agency, Inc. (a subsidiary of Medical Mutual Insurance Company of North Carolina). The Plan has contracted with Blue Cross and Blue Shield of North Carolina (BCBSNC) to provide administrative services including, but not limited to, health membership maintenance, access to provider network, and claims adjudication.

Group eligibility for the Plan requires that all employed physicians of a participating group be current members of the North Carolina Medical Society. Please refer to the Plan's Trust Agreement and Participation Agreement for further information regarding group eligibility requirements. For questions regarding the North Carolina Medical Society, including membership and services, please contact the Society at (800) 722-1350.

I. Membership Maintenance Updates

Maintenance, or correspondence as it is often referred, is any change to your member's certificate. Membership maintenance falls into three categories:

- **Additions** – adding a member onto a new or existing certificate and re-enrollments
- **Changes** – changing name, address, marital status and coverage type
- **Terminations** – removing any member from an active certificate at the time ineligibility occurs

A. Member Eligibility

The following are the North Carolina Medical Society Employee Benefit Plan's standard eligibility definitions.

1. Eligible Employees

An eligible employee is an active full-time employee of the group who works, year-round, a minimum of 30 hours or 24 hours per week (as determined by the employer), has annual reporting of FICA withholdings by means of a Form W-2 and is listed on the group's wage and tax statement. Sole proprietors and partners devoting a minimum of 30 hours or 24 hours per week to the business are considered eligible employees. Statutory employees are also considered eligible employees. Statutory employees may report income and expenses on Schedule C or 1099. For statutory employees, the employer may be required to submit a Form W-2 or 1099 to the Plan, as well as a letter attesting to each statutory employee's full-time status.

2. Military Leave of Absence

The federal Uniformed Services Employment and Reemployment Act (USERRA) requires employers to allow employees who enter into service in the Uniformed Services and their covered dependents to extend group health coverage. The Uniformed Services includes the Armed Forces, the Army and Air National Guards, and the Commissioned Corps of the Public Health Service *(and any other category of persons designated by the President of the United States in time of war or national emergency)*. This period of time is referred to as a military leave of absence.

- The employer must provide the employee an opportunity to elect extension of coverage *(for him/herself and covered dependents)* beginning on the date the absence from employment begins, for the lesser of:
    a) A period of 24-months beginning on the date which the employee's absence for the purpose of performing service begins, or
    b) A period beginning on the date on which the employee's absence for the purpose of performing service begin, and ending on the date on which he or she fails to return to work from service or apply for a position of employment.
- An employee who elects to continue coverage, as described in 1 above, may not be required to pay more than 102% of the full premium under the plan, in the same manner it is calculated for COBRA.
- If service in the Uniformed Services is less than 31 days, the person who continued coverage may not be charged more than the regular employee contribution under the plan for him/herself and any covered dependents.
- An employer must notify the Plan within 90 days following the start of the military leave that the employee's coverage is to be extended/suspended. Notification is indicated on the monthly invoice by entering the MLT activity code.
- Employees returning to their civilian employers after military leave must be treated as if they had been employed continuously. They should be considered as having been on furlough or leave of absence during their period of active service. They are entitled to participate in insurance benefits offered by the employer in accordance with the employer's rules and practices related to employees on furlough or leave of absence.
- Pre-existing provisions and medical underwriting are waived for returning employees who apply for reinstatement within 30 days following release from active duty. A Change Form must be submitted as well as a copy of the discharge notification.

The full text of USERRA can be found at **http://www.esgr.org/userra.html**.

3. Medicare-Eligible Employees

Federal Medicare regulations require the Plan to be the primary coverage and Medicare secondary coverage for any member who:

a) Is covered under the group health plan by virtue of his/her current employment status, and

b) Has Medicare coverage due to any disability except end-stage renal disease.

Groups must offer coverage under the Plan without regard to an employee's eligibility for Medicare. Coverage must also be offered to the Medicare-eligible spouse of an employee. Medicare-eligible employees and spouses are entitled to continue coverage under the Plan until the employee no longer meets eligibility requirements.

- **End Stage Renal Disease:**

  The Plan is primary coverage for up to 30 months for members who have Medicare solely because of permanent kidney failure *(End Stage Renal Disease)*. The period during which the Plan is primary begins with the earlier of:

  a) The first of the month in which the member becomes eligible for Medicare Part A; or

b) *(If earlier)*, the first of the month in which the member would have becomes entitled to Medicare Part A, if he or she had filed an application for such benefits.

