Educators Health Alliance

Administration Guide

BlueCross BlueShield Nebraska

CONTENTS

HOW TO CONTACT US

For questions about:

- Employee reinstatements or unique eligibility issues
- Billing
- Claim resolutions*
- Coverage or benefits

Contact the Group Leader Line in one of these ways:

ONLINE
GroupLeader@NebraskaBlue.com

FAX
402-392-4150
Use the special Group Leader Member Services department Fax Sheet to communicate with us by fax.

PHONE
888-232-0942
Monday – Friday, 8 a.m. – 5 p.m. CT
Our dedicated Group Leader representatives are ready to assist you

Because we want to be able to respond to our group leaders in a timely fashion, please do not give your employees the Group Leader telephone number. If your employees have a question or concern regarding their coverage, they should call our Member Services department at the number shown on the back of their Blue Cross and Blue Shield of Nebraska (BCBSNE) member ID card.

In most situations, their questions or concerns will be addressed at this level. If, for any reason, your employees are unable to address their concerns by contacting Member Services directly, please contact Group Leader Line on their behalf.

***PLEASE NOTE:** We will not be able to discuss questions pertaining to member's personal health information unless they have submitted an Authorization for Release of Protected Health Information allowing us to do so. Copies of this form are available from our Member Services department, or may be downloaded at **NebraskaBlue.com/Forms.**

Other important telephone and fax numbers

Accounting Department

Fax: 402-398-3809

BlueCard Provider Directory

Phone: 800-810-2583 (available 24/7)
Website: NebraskaBlue.com/Find-a-Doctor

BluesEnroll

Issues loading new enrollments, terminations or changes to enrollments

Email: eEnrollSupportTeam@NebraskaBlue.com
Phone: 800-843-2373

Coordination of Benefits Department

If an employee and/or a dependent has other insurance, we need to know in order to process claims.

Phone: 402-390-1840 or 800-462-2924
Fax: 402-392-4126

Member Services

Phone: 877-721-2583

Membership Department

Fax: 402-343-3308
Email: Membership@NebraskaBlue.com

Notification/Certification of Benefits for an Inpatient Admission

Please see the section titled "Inpatient Notification and Certification" for information regarding this program.

Phone: 402-390-1870 or 800-247-1103
Fax: 402-392-4141 or 800-255-2838

Subrogation Department

The Subrogation department is responsible for recovery of benefits on claims where a third party is responsible for payment of services.

Phone: 402-390-1847 or 800-662-3554
Fax: 402-392-4206

Workers' Compensation Department

Workers' Compensation is responsible for identifying and recovering claim payments as the result of a work-related injury or illness.

Phone: 402-398-3615 or 800-821-4786
Fax: 402-392-4109
Email: Workers_Compensation@NebraskaBlue.com

BCBSNE Mailing Address*

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, NE 68180-0001

*Premium payments must be sent to:
P.O. Box 2638, Omaha, NE 68103-2638

Fax: 402-392-4153
Website: NebraskaBlue.com

COBRA

Payflex

Primary Contact for School Admins:

Laurie Starman

Phone: 402-758-7893
Fax: 402-978-3721
Email: lstarman@payflex.com

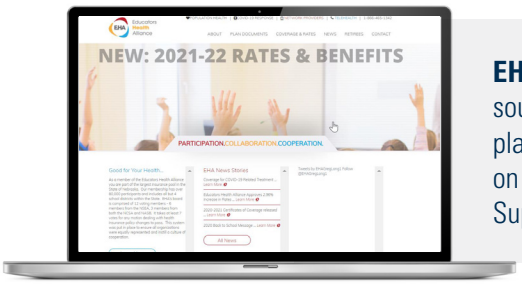
Enrollment & Payments:

*Enrollment Forms & Premium Payments should be sent to:
PayFlex Systems USA, Inc.
BENEFITS BILLING DEPARTMENT
PO Box 953374
St. Louis, MO 63195-3374

Email: cobramail@payflex.com
Fax: 402-231-4302
Online: Enrollment & Payments can be made at payflex.com

