NC MS

***North Carolina Medical Society***
***Employee Benefit Plan***

Health Insurance Program

# Group Administrator Guide

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Administered by Blue Cross and Blue Shield of North Carolina

# Contents

## Welcome to the North Carolina Medical Society Employee Benefit Plan (NCMS Plan) Employer Reference Guide.

This comprehensive guide is designed to give you, our Practice Administrators, the information you need to oversee the insurance benefits of your practice.

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 NCMS Plan representative.

### I. Communicating With Us

Communication is essential to any relationship. We are available to answer questions that may arise or assist you in any way we can.

BCBSNC Group Membership is 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)
- processes State Continuation and COBRA requests
- reconciles your monthly billing

You may contact Group Membership's Employer Services Line ncms@bcbsnc.com. E-mailing this address will put you in touch with a NCMS Plan dedicated Group Service Advisor who can help you with any membership and billing questions, concerns, issues and requests. If you feel you need to discuss your situation with a manager, request a manager and the call will be escalated.

#### A. Helpful Numbers and Contact Information

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.

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| NCMS Plan/MMIC Agency LLC | Rachel Eaton, 919-878-7561 |
| BCBSNC Headquarters | 919-489-7431 |
| Hearing Impaired (TDD) | 800-442-7028 |
| BCBSNC Website | www.bcbsnc.com |
| Questions about your initial rates | Contact your NCMS Plan agent or call MMIC Agency at 800-662-7917 |
| Questions about your renewal rates | Contact your NCMS Plan agent or call MMIC Agency at 800-662-7917 |
| Questions about membership adds, changes, terminations, State Continuation, eligibility guidelines, group billing, or delinquency | Call Employer Services (877) 237-6275<br>8:00 am – 6:00 pm, M-F (except holidays) |

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|---|---|
| Questions about COBRA administration | Call Flores & Associates at (800) 532-3327 |
| Questions about your benefits and/or claims | Call Customer Service (877) 258-3334<br>8:00 am – 6:00 pm, M-F (except holidays) |
| BCBSNC Pre-Admission/Prior-Approval | Call (800) 672-7897 |
| Megallan Behavioral Health of NC (Mental Health/Substance Abuse)<br>Call to obtain referrals for mental health and chemical dependency treatment for Blue Care® (HMO). For inpatient stays and outpatient care on Blue Options sm (PPO) please call for admission certification. | Call Magellan at (800) 359-2422 |
| Prime Therapeutics®1 (Prime)<br>Members may call with questions regarding extended pharmacy mail order request, order forms | Call (888) 274-5180, 24 hours a day, 7 days a week. TTY users call 711. |
| PPO BlueCard® Worldwide | (800) 810-2583 (BLUE) in the US or (800) 673-1140 (Call collect outside the US) |
| BlueCard Provider Website | http://provider.bcbs.com |
| Member Health Partnership | (800) 260-0091 |
| Member Services | (888) 705-7050 |
| HealthLine Blue sm – 24 hour nurse line | (877) 477-2424 |
| eBenefits Now | (843) 881-8111<br>ebenefitsnow@benefitfocus.com |
| General Correspondence<br>Members can fax their claims for vision hardware reimbursement | (919) 765-1920 |

### 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

All payments should be sent to:

Post Office Box 580017, Charlotte, North Carolina 28258-0017

Payments are processed in Charlotte to streamline the payment remittance process. Payments received at the Charlotte address will be applied to your account on the same day that they are received.

### C. Fax

You can fax information to NCMS Plan dedicated Group Membership. When submitting a fax, please use a cover sheet to detail your request. The fax number is (919) 765-3564.

## 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. Prescription Drug Services

The NCMS Plan contracts with Prime Therapeutics®1 (Prime) to manage pharmacy benefits. Prime 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 Prime with the member's ID number, name, date of birth and information about the drug being dispensed. Prime 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:

Prime Therapeutics
Mail Route: BCBSNC
P.O. Box 14501
Lexington, KY 40512-4501

### B. Mental Health and Substance Abuse Services

The NCMS Plan via 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.

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 (UM) 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

### A. Member Eligibility

The following are the NCMS 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 24 or 30 hours per week (as elected by your practice), 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 per week to the business are considered eligible employees. Statutory employees, such as full-time life insurance salespersons, drivers who are agents of the employer or are paid on commission, employees working at home on materials or goods provided by their employer and full-time traveling or city salesperson are also considered eligible employees.
Statutory employees must work on a full-time basis (24 or more hours) to be eligible and may report income and expenses on a Schedule C or 1099 form. If you have statutory employees, you may be required to submit a Form W-2 or 1099 form to BCBSNC, as well as a letter confirming each statutory employee's full-time status.