- **Penalties for Failure to Comply with Medicare:**

  A group health plan that fails to conform with federal law regarding coverage of individuals eligible for Medicare could be subject to a tax equal to 25 percent of the group health plan's annual expenses. Additionally, the federal government may bring a civil action to recover double damages against an employer or other entity that does not comply with Medicare Secondary Payer requirements.

  It is unlawful for an employer to offer any financial or other incentive for an individual entitled to Medicare not to enroll under a group health plan that would be a primary plan. This act could result in a civil monetary penalty.

4. Eligible Partners

An eligible partner is a person married to the employee or the domestic partner (same or opposite sex) of said employee. The person is eligible while married to or the domestic partner of the employee. The marriage must be legally valid. The domestic partnership must be certified by an executed *Affidavit of Domestic Partnership*. An employee cannot have more than one domestic partner covered under the Plan and cannot have had a different domestic partner within the past twelve months before adding a new domestic partner, unless the previous partner was removed from the Plan as the result of death.

a. If Employee Marries or Certifies a Domestic Partnership:

   If an employee marries or certifies a domestic partnership and chooses to include his or her spouse or domestic partner on the Plan, the employee must complete a change application within 30 days following the date of marriage or certification. The coverage change becomes effective on the date of the event. Any requests for coverage of a spouse or domestic partner made more than 30 days after the date of the event may require a waiting period.

b. If Employee Separates:

   In the event of a separation, the employee may continue coverage of the spouse or domestic partner during the period of separation or remove the spouse or domestic partner from his/her group coverage. If the spouse or domestic partner is to be removed, the employee must complete and sign a Change Application. You should make sure that the date of separation and the name and address of each member to be removed are recorded on the form. A change in the employee's marital or partner status may necessitate a change in the type of contract. A dependent spouse or partner must be removed from the employee's group program in the event of death or divorce.

c. Definition of Domestic Partner:

   The Plan defines a Domestic Partner as listed below:

   1. At least eighteen (18) years of age.

   2. Not related to the employee by blood or to a degree of closeness that would prohibit legal marriage in the State of North Carolina.

   3. Not married to anyone else.

   4. Not had another domestic partner within 12 months prior to the date employee enrolls the domestic partner under this group policy.

5. Shared the same residence for at least 12 months prior to the date employee enrolls the domestic partner under this group policy and expected to do so indefinitely.
6. Mutually responsible with employee for the cost of basic living expenses as evidenced by joint home ownership, common investments, or some other evidence of financial interdependence for at least 12 months prior to enrollment date.

5. Eligible Dependent Children

If the same group employs both parents and each is enrolled on a separate certificate, eligible children may be split between the two certificates. However, both spouses cannot cover the same children on each of their certificates. Employees may cover their dependent children not living with them if they are legally responsible for their health care. Legal court ordered documentation would be required.

a. *Definition of Dependent Children*

The Plan defines dependent children as listed below:

1. The employees' natural children less than age 19. Effective August 1st, 2009, and upon your group's renewal coverage effective date thereafter, children up to age 26 regardless of student status.
2. Legally adopted children, children legally placed for adoption, stepchildren and foster children less than age 19. Children legally placed for adoption require additional court ordered documentation. (Definition change noted in a(1) applies)
3. Full-time students up to age 26. *(Coverage remains in effect during normal school vacations, including summer vacation if the student is returning to school in the fall on a full-time basis.)* (Definition change noted in a(1) applies)
4. Mentally retarded and/or physically disabled children, if the condition existed and coverage was in effect upon attainment of the limiting age. In order to establish a child's eligibility for continuation of coverage after attainment of the limiting age, Form P24 "Coverage Request for Mentally Retarded or Physically Handicapped Children" must be completed and submitted for underwriter approval within 30 days of the limiting age. An eligible mentally retarded and/or physically disabled child may be continued until:
    a. The child ceases to be classified as mentally retarded and/or physically disabled.
    b. The child marries *(if this occurs, the child is no longer eligible for coverage regardless of age, subsequent separation, or divorce)*; or the employee removes the child from coverage.
5. A newborn infant from the time of birth, if the current coverage includes benefits for family members *(i.e. Employee-Children or Family certificate type)*. If this applies, within 30 days of the birth the employee should call the customer service phone line indicated on their ID card and furnish the name and birth date of the child to be added. If the current coverage does not include benefits for family members *(i.e. Employee Only or Employee/Spouse Certificate Type)*, the employee must sign a change application within 30 days after the birth of the child, listing the newborn's name and date of birth, and indicating the new certificate type.