EHA Client Contact List

	Phone	Role	Email
STRATEGIC ACCOUNT EXECUTIVE			
Brett Young 	Office: 402-982-7622 Cell: 402-630-5117	• Primary account contact • Renewal activities • Plan review and analysis • Reporting analysis • Wellness initiatives • Resolve complex problems	Brett.Young@NebraskaBlue.com
ACCOUNT SPECIALISTS – ACTIVE EMPLOYEES			
Linda Farahani 	Office: 402-458-4803 Cell: 402-676-3042	• Escalated service inquires contact • Amendments • Claims questions • Group meetings	EHATeam@NebraskaBlue.com
Jason Rothermund 	Office: 402-982-6858 Cell: 402-249-1566		
ACCOUNT SPECIALIST – RETIREES			
Jon Tidwell 	Office: 402-458-4855 Cell: 402-253-9069	• Direct bill early retiree inquiries • Educators Medicare supplement inquires • Notification of member terminations – age 50+	EHARetiree@NebraskaBlue.com
GROUP LEADER LINE			
	Phone: 888-232-0942 Fax: 402-392-4150	• Billing • Ordering ID Cards • Employee reinstatements • Coverage or benefit questions • Password reset • MyBlue	GroupLeader@NebraskaBlue.com



EHAPlan.org EHAPlan.org is a great source of information where you can find plan documents, EHA news, and webinars on topics such as Educators Medicare Supplements and Bookkeeper Meetings.

ADMINISTERING YOUR COVERAGE

Membership and Eligibility Policies and Procedures

Adding new employees

New employees may apply for coverage immediately upon hire. The effective date of coverage will be assigned according to the group's probationary period, generally the first of the month following the probationary period. The probationary period is the length of time an employee must work for the employer before they are eligible for coverage.

To be considered a timely enrollee, the enrollment form must be received within 31 days from when the employee's coverage becomes effective. For example, if a group has a 60-day probationary period and the employee is hired on Jan. 15, the effective date of coverage will be April 1. We must receive the enrollment form by May 1.

Dependents of new employees

To include dependents on a new employee's coverage, Sections A, D and E must be completed on the enrollment form. Each dependent's full name must be listed, along with Social Security number, date of birth, gender and relationship to the subscriber.

An eligible dependent may continue coverage when they reach age 26 if certain requirements are met, the subscriber elects to continue coverage for the dependent and pays an additional premium. Coverage will continue until the dependent reaches age 30. BCBSNE must receive a completed Extension of Coverage Request for Extended Eligibility to Age 30 Form within 31 days from the date the dependent would otherwise lose coverage.

Adding a new spouse

A new spouse can be added to an employee's coverage by completing the enrollment form within 31 days of the marriage date. The effective date will be the first of the month after receipt of the application.

Adding dependents

A dependent can be added to an employee's coverage by completing the enrollment form within 31 days of the date the dependent becomes eligible.

Adding a newborn

Nebraska law requires automatic coverage for newborns for a period of 31 days from the date of birth. If an employee is covered under a single membership or EE/Spouse, they must request a change to family or employee-children coverage within the 31-day period and pay the additional premium in order to continue coverage beyond this time. A new enrollment form must be completed to make this membership change.

Employees already enrolled under family membership must provide both their employer and BCBSNE with the newborn's name and date of birth within 31 days of the birth. This can be done by completing an enrollment form or a Group Membership Change Request, or the employee may call the BCBSNE Member Services department.

Adding an adopted child

Coverage will be provided for 31 days from the earlier of the date the child is placed for adoption or the date a court order grants custody to the adoptive parents regardless of the membership option. (In order to avoid claim delays, you must notify BCBSNE of the adoption within 31 days of the placement.) In order to continue coverage, the adopted child(ren) must be enrolled as a special enrollee within the 31-day period.

Adding grandchildren

A grandchild may be eligible if they live with the employee in a parent/child relationship where the grandchild receives no support or maintenance from the parent and where the subscriber is a court-appointed guardian of the grandchild. BCBSNE must receive a Dependency Statement and documentation of court-appointment within 31 days of the date the dependent becomes eligible for coverage. This application is subject to eligibility review and approval.

Adding dependents by court order

In some cases, the employee may be ordered by the court to provide health care coverage for a dependent. The employee must send a completed enrollment form noting the change, along with the Qualified Medical Child Support Order, to BCBSNE's Membership department as soon as possible. The effective date for the new dependent will be the first of the month after receipt of the application.