Groups who are not eligible for FMLA but have employees "Not Actively at Work"
If an employee is not actively at work, they will be considered terminated from employment unless there is an assumption that they will return to work within 60 days. If an option, COBRA should be offered during this period of time in lieu of continuing coverage.

Groups who are eligible for FMLA with employees "Not Actively at Work"
FMLA only applies to practices with 50 or more employees. Groups who are in compliance with FMLA are required by law to maintain coverage during the 12 weeks of FMLA. Employees in this category are to be treated, with regard to health coverage, as if they are actively at work. Therefore, employees in this situation will be allowed to stay on the group plan for 12 weeks (4 months).

2. Military Leave of Absence

The federal Uniformed Services Employment and Reemployment Rights Act (USERRA) requires employers to allow employees who enter into service in the Uniformed Services and their covered dependents to extend group health coverage. This period of time is referred to as a military leave of absence. You can find the full text of USERRA at http://esgr.org/site/USERRA/tabid/75/Default.aspx

3. Medicare-Eligible Employees

As defined by federal Medicare regulations, groups must offer coverage under the group health plan to any employee 65 or older who is eligible for coverage under the group health plan regardless of the employee's eligibility for Medicare. This option must also be provided to the spouse of an employee with current employment status if the spouse is 65 or older.

- Employees and/or their spouses who are 65 or older may continue coverage under the group health plan until the employee retires or no longer meets eligibility requirements. When the employee or spouse chooses the group health plan, it is the primary coverage and Medicare is secondary coverage.
- Employees and/or spouses who choose Medicare as their primary coverage are not eligible to remain on the group health plan. These employees and/or spouses may change to a non-group Medicare supplemental program. For more information on non-group programs, employees should call Individual Sales at (800) 478-0583.

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

a) Is covered under the group health plan due to his/her current employment status, and
b) Has Medicare coverage due to any disability except End-Stage Renal Disease.

- End-Stage Renal Disease:

For members who have Medicare solely because of permanent kidney failure (End-Stage Renal Disease), the group health plan provides primary coverage for up to 30 months. This is applicable to all size groups and all employment statuses. The period during which the group health plan is primary begins with:

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 become entitled to Medicare Part A, if an application for such benefits had been filed.

4. Eligible Partners

An eligible partner is defined as a person legally married to the member or a domestic partner of the member, as defined by the group contract. This partner is eligible while the relationship, as defined above, exists between him/her and the employee.

a) If Employee Marries:

If an employee marries and chooses to include his or her spouse on the group health plan, the employee must complete an Enrollment and Change Application within 30 days following the date of marriage. The coverage change becomes effective on the date of the event. Any requests for coverage of a spouse made more than 30 days after the date of marriage may require a waiting period and coverage may become effective on the first day of the month following the completion of the change application.

b) If Employee Separates:

In the event of a marital separation, the employee may continue covering the spouse during the separation period. The spouse is still an eligible dependent. If the employee wishes to remove him/her from group coverage, the employee must complete and sign an Enrollment and Change Application. Be 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 status may require a change in the type of contract. A dependent spouse must be removed from the employee's group program in the event of death or divorce. **Note: In the state of North Carolina, legal separation is not recognized by statute and is therefore not a qualifying event under COBRA. The qualifying event is the date of divorce.**

5. Eligible Dependent Children

a) If the same group employs both parents and each is enrolled as a member, eligible children may be split between the two policies. However, both spouses cannot cover the same children on each of their policies. Employees may cover their dependent children not living with them if they are legally responsible for their health care.

b) Definition of Dependent Children

BCBSNC defines dependent children as:

- The employee's natural children in compliance up to age 26 without regard to student status.
- Legally adopted children, children legally placed for adoption, stepchildren and foster children in compliance up to age 26 without regard to student status. Children legally placed for adoption require additional court-ordered documentation.
- Mentally retarded and/or physically disabled children, if the condition existed and coverage was in effect upon reaching the limiting age. In order to establish a child's eligibility for continuation of coverage after reaching 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. The child's physician must complete a portion of this form. You can download a copy from the Employer section of our website at bcbsnc.com/content/employers/forms.htm.