b. *Removing a Dependent Child*

To remove a dependent child, the employee must complete and sign a Change Application. You should make sure that the name and address of each member to be removed are

recorded on the form. A change in the employee's dependent coverage may necessitate a change in the type of contract. A dependent child must be removed from the group program if one of the following occurs:

1. Child reaches the maximum age of 19 and does not qualify as a full-time student, (Definition change noted in a(1) applies)
2. Child is a full-time student who reaches the age of 26 or age defined by the group contract, (Definition change noted in a(1) applies)
3. Child is a full-time student who graduates or no longer attends school on a full-time basis, (Definition change noted in a(1) applies)
4. Child marries,
5. Child dies, or
6. Child no longer qualifies as mentally retarded and/or physically disabled.

B. Late Enrollments

1. Health Late Enrollments

If employees and/or their dependents are enrolling at a time, which does not qualify as a timely enrollee, then your employees and/or their dependents will be considered a late enrollee. Waiting periods may apply. If a member applies for coverage within 63 days of terminating their prior coverage, credit toward the pre-existing waiting period will be given.

2. Life Late Enrollments

If the employer chooses any basic Life and AD&D coverage, all eligible employees must participate in the program. If an eligible employee rejects the health coverage, a life enrollment application is still required in order to enroll the employee on the life coverage. If an application is not submitted and it's determined at a later date that an eligible employee was not enrolled on the life coverage timely, then the employee will be enrolled with life coverage as of the original date of eligibility and the group will be back billed for the life premium.

C. Submitting Member Maintenance

Employer groups should submit changes on a daily basis and prior to the bill cycle run date. The request will be processed within 5-7 business days of the receipt date. BCBSNC will update your group's membership and reconcile your invoice according to the maintenance submitted. In order to ensure your membership is processed in a timely manner, ask yourself these questions before submitting your maintenance:

1. Did the member fill out the enrollment application completely?
2. Did the member indicate whether they are a physician or non-physician?
3. Did the member sign the application and is the application signature and date current *(not more than 30 days in age)*? Members will be made effective as a late add and will be subject to pre-existing conditions if the application is not signed and received within 30 days of eligibility. If a member applies for coverage within 63 days of terminating their prior coverage, credit toward the pre-existing waiting period will be given.
4. Is there an effective date listed on the application?

5. Is the group or account number listed?
6. Did the member include hire date, birth date and dependent information on the application?
7. Is the product request indicated?
8. Is the tier *(i.e. single, employee-child)* request indicated?
9. Is all prior coverage information, including beginning and ending dates, on the enrollment and change application? This information is especially important to ensure that your members are given prior coverage credit.

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.

Probationary periods for new employees were selected by your group and may be different for physicians and non-physicians. The Plan allows groups to choose from the following:

- **a.** 0 True: Coverage effective on first day of employment.
- **b.** 30 Days: Coverage effective first of month following completion of 30 days of employment.
- **c.** 60 Days: Coverage effective first of month following completion of 60 days of employment.
- **d.** 90 True: Coverage effective on 90th day of employment.

Qualifying events must be submitted in writing within 30 days of the event. Depending on the terms of your group contract, a member being added due to a qualifying event will be added either the day of the event or 30 days from the qualifying event. A qualifying event is one of the following:

1. Marriage
2. Birth
3. Adoption or foster care, from date of legal placement
4. 90-day probationary period

II. Reconciling Your Monthly Invoice

A. The Invoice

BCBSNC will produce your group's invoice systematically. It will be mailed 20 calendar days prior to the due date. Your monthly invoice is made up of several components that break down the total monthly charges for your group. The length of your invoice will depend upon the size of your account.

- The first page(s) will list each subscriber and any applicable charges.
- After all of your subscribers have been listed on the detail page(s), you will be provided with a summary sheet. This sheet will list a total summary of each account that is tied to your group, and will be followed up by a summary of the total group information.
- The final page of the invoice will be a reconciliation and remittance statement. List any new adds, changes and terminations on this statement. This page will also list the last date a payment was received and the amount of that payment. This

information is listed directly above the Bill Totals Line. This form must be returned with your monthly premiums and any relevant applications.