Coverage for disabled dependents

A covered child who is mentally or physically handicapped may continue as an eligible dependent upon reaching age 26. Coverage will not end as long as the child is and remains, incapable of self-sustaining employment, or if returning to school as a full-time student, by reason of a mental or physical handicap and dependent upon the Subscriber for support and maintenance. An application for extension of coverage must be submitted within 31 days of the 26th birthday or within 31 days of the disability, if over age 26. This application for extension will be subject to Underwriting Department approval.

Late enrollment

A "late enrollee" is defined as a subscriber or dependent who does not timely enroll, or does not enroll for coverage within the first period in which he or she is eligible to enroll. Late enrollment is only allowed during the group's open enrollment period. A person who enrolls for coverage during a "special enrollment" is not considered a "late enrollee." For additional information on the open enrollment period, please contact your human resources department.

Events affecting eligibility

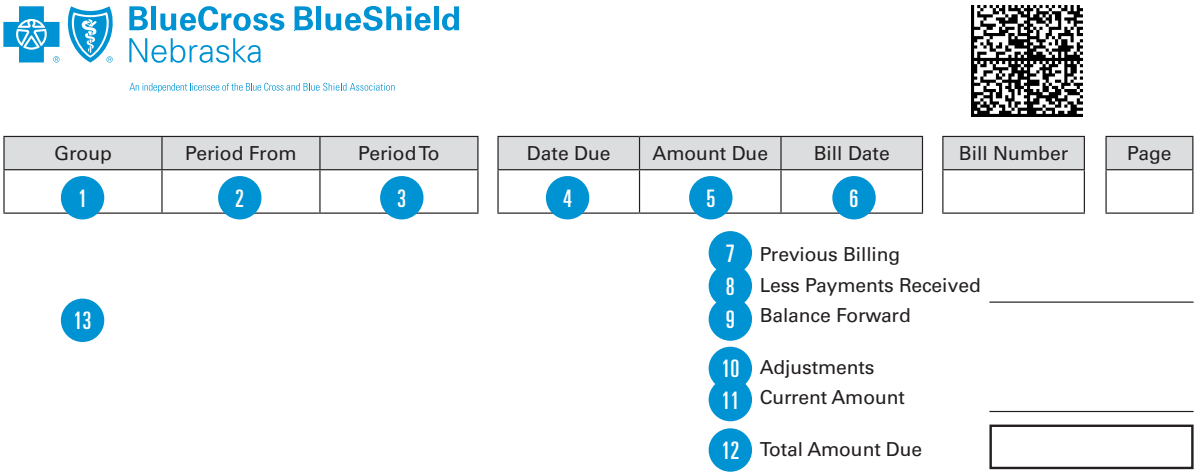
In addition to termination of employment, other events can affect an employee or dependent's eligibility. Some examples of eligibility loss include: reaching the contract's maximum age for a dependent child; a reduction in work hours; divorce; death.

Electronic enrollees

For groups that have electronically enrolled, all updates must be made throughout Blues Enroll/Benefit Focus.

SAMPLE BILL (PAGE 1)

Billing statements are sent out by the 20th of each month and are due on the 1st of the following month. Below is a sample billing statement you would receive.



1. **Group** – The numbers we have assigned to the group that help us identify it.
2. **Period From** – The beginning of the month that the billing is for and that coverage is effective.
3. **Period To** – The date shown is the beginning of the next month, but this billing actually covers you through midnight prior to this date.
4. **Date Due** – The date payment is due to be received by BCBSNE.
5. **Amount Due** – The total amount due for this billing.
6. **Bill Date** – The date the billing was produced. We must receive all of the group's requested changes by the bill date in order for them to be reflected in the current billing. We will bill the 16th of every month for the following month's premium.
7. **Previous Billing** – The amount of the prior month's billing.
8. **Less Payments Received** – Less any money received for the prior month's billing.
9. **Balance Forward** – Balance of #7 and #8.
10. **Adjustments** – The Adjustments Detail section total, either negative or positive.
11. **Current Amount** – Balance of the Current Premium section.
12. **Total Amount Due** – The combination of #10 and #11.
13. **Group Leader and Address** – The address where the billing will be sent.

SECTION 1: ADJUSTMENT DETAIL

14. **Current Adjustments** – Current adjustments made during this billing period.
15. **Miscellaneous Adjustments** – Total Adjustments made during this billing period.

SECTION 2: CURRENT PREMIUM

16. **ID Number –** The subscriber's ID number.
17. **Name –** The subscriber's name.
18. **Medical –** The current health premium associated with this subscriber.
19. **Dental –** The current dental premium associated with this subscriber.