  The form is only required for dependents over age 26. Coverage for an eligible mentally retarded and/or physically disabled child may be continued until:

  1. The child is no longer classified as mentally retarded and/or physically disabled.
  2. The child marries (if this occurs, the child is no longer eligible for coverage regardless of age, subsequent separation, or divorce).
  3. The employee removes the child from coverage.

Please refer to the plan benefit booklet to add or remove dependents.

## B. Late Enrollments

All late enrollments are processed for a first-of-the-month effective date.

1. Health Coverage Late Enrollments

If employees and/or their dependents miss the enrollment deadline, they will be considered late enrollees. Waiting periods for coverage may apply. Eligible children who are added as a result of a court order will be considered timely enrollees.

### C. 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. 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.

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).
    - o 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 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 dual coverage information for all eligible persons, including names and beginning and ending dates, on the Enrollment and Change Application?

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. You may submit your maintenance requests via e-mail to: ncms@bcbsnc.com or by fax at (919) 765-3564.

## IV. Continuation Coverage

Consolidated Omnibus Budget Reconciliation Act (COBRA)

Federal COBRA Continuation Law applies to employer groups that had 20 or more total employees for 50% of the business days in the preceding calendar year. 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.

The NCMS Plan has chosen Flores & Associates to assist groups in providing COBRA compliance services. When a group initially enrolls with the NCMS Plan, and is COBRA compliant, the NCMS Plan will forward the information to Flores to set up a COBRA account. It usually takes about 1 month for the group to receive their welcome kit from Flores. The kit includes a 1,2,3 booklet, COBRA procedures manual, a rate sheet, continuant takeover forms, and COBRA notification forms.

Other transactions performed by Flores include: handle all billing of continuants (employee or dependents), report maintenance and forward premiums to group administrators, process disability extension requests, advise groups of legal changes, and provide reports to group administrators.

If your group chooses not to utilize the services of Flores, your benefit administrator is responsible for tracking COBRA membership and collecting fees from members. Neither Flores, the NCMS Plan, nor BCBSNC assume any responsibility for your group's COBRA administration if an administrator other than Flores 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 total 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. Federal COBRA continuation law does not recognize domestic partners as 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

D. **Renewing Flores Rates**

You should receive a Rate Expiration Report from Flores 60 days in advance of your contract expiration date, however the NCMS Plan will provide Flores with your new rates. Flores will continue to bill your continuants at the old rate until the new rate is provided. Our contract with Flores requires that renewal rates be received by them 30 days in advance of the renewal. A delay in renewal decision can delay the update of Flores rates.

If your group number changes for any reason at the renewal period, the NCMS Plan notifies Flores 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 group that is exempt from Federal COBRA continuation 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, the NCMS 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.

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).

## V. Invoice and Payment

### 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 or MMIC Agency 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

If your group coverage is terminated due to lack of payment, your group may be eligible for reinstatement if you meet the following criteria:

- You request reinstatement within 30 days of being notified
- You have not been canceled and reinstated in the last 12 months
- You have not had more than one returned check due to nonsufficient funds within the last 12 months
- You submit all outstanding premiums through the current month to us in the form of a cashier's check or money order.

If you meet the above criteria and would like to reinstate your group coverage, please call you're the NCMS Plan at (800) 662-7917 x7561 for more details.

## VI. Continuity of Care Process

Continuity of Care is designed to assist members and eligible dependents in the continuation of their care from a provider who is no longer in-network/participating. Please refer your employees to their benefit booklets for more information about Continuity of Care, including how to get a copy of the Continuity of Care form.

## VII. 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

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| Account Number | Number assigned to your group; made up of six numbers. |
| Account Service Representative | Rachel Eaton works with your NCMS Plan representative to service your 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. |

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| 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 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 member or (2) services rendered by a physician or supplier. |
| Birthday Rule | Process under the "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 in 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. |
| 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 |
| Coordination of Benefits | Method of determining the primary payment source when a person is covered under more than one group medical program. Helps eliminate over-insurance or duplication of benefits paid. |
| 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. |
| Disenrollment | 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 24 or 30 or more hours per week (as elected by your practice), 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. |

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| 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 within a given time period. |
| Identification Card | Card issued by a plan to a member 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 NCMS Plan has a contractual obligation to provide, or arrange for the provision of, health services. |

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| 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 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. |

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| Subrogation | To substitute one person for another in regard to a claim or right. |
| Subscriber | Employee who is enrolled according to the records of the Plan. |
| Thru Date | Ending period of the billing cycle. |
| 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. |