B. Reviewing Your Monthly Invoice

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

- The Enrollment of All Eligible Employees
- Rates
- Tiers
- Paid Thru Dates
- Balance Forwards

If your group does not receive a regularly scheduled invoice, call BCBSNC Group Membership Services 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. It 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 note a discrepancy in your invoice, contact Group Membership Services immediately. Once the discrepancy has been validated, the adjustments will be made and will be reflected on your next month’s invoice.

- **One check for multiple groups.** If you pay for more than one group but use only one check, please list the account number along with the allocated dollar amount per account.

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

D. Group Reinstatement

Groups terminated due to non-payment of premiums are not eligible for reinstatement without express approval from the Plan and under limited circumstances.

III. Continuation and Conversion

The NC Continuation and Conversion Law (NC Law) is applicable to most groups of any size. For groups that must comply with COBRA, the provisions of COBRA prevail since COBRA affords the continuant a greater opportunity for continuing group benefits; however, the NC Law is applicable when COBRA is not applicable due to “gross misconduct”. Groups not complying with COBRA should be complying with the NC Law. This means that under NC Law for State Continuation, coverage must be offered even in the case of termination due to “gross misconduct”.

The Plan has chosen Ceridian Benefits Services to assist groups in providing COBRA compliance services. Ceridian’s state-of-the-art system helps you comply with COBRA’s requirements, and allows your employees to receive the full measure of their COBRA rights. COBRA is a federal law applicable to groups with 20 or more employees for 50 percent of the workdays for that year. The procedures and forms for continuation and conversion depend on

which legislation applies to the situation. Stiff penalties may be imposed on groups that do not comply with this legislation.

If your group does not currently utilize the services of Ceridian, the benefit administrator is responsible for tracking COBRA membership and collecting fees from members. Neither the Plan, MMIC Agency, Inc., Ceridian, nor BCBSNC assume any responsibility for your group's COBRA administration.

A. State Continuation

Employees and their dependents have the option to continue group coverage for 18 months from the date that they cease to be eligible for coverage under the health benefit plan. Employees are not eligible for continuation under state law if:

- The employee's insurance terminated because they failed to pay the appropriate contribution,
- The employee or their dependents requesting continuation are eligible for another group healh benefit plan,
- The employee was covered less than three consecutive months prior to termination.

The member must notify the group of the intention to continue coverage and pay the applicable fees within 60 days following the end of eligibility. Upon receipt of the notice of continuation and applicable fees, the Plan 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.

Group continuation under state law will end after 18 months or earlier if:

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

B. How to Document Election of NC State Continuation

If an employee elects NC State Continuation:

- 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 NC State Continuation:

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

C. Conversion to Individual Coverage

Once continuation has been in effect for 18 months or if the group ceases to provide a health benefit plan to employees, the subscriber is eligible for non-group conversion with continuous coverage.

Persons who have exhausted their continuation coverage rights may also be eligible for a federally mandated product many insurance companies must offer. If members meet the following requirements, they should check with BCBSNC or another insurance carrier to see if they qualify:

- The applicant has 18 or more months of prior creditable coverage

- The applicant's most recent coverage was group coverage
- The applicant is not eligible for Medicare, Medicaid or another group health insurance plan
- Most recent coverage was not terminated for non-payment of premiums or fraud.

D. Adding New Employees and New Dependents to COBRA

When employees and dependents are added to your group health program, they must also receive a COBRA notification letter. To add a new employee and/or an employee's new dependent, send an initial COBRA notification letter on your corporate letterhead. The letter should be sent via first class mail addressed to the employee and spouse *(if applicable)* at the last known home address. In most cases, Ceridian will provide this service. Refer to your Ceridian Implementation Kit for more information.

E. Managing Qualifying Events

There are several events that would cause an employee to lose health care coverage. Any of the following are considered qualifying events:

1. Employee is terminated from employment for any reason other than for gross misconduct *(layoff, resignation, retirement, etc.)*,
2. Employee has a reduction of hours worked,
3. Employee dies,
4. Employee gets divorced,
5. Dependent child ceasing to meet eligibility requirements,
6. Active employee (or COBRA continuant) reaches age 65 and becomes eligible for Medicare, thereby causing dependent to be ineligible for coverage, or
7. Retiree or retiree's spouse or child loses coverage within one year before or after the commencement of proceedings under Title 11 *(bankruptcy)* United States Code.