SAMPLE BILL (PAGE 2)

BlueCross BlueShield Nebraska

An independent licensee of the Blue Cross and Blue Shield Association

Group	Period From	Period To	Group Name	Bill Date	Bill Number	Page
1	2	3	26	6		

7 Previous Billing
8 Less Payments Received
9 Balance Forward
10 Adjustments
11 Current Amount
12 Total Amount Due

DETACH AND RETURN WITH PAYMENT

BlueCross BlueShield Nebraska

An independent licensee of the Blue Cross and Blue Shield Association

GROUP	BILL DATE	BILL NUMBER	PERIOD FROM	PERIOD TO	DUE DATE	AMOUNT DUE

27 AMOUNT ENCLOSED $

28 BLUE CROSS AND BLUE SHIELD OF NEBRASKA
PO BOX 2638
OMAHA NE 68103-2638

000000000458371 00000026766 062317 000433602 9

20. **Total Premium –** The total current premium associated with this subscriber.
21. **Total Current Premium Medical –** The total health premium associated with all subscribers.
22. **Total Current Premium Dental –** The total dental premium associated with all subscribers.
23. **Total Premium –** The total premium associated with all subscribers.
24. **Number of IDs Medical –** The total number of health contracts associated with all subscribers.
25. **Number of IDs Dental –** The total number of dental contracts associated with all subscribers.
26. **Group** – Name of group; city, state and zip code; group contact phone number.

THE PAYMENT STUB

27. **Amount Enclosed –** This amount should equal the Amount Due as shown on the payment stub.
28. Blue Cross and Blue Shield of Nebraska mailing address.
NOTE: Any payments should be mailed to: PO Box 2638 • Omaha, NE 68103
All other correspondence should be mailed to: P.O. Box 3248 • Omaha, NE 68180

HIPAA Privacy Rule's Impact on Employers and Group Health Plans

BCBSNE Summary Guide

This document is provided as an information source only. It is provided with the understanding that BCBSNE is not rendering legal advice. To ensure that you and/or your organization are taking the necessary steps to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, you should consult your attorney.

OVERVIEW OF HIPAA PRIVACY REQUIREMENTS

HIPAA is the Health Insurance Portability and Accountability Act of 1996. HIPAA, and regulations issued by federal agencies pursuant to HIPAA, is far reaching legislation designed to improve portability of coverage, reduce health system costs, and improve the privacy of health information for individuals. HIPAA regulations apply not just to health insurers, but also to health plans maintained by employers. This outline addresses only the privacy regulations, not the other regulations pertaining to portability and standard transactions. A wide range of organizations are affected by HIPAA and are referred to under the law as "covered entities."

HIPAA Title II regulations have a number of implications for employer plan sponsors, even though they are not "covered entities." This overview is a summary only.

These include:

- health plans;
- healthcare clearinghouses; and
- healthcare providers who transmit certain health information in electronic form.

DEFINITIONS

To comply with the HIPAA Privacy Regulation, it is important to understand some key definitions. We recommend you become familiar with the following.

Health Information is information, whether oral or recorded in any form, created or received by a health plan, provider, clearinghouse, employer, public health authority, life insurer, or school that relates to:

- An individual's past, present, or future physical or mental health or condition;
- The provision of healthcare to an individual; or
- The past, present, or future payment for the provision of health care to an individual.

Protected Health Information (PHI) is health information that identifies an individual and is maintained or transmitted by a covered entity.

Summary Health Information is PHI that:

- Has been stripped of name, address, and other specified identifiers and
- Summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom an employer provides health benefits under a group health plan.

As explained in this document, plan sponsors and group health plans that do not get any PHI other than enrollment information and Summary Health Information may have greatly reduced HIPAA Privacy burdens.

Health Plan is an "individual or group plan that provides, or pays the costs of, medical care." A health plan includes health insurance companies, managed care plans, essentially all government health plans, Medicare, Medicare supplemental plans and Medicaid. **Most importantly for purposes of this outline, it also includes group health plans maintained by employers.**

As a result, employers (through operation of a health plan) will be subjected to some obligations under HIPAA Title II.

Group Health Plan is a plan maintained by an employer or an employee or member organization that provides medical care to employees or their dependents, directly or through insurance. The group health plan is considered a separate legal entity from the employer or other sponsor, even though in reality it is just a set of documents. It will help if an employer designates certain individuals as group health plan staff.

If any PHI is to be received by the group health plan, these individuals must be clearly identified by name or position by the employer and they must carefully protect the privacy of individuals in the health plan.

Plan Sponsor is a legal entity that offers the group health plan to its employees or members (as defined by the ERISA statute). The plan sponsor of a single employer plan is the employer that maintains the plan.

The HIPAA regulations regard the group health plan and the plan sponsor as two separate entities.

PRIVACY RULE SPECIFICS

The Privacy Rule sets a national minimum standard for the protection of individuals' PHI regardless of the form of that information. State laws still apply if they give the enrollee more privacy protection.

The Privacy Rule sets out requirements for:

- Contracts with "business associates"
- Uses of "authorizations"
- Uses and disclosures of PHI
- A "notice of privacy practices"
- Member rights with regard to:
  - access to PHI,
  - amendment to PHI,
  - accounting of certain disclosures of PHI, and
  - restrictions on use of PHI
- Privacy policies and procedures, including handling complaints, appointing a privacy officer, record retention, and providing staff training.

The Privacy Rule uses the structure created by ERISA, which sets up two distinct components within an entity offering health insurance benefits to employees to set its requirements. These components are the plan sponsor (i.e., the employer) and the group health plan (i.e. those who administer the plan).

The Privacy Rule creates a regulatory barrier to restrict the flow of PHI between a group health plan and the plan sponsor. **THE PRIMARY GOAL OF THIS SEPARATION IS TO PREVENT EMPLOYERS FROM USING THEIR EMPLOYEES' PHI WHEN MAKING EMPLOYMENT-RELATED DECISIONS.**

IMPACT ON EMPLOYERS

Again, group health plans are considered covered entities under the Privacy Rule and as such, must comply with the requirements of the regulation in the same way as health insurers and providers. But, as noted below, the extent of activity required varies based on the Plan Sponsor's arrangement with the insurer or administrator and the specifics of the funding of a health plan (self-funded v. fully insured) and how it is operated and managed.

DIFFERENT RULES FOR INSURED AND SELF-INSURED GROUPS

1. **Insured Group Health Plans That Do Not Receive PHI** other than Summary Health Information or information on who is enrolled in the Plan.

   A group health plan that fits this category has reduced burdens under the Privacy Rule. The plan must simply:

   1. Refrain from interfering with employees exercising their rights under the Privacy Rule (e.g., requesting access to or a copy of their health information, filing a privacy complaint); and
   2. Refrain from requiring any person to waive rights under the Privacy Rule as a condition of receiving payment, enrolling in a health plan or being eligible for benefits.

   Other than those requirements, the job of securing privacy is left with the insurer, not the employer.

2. **Insured Group Health Plans That Receive PHI** Group health plans that fall into this category must fully comply with the Privacy Rule in the same way that a health insurer or provider would have to comply.

In addition to the two obligations imposed on insured group health plans that do not receive PHI (listed immediately above), insured group health plans that receive PHI must:

1. **Designate a privacy official** who is responsible for the development and implementation of the health plan's policies and procedures;
2. **Designate a contact person (or office)** who is responsible for receiving complaints filed under the Privacy Rule;
3. **Establish policies and procedures** concerning PHI that comply with the Privacy Rule;

4. **Train all members of the workforce** on the health plan's PHI policies and procedures;
5. **Establish appropriate administrative, technical, and physical safeguards** to protect the privacy of PHI from intentional or unintentional use or disclosure that violates the Privacy Rule;
6. **Provide a process for individuals to make complaints** concerning the group health plan's policies and procedures, or its compliance with its policies and procedures or the Privacy Rule;
7. **Establish and apply appropriate disciplinary measures** against members of its workforce for violations of the group health plan's policies and procedures, or the Privacy Rule; and
8. **Act promptly to correct a violation or otherwise lessen the harmful effects** resulting from a violation of its policies and procedures about which it has knowledge.

PLAN SPONSOR OBLIGATIONS

A plan sponsor's obligations will vary depending on whether it receives PHI, summary health information or no health information at all.

If the plan sponsor needs no health information at all (neither PHI or summary health information):

The plan sponsor has no formal compliance obligations under HIPAA Title II.