When an employee and/or dependent leaves the group or has a qualifying event, Ceridian refers to that person as a "qualified beneficiary". A qualified beneficiary is anyone eligible for COBRA. At the occurrence of a qualifying event, you should do the following:

1. Remove the employee and/or dependent from the billing statement as described in the "submitting member maintenance" section of this guide. A qualified beneficiary should never be continued on the group health program while awaiting notification from Ceridian of employee's election.
2. Mail a COBRA notification form and rate sheet to the employee and spouse *(if applicable)* at the last known home address. The COBRA rate sheet outlines all medical plans and rates applicable to the qualified beneficiary. A supply of COBRA notification forms and rate sheets can be found in the Ceridian implementation kit. In most cases, Ceridian will provide this service. Refer to your Ceridian Implementation Kit for more information.

   a. The qualified beneficiary must complete the appropriate section of the notification form and mail it to Ceridian.

   b. If the employee or dependent elects COBRA, Ceridian will verify that the qualified beneficiary has made a timely election and has paid applicable premiums. A beneficiary who elects COBRA is considered a COBRA continuant. The continuant is assigned a nine-digit number based on social security number.

c. Ceridian will issue a Participant Update Form to the group explaining what action to take regarding the participant's health program.

3. After receiving the Participant Update Form, please forward to BCBSNC as soon as possible. These requests can be mailed in the salmon-colored envelope inserted with your invoice, faxed or e-mailed.

4. Ceridian bills the beneficiary, collects the fees, and sends a monthly member status report and a check for fees collected to you. BCBSNC will bill you for the continuant on your monthly billing statement. Payment for the continuant should be included with your regular monthly payment.

F. Removing Employees and Dependents

A qualified beneficiary is removed from COBRA for failure to make timely payments, reaching the end of the continuation period or becoming ineligible. Upon identification of a termination reason:

1. Ceridian will forward a participant update report indicating the termination reason and date to your attention.
2. You should remove the beneficiary from the next billing statement *(using the applicable activity code)* sent to BCBSNC. Include a copy of the participant update report with your billing statement.
3. BCBSNC will credit your account for all premiums paid beyond the termination date indicated on Ceridian's participant update report.

G. Renewing Rates with Ceridian

MMIC Agency, Inc. will provide Ceridian with your group's renewal rates. 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 30 days in advance of the renewal.

If your group number changes for any reason at the renewal period, MMIC Agency, Inc. will notify Ceridian of the new group number and rates associated with the new number.

IV. How To Communicate With Us

A. Telephone

Rating, Enrollment and Billing Operations (also referred to as "REBO" or "Billing") is responsible for monthly administration of your group's membership and billing. Simply put, REBO:

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

As a participant in the Plan, you have access to a dedicated Group Enrollment Specialist. The dedicated Specialist will be happy to assist you with questions, concerns, issues, and requests. If at anytime your situation requires management intervention, inform the Specialist of your desire to speak with management and your call will be referred accordingly. If a member of management is unavailable, your call will be returned within 24 hours.

REBO will exhaust all means to assist you at the time of your call, however, there may be circumstances in which it will be appropriate for your call to be referred to another area. The following chart will assist you in reaching the appropriate party on initial contact.

Questions about your **rates**	Call MMIC Agency, Inc.	**(800) 662-7917**
Questions about **membership maintenance or billing**	Call your dedicated Group Enrollment Specialist	**(919) 765-1741**
Questions about your **benefits or employee claim issues**	Call BCBSNC Customer Service Call MMIC Agency, Inc.	**(800) 621-5015** or **(800) 662-7917**
Questions about **COBRA** Subscriber information Group information COBRA enrollment status	 Call Ceridian Call Ceridian Call your dedicated Group Enrollment Specialist	 **(800) 877-7994** **(800) 488-8757** **(919) 765-1741**

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 REBO. Correspondence is 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 billing address for invoices is:

Post Office Box 538660
Atlanta, GA 30353-8660

To correspond by mail with MMIC Agency, Inc., address communication to:

MMIC Agency, Inc.
Attn: NCMS Plan
Post Office Box 97968
Raleigh, NC 27624

C. Fax

You can fax information directly to your dedicated Group Enrollment Specialist. When submitting a fax, please use a cover sheet to detail your request. Emergency requests are processed within 24 hours of receipt. The fax number is (919) 765-3564. Please do not send multiple requests.

D. E-mail

You can e-mail information directly to your dedicated Group Enrollment Specialist. Please provide sufficient detail in your request as well as complete contact information. The e-mail address is ncms@bcbsnc.com.

E. Internet

You can submit membership, billing address and group administrator changes to: ncms@bcbsnc.com

V. How To Communicate With Affiliated Companies

The Plan and BCBSNC partner with specialized companies to administer claims and customer service for prescription drugs and mental health services. The following information will assist you in contacting the appropriate company.

A. Prescription Drug Services

BCBSNC contracts with Medco Health, Inc. (Medco) for pharmacy benefit management. Medco handles electronic claims, adjudication, real-time and retrospective drug utilization review, provides clinical support for the P&T Committee and assists with physician and pharmacist education initiatives. When obtaining a prescription, the member shows 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.

If a member needs to file a paper claim, completed prescription drug reimbursement forms, which can be found at www.bcbsnc.com, should be mailed to:

PAID Prescriptions, L.L.C.
P.O. Box 307
Lee's Summit, MO 64063-2187

B. Mental Health and Substance Abuse Services

BCBSNC delegates a variety of activities to Magellan Behavioral Health, the nation's leading behavioral health disease management and employee assistance company.

BCBSNC administers the provider network, Quality Management, customer service, claims inquiries, first level appeals for claims and member eligibility or/benefit verification. Magellan administers the utilization management programs and first level appeals for UM. 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.

Written Inquiries Regarding Claims Submission	Written Inquiries Regarding Appeals/Grievances
BlueCross BlueShield of North Carolina Claims Department PO Box 35 Durham, NC 27702	Attention: Appeals Coordinator Magellan Behavioral Health PO Box 1619 Alpharetta, Georgia 30009

VI. Continuity of Care Process

In compliance with all state and federal mandates and National Committee for Quality Assurance (NCQA) regulations, BCBSNC offers a process to assist members who need to continue receiving care from a provider who no longer participates in the Blue Options network or to a member voluntarily or involuntarily changing health plans.

Provider Termination

Notification of a provider termination is sent to a member within 30 days of Plan receipt of notification or Plan communication of a provider termination.

Member Voluntarily or Involuntarily Changing Health Plan

It is the policy of BCBSNC that a member voluntarily or involuntarily changing health plans must request continuity of care within 45 days of the effective date of coverage by the Plan if they wish to continue care with the non participating provider.

A. Eligibility for Continuity of Care

To be eligible for continuity of care, one of the following conditions must apply:

1. Member has an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.

2. Member has a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time.

3. Member is in the second or third trimester of pregnancy or completing postpartum care.

4. Member is terminally ill, a medical prognosis that the individual's life expectancy is six months or less.

5. Member has certification for medical services that will occur on or after their effective date of coverage for the conditions described above.

B. Continuity of Care Form

A sample of the continuity of care form is included in this document.

Upon receipt of the form, a BCBSNC medical professional will review the request based on the information on the form and any additional information provided by the provider. The member will be notified by telephone if the request is approved or denied. Additionally, the member will receive an explanation letter if the request is denied. If approved, the member can continue to see their provider for the specified timeframe authorized. Prior to the expiration of the authorization, BCBSNC will assist the member in finding another in-network provider for future services.

BlueCross BlueShield of North Carolina

An Independent Licensee of the Blue Cross and Blue Shield Association

Continuity of Care Form

HMO/POS/PPO

Patient Name______________________________Date ______________
Date of Birth ______________________ BCBSNC ID #______________
Address____
Telephone Number (home) (____)_____________(work) (___)______________
Employer/Group Name ______________________________________

Continuity of Care is a process aimed to assist members with an acute, chronic or terminal illness, or is in the second trimester of pregnancy to continue receiving care from a provider when the member changes health plans or when the provider no longer participates in a network. To be eligible for continuity of care one of the following conditions must apply:

1. **Member has an acute illness,** a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.
2. **Member has a chronic illness or condition,** a disease or condition that is life- threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time.
3. **Member is in the second or third trimester of pregnancy or completing postpartum care.**
4. **Member is terminally ill,** a medical prognosis that the individual's life expectancy is six months or less.

Continuity of Care requests will be reviewed by a medical professional based on the information provided on this form about specific medical conditions. Notification about eligibility for Continuity of Care will be sent after a decision is made. If a Continuity of Care request is approved, members may continue to see their current provider through the timeframe specified on their authorization number. Members will by assisted by BCBSNC with finding an in network provider for any future services before the applicable transition period expires.

If you are a member who is currently receiving care for Mental Health or Substance Abuse, and you are enrolling in PCP, MedPoint, Blue Care, or Blue Choice, please call 1-800-359-2422 to determine if Continuity of Care is applicable.