If the plan sponsor needs no PHI, but only needs summary health information or information on whether an individual is enrolled or disenrolled from an insurer or HMO:

The impact of the Privacy Rule will be minimal. Summary health information may be released to a plan sponsor if the plan sponsor agrees to only use the information to:

1. Obtain premium bids for health insurance coverage to the group health plan; or
2. Modify, amend or terminate the group health plan.

If a plan sponsor requires PHI to manage its health benefits program:

The compliance requirements increase dramatically in this situation. Before the plan sponsor may receive PHI from either the group health plan or the insurer, it must "certify" to the group health plan that its plan documents have been amended to incorporate the following provisions, and that it agrees to abide by them.

The plan sponsor must:

1. Only disclose PHI as permitted by the plan documents or as required by law;
2. Not use or disclose the PHI for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of the sponsor;
3. Ensure that "adequate separation" of records and employees is established and maintained between the group health plan and the plan sponsor;
4. Ensure that the plan sponsor's agents and subcontractors (e.g., benefits consultants) agree to abide by the same restrictions and conditions as the plan sponsor in regard to the use of PHI received from the group health plan;
5. Report any improper use or disclosure of PHI to the group health plan;
6. Allow individuals to inspect and obtain copies of PHI about themselves;
7. Allow individuals to request to amend PHI about themselves;
8. Provide individuals with an accounting of disclosures of PHI made within the six years prior to the request for such accounting; and
9. Make its internal practices, books and records relating to the use and disclosure of PHI available to the Department of Health and Human Services (HHS) for purposes of auditing the group health plan's compliance with the Privacy Rule.

It may be relatively easy to certify that the plan sponsor will not use employee PHI for employment decisions. However, in some situations, when the employees managing the group health plan are the same persons responsible for other employment-related matters, potentially posing a challenge to the requirement of maintaining "adequate separation" of employee records, these requirements create significant complexity for employers as plan sponsors.

An employer, in its role as plan sponsor, must carefully consider the implications of these requirements to determine whether it wishes to receive PHI.

BUSINESS ASSOCIATES

A business associate is an external person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity. **When a business associate relationship exists, the covered entity must execute a business associate agreement with the person or entity performing the function or service**, which is designed to safeguard the use and disclosure of protected health information being shared. A contract between the covered entity and a business associate must meet requirements set out in the HIPAA regulation. The regulators provided sample business associate contract language in August of 2002. See www.hhs.gov/ocr/hipaa/contractprov.html

Blue Cross and Blue Shield of Nebraska (BCBSNE) has created HIPAA-compliant business associate contracts and provided them to its self-insured groups since BCBSNE is a business associate of the self-insured groups.

Examples of business associates include contractors, brokers, attorneys or third-party administrators that rely upon protected health information to perform services on behalf of the covered entity. Simply being exposed to protected health information or being a conduit of protected health information does not automatically qualify a vendor or an organization as a business associate. Vendors or organizations that provide services and functions that do not involve the use, or are limited to incidental exposure of protected health information are not considered business associates under the rule.

Janitorial and postal services would not be generally considered a business associate of the covered entity, since the services performed do not rely upon the use or disclosure of protected health information are not a primary part of the function or service being rendered. However, if the duties of the janitorial services company included the shredding of protected health materials or the postal service provided mailroom services including the stuffing of member mailings, each would be considered a business associate of the covered entity.

An employer health plan that receives PHI must assess its relationships with its business partners and vendors and execute business associate agreements where PHI is being disclosed as part of the function or services being provided.

AUTHORIZATION FOR USE OR DISCLOSURE OF PHI

A Covered Entity requires a valid written authorization from the individual to use or disclose his/her protected health information (PHI) outside of treatment, payment or health care operations (TPO) or for any use or disclosure that – without an authorization – is otherwise not permitted or required by the Privacy Rule. For instance, prior to disclosing claim history to a spouse or an employer benefits manager of an insured group aiding an employee with a claim, an authorization must be completed, signed and returned to BCBSNE by the individual in question.

An authorization is simply written permission given by an individual to a Covered Entity or its business associate for a specific purpose. It is finite in nature and generally valid for a specific period of time. It describes in detail what PHI is being authorized for use and/or disclosure and to whom disclosure of PHI may be made. It has an effective date and an expiration date or event. An authorization can be obtained at the request of either: 1) the individual 2) covered entity or 3) business associate of a covered entity. It would be good practice for you to have blank authorization forms on hand to use when needed.

The Privacy Rule provides limited provisions for use or disclosure of PHI when an individual is unavailable due to incapacity or for an emergency/disaster situation.

YOUR RELATIONSHIP WITH BCBSNE UNDER HIPAA

BCBSNE has spent significant time examining how the HIPAA privacy regulations affect our business relationship with plan sponsors and health plans. We believe our policies and practices will allow both BCBSNE and you to continue to administer coverage in a manner that minimizes disruption to the service you and your employees enjoy and expect from BCBSNE.

INSURED GROUP HEALTH PLANS

By adhering to the following protocol, an insured group health plan WILL NOT be required to meet the eight Privacy Rule requirements listed on bottom of pages 14 and 15. Remember, the group health plan or a plan sponsor can still receive summary health information or information on whether an individual is enrolled or disenrolled from an insurer without the need to meet all HIPAA requirements.

Item	What BCBSNE Will Do
Reporting	• Provide Summary Health Information (SHI) Only

Phone Interactions	• Verify individual is a representative of the Group Health Plan (not plan sponsor).
	• Will not provide PHI to plan representative without member authorization.
	  • If the member is in the presence of the group health plan representative while he or she is attempting to contacts us, we will accept a verbal permission from the member following verification of the particular member's identity. The verbal permission is valid only for the current encounter.
	  • If the member is not present, we will accept a written or faxed authorization from the member that specifies that we may speak with the Group Health Plan representative.

Notice of Privacy Practices	• Verify individual is a representative of the Group Health Plan (not plan sponsor).

PLAN SPONSORS

As a corporate policy, we will not provide PHI to a plan sponsor. The plan sponsor can still receive summary health information for certain limited purposes or information on whether an individual is enrolled or disenrolled from an insurer. PHI will be shared only with the group health plan and the employees identified as administering the plan.

Item	What BCBSNE Will Do
Reporting	• BCBSNE's policy is to provide no reports to the plan sponsor; BCBSNE will address reports to authorized plan contacts. • It will be the discretion of the Group Health Plan to provide the plan sponsor with SHI for the purposes of obtaining premium bids for providing health insurance coverage to the group health plan or to modify, amend or terminate the group health plan.
Phone Interactions	• Verify individual is Group Health Plan plan sponsor. • Provide plan sponsor with general information regarding plan of benefits and plan premiums.

WHAT EMPLOYERS SHOULD DO

You must understand and analyze the HIPAA Privacy Rule as it applies to your health benefits plan(s). By answering the following questions, you can begin to plan your compliance strategy.

- Is the plan insured or self-insured?
- Is there a single plan or multiple plans?
- How involved is the employer in the operation of the plan?
- What kinds of information does the employer receive about the health plan? What do they need?
- Are there other kinds of benefit plans (e.g., disability, workers' compensation) that the employer is trying to integrate with the health plan?
- What should the employer do about these questions if it is not covered by the ERISA statute (for example, a health plan for state or local government employees)?

Next, assess whether your organization's plan sponsor or group health plan requires PHI by answering the following:

PLAN SPONSOR

- Does the employer as plan sponsor wish to be involved in the overall management of the group health plan?
- If so, can the plan sponsor accomplish its business goals by performing the plan administration functions without receiving any PHI?

If the plan sponsor feels that it must receive or use PHI to achieve its goals, then the plan sponsor will need to comply with the HIPAA privacy requirements outlined in this booklet in order to receive PHI from the group health plan.

GROUP HEALTH PLAN

- Is the plan insured or self-insured?
- If insured, does the group health plan need to receive PHI to administer the health plan?*

**Remember, if the plan is insured and no PHI is received by the group health plan, then the plan may be able to avoid many of the compliance obligations imposed by HIPAA. If the plan receives PHI, it will need to comply with the full range of requirements imposed by HIPAA.*

PENALTIES FOR NONCOMPLIANCE

In addition to potential criminal penalties, civil monetary penalties may be imposed on a covered entity for failure to comply with a requirement of the HIPAA Privacy Rule. Penalties will vary significantly depending on factors such as the date of the violation, whether the covered entity knew or should have known of the failure to comply, or whether the covered entity's failure to comply was due to willful neglect. For further information, please consult the U.S. Department of Health and Human Services website at: www.hhs.gov/ocr/privacy.