FORM COMPLETION STEPS

1. **Determine if you qualify for Continuity of Care approval. (If yes, you must complete steps 2-4)**
2. Complete the portions of the form below
3. Complete the Release of Information Authorization Section
4. Mail the form to:

Blue Cross Blue Shield of NC
Member Health Partnerships Operations
Health Coaching and Interventions
HQ 2nd floor
PO Box 30004
Durham, NC 27702 Fax: 800-228-0838

For BCBSNC Use only:

Authorization #______________
Date of Service______________
Number of Visits Approved______________
Reviewer's Initials______________

What is your medical condition?____

*****Please complete ONLY the sections below that apply to you or any dependents*****

1. Do you have an **existing certification or authorization** for medical services? If yes, please provide the following information.
   Patient Name__________________________________ Date of Birth ________________________________
   What services are you receiving?____
   Name of Physician___________________________________ Phone # (____) ____________________________
   Physician's Address____

2. Are you in your **2nd or 3rd trimester of pregnancy or receiving postpartum care** (greater than 12 weeks pregnant or delivered within the last 2 months)? If yes:
   Patient Name__________________________________ Date of Birth ________________________________
   Name of Physician___________________________________ Phone # (____) ____________________________
   Physician's Address____
   Due date_________________________ Hospital ____
   Next appointment date____

3. Are you being treated or expect (within 90 days of effective date) to be treated as an **inpatient (hospital, skilled nursing or rehabilitation facility)**? If yes:
   Patient Name___________________________________ Date of Birth _______________________________
   Name of Inpatient facility____
   Anticipated admission date____
   Name of Physician___________________________________ Phone # (____)____________________________
   Physician's Address____
   Anticipated treatment / surgery____

4. Are you receiving **outpatient care on a long-term basis** for conditions such as but not limited to cancer, kidney dialysis, asthma or other chronic ailments? If yes:
   Patient Name____________________________________ Date of Birth______________________________
   What services are you receiving?____
   Where are you receiving the services?____
   Date of scheduled appointment(s)______________________ Date of last service__________________________
   Name of Primary Care Provider____

5. Are you receiving **home care services**? If yes:
   Patient Name____________________________________ Date of Birth____________________________
   What services are you receiving?____
   Name and address of agency rendering the service____
   ____
   Name of Primary Care Physician____

6. Do you have **durable medical equipment** in the home, such as oxygen, a wheelchair, etc. that is currently being paid for by your medical benefit plan? If yes:
   Patient Name____________________________________ Date of Birth _____________________________
   List the equipment and rental agency____
   Name of Primary Care Physician____

7. Is a physician or other health care provider actively seeing you? **(Actively = 3 or more times in the past 6 months or 4 or more times in the past 12 months)** If yes, please provide the following information.
   Patient Name___________________________________ Date of Birth ________________________________
   What services are you receiving?____
   Name of Physician__________________________________Phone # (____)____________________________
   Physician's Address____

AUTHORIZATION
FOR RELEASE OF PROTECTED HEALTH INFORMATION
FOR CONTINUITY OF CARE

I authorize the use and disclosure of my protected health information as described below.

I understand that my protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I authorize any current or past medical professional, medical care institution, pharmacy or other medical caregiver that has treated me or provided medical services or supplies to me to disclose my protected health information to **Blue Cross and Blue Shield of North Carolina ("BCBSNC")**.

The protected health information that may be used and disclosed is as follows:

Medical records or any information concerning my current or past health status or treatment received from my medical care providers.

I understand that BCBSNC will use and disclose my protected health information for the following purposes: **To coordinate continuity of medical care**.

I understand that if my protected health information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations.

I understand that BCBSNC will not condition the provision of health plan benefits on this authorization.

I understand that I may revoke this authorization at any time by sending a written notification addressed to: **Medical Resource Management Department, Attention: Continuity of Care Coordinator, Blue Cross and Blue Shield of North Carolina, P. O. Box 2291, Durham, NC 27703**, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective: (i) for information that BCBSNC already has used or disclosed, relying on this authorization or (ii) if the authorization was obtained as a condition for coverage in BCBSNC and, by law, BCBSNC has a right to contest the coverage.

This authorization expires 30 months from the date of signature.

____ ___________________
Signature of Patient or Personal Representative Date

____
Name of Patient or Personal Representative

____
Description of Personal Representative's Authority

Return this Authorization Form to:
Blue Cross and Blue Shield of North Carolina
Medical Resource Management Dept., CSC 2W
Attn: Continuity of Care Coordinator
P. O. Box 2291
Durham, North Carolina 27702-2291
FAX: 800.228.0838

BCBSNC WILL PROVIDE PATIENT WITH A COPY OF THIS AUTHORIZATION

VIII. Glossary of Terms

The following is a glossary of terms that may be found in this administrative guide. While these terms are not comprehensive nor universally accepted definitions, they are meant to assist you in understanding concepts, services and information related to the Plan. Please refer to the member Benefit Booklet for additional health care definitions.

Account Number	Number assigned to your group; made up of six numbers only, or six numbers followed by an alpha character and three more numbers (examples: 009000 or 004200A000)
Adjudication	Process of determining the reimbursement applicable to a particular claim.
Administrative Costs	Costs assumed by a health care plan for administrative services such as claims processing, billing and overhead costs.
Administrator	Company with which the Plan has contracted to provide administrative services to its participating groups, in this case, BCBSNC. Services include membership adminsitration and claims processing.
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 cycle
Benefit Package	(Ben. Pkg.); the product in which the group/subscriber 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 service provided to a member must be incurred in order to be eligible for payment.
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 will produce
Billed Charge	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 subscriber or (2) services rendered by a physician or supplier.
Birthday Rule	Process under "coordination of benefits" clause in a contract that determines which parent's coverage pays first when a dependent child has health insurance coverage through both parents. This rule states that the parent whose birthday falls first during the calendar year is primary *(his/her coverage pays first)*.
Bill to Account	(BTA); aggregate bill for all your group's sub-accounts

Calendar Year	Period of time beginning on January 1st and ending on December 31st 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
Co-Payment	Cost sharing arrangement in which member pays a specified charge for a specific service at the time the service is rendered.
Continuant	Someone who has elected COBRA coverage
Conversion	Privilege given to eligible member to convert to individual policy with no health statement requirements when their group insurance ends.
Coordination of Benefits	Method of determining the primary payment source when a person is covered under more than one group medical program. Requires that all programs to eliminate over-insurance or duplication of benefits will coordinate payment.
Date of Service	Date on which health care services were provided to the member.
Deductible	Flat amount a member pays before BCBSNC makes any benefit payments.
Dis-Enrollment	Process of terminating individuals or groups from their enrollment with a carrier.
Effective Date	Date on which coverage begins under a certificate.
Eligible Employee	Full-time individual working a minimum of 24 or 30 hours per week receiving an annual W2 compensation record from the employer.
Eligibility Date	Date on which an individual becomes eligible for benefits under an insurance plan.
Exclusions	Specific conditions or services listed in the certificate for which benefits are not available.
Explanation of Benefits	Statement to the member that explains the action taken on each claim.
Formulary	List of outpatient prescription drugs and insulin that are available to members.
From Date	Starting billing period for that bill cycle
From/Thru	Statement period
Grievance	Request for review of a denied claim for services that have been received *(i.e., the denial of a claim after services have occurred)*.
Incurred Services	Services rendered during a given time period.
Identification Card	Card issued by a plan to a subscriber as evidence of membership.
Inquiry	Request for information, action or document from a member, provider, account or general public. Inquiries can be telephonic or written.
Lapse	Termination of a policy upon the policyholder's failure to pay the premium within the time required.

Legend Drugs	Drugs that require a written prescription from a licensed physician.
Medical Review	Process of determining the appropriateness of care or treatment; usually a part of claims adjudication.
Member	An individual for whom the Plan 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.
Out-of-Network Service	Services performed by a provider who has not signed a contract with the member's health plan to be part of a provider network.
Out-of-Pocket Costs	Portion of payments for health services paid by the member including co-payments, deductibles and coinsurance.
Plan	The North Carolina Medical Society Employee Benefit Plan
Premium	Payment required to keep policy in force.
Probationary Period	Period after beginning a job that an individual must wait before becoming eligible for group coverage, also known as waiting period.
Qualified Beneficiary	Anyone who is eligible for COBRA coverage.
Service Edit	Pre-existing condition period for your health benefits.
Subrogation	Substitutes one person for another. For example, when an insured has a cause of action against another, the insurer can pay the insured for the loss, and then be substituted *(subrogated)* to the insured's position, with the same rights as the insured against the third party.
Subscriber	Employee who is enrolled according to the records of the Plan.
Team Code	Geographic location of your group.
Thru Date	Ending period of the billing cycle.
Tier	Package type *(i.e. single, family, etc.)*