HIPAA's IMPACT ON EMPLOYERS: A SUMMARY

Group health plans are considered covered entities under HIPAA's Privacy Rule and as such, must comply with the requirements of the regulation in the same way health insurers and providers must comply. Use the information below as a quick reference to ensure your company is in compliance.

NOTE: Under HIPAA, **there are two components of an employer group: (1)** the group health plan and **(2)** the plan sponsor. Compliance may vary for your company depending on which component wishes to receive PHI.

RULES FOR GROUP HEALTH PLANS

(Staff who administer health plan benefits on behalf of employer)

TYPE OF FUNDING	RECEIVE Personal Health Info (PHI)?	RECEIVE Summary Plan Health Info (SHI)?	PRIVACY REQUIREMENTS
INSURED	✗ No	✔ Yes	1. **Refrain from interfering with employees exercising their rights under the Privacy Rule** (e.g., requesting access to or a copy of their health information, filing a privacy complaint); and 2. **Refrain from requiring any person to waive rights under the Privacy Rule** as a condition of receiving payment, enrolling in a health plan or being eligible for benefits.
INSURED	✔ Yes	✔ Yes	1. **Refrain from interfering with employees exercising their rights under the Privacy Rule** (e.g., requesting access to or a copy of their health information, filing a privacy complaint); and 2. **Refrain from requiring any person to waive rights under the Privacy Rule** as a condition of receiving payment, enrolling in a health plan or being eligible for benefits. 3. **Designate a privacy official** who is responsible for the development and implementation of the health plan's policies and procedures; 4. **Designate a contact person (or office)** who is responsible for receiving complaints filed under the Privacy Rule; 5. **Establish policies and procedures** concerning PHI that comply with the Privacy Rule; 6. **Train all members of the workforce** on the health plan's PHI policies and procedures; 7. **Establish appropriate administrative, technical, and physical safeguards** to protect the privacy of PHI from intentional or unintentional use or disclosure that violates the Privacy Rule; 8. **Provide a process for individuals to make complaints** concerning the group health plan's policies and procedures, or its compliance with its policies and procedures or the Privacy Rule; 9. **Establish and apply appropriate disciplinary measures** against members of its workforce for violations of the group health plan's policies and procedures, or the Privacy Rule; and 10. **Act promptly to correct a violation or otherwise lessen the harmful effects** resulting from a violation of its policies and procedures about which it has knowledge.

RULES FOR PLAN SPONSORS

(Employers)

TYPE OF FUNDING	RECEIVE Personal Health Info (PHI)?	RECEIVE Summary Plan Health Info (SHI)?	PRIVACY REQUIREMENTS
INSURED	✗ No	✗ No	The plan sponsor has no compliance obligations.
INSURED	✗ No	✔ Yes	SHI may be released to a plan sponsor if the plan sponsor agrees to only use the information to obtain premium bids for providing health insurance coverage to the group health plan, or to modify, amend or terminate the group health plan.
INSURED	✔ Yes	✔ Yes	Plan documents must be amended to incorporate the following provisions. The plan sponsor must: 1. Only disclose PHI as permitted **by the plan documents or as required by law;** 2. Not use or disclose the PHI for employment-related actions or decisions, **or in connection with any other benefit or employee benefit plan of the sponsor;** 3. Ensure "adequate separation" **of records and employees is established and maintained between the group health plan and the plan sponsor;** **4. Ensure agents and subcontractors** (e.g., benefits consultants) agree to abide by the same restrictions and conditions as the plan sponsor in regard to the use of PHI received from the group health plan; **5. Report any improper use or disclosure of PHI** to the group health plan; **6. Allow individuals to inspect and obtain copies of PHI** about themselves; **7. Allow individuals to request to amend PHI** about themselves; **8. Provide individuals with an accounting of disclosures of PHI made** within the six years prior to the request for such accounting; and **9. Make its internal practices, books and records relating to the use and disclosure of PHI available to the Dept. of Health and Human Services** (HHS) for purposes of auditing the group health plan's compliance with the Privacy Rule.

These guidelines are provided as an information source only. This is not intended to replace or serve as legal counsel. To ensure that you and/or your company are taking the necessary steps to comply with HIPAA, you should consult your attorney or other adviser.

THE BLUECARD® PROGRAM

What is the BlueCard Program?

BlueCard is a national program that enables members of one Blue plan to obtain health care services while traveling or living in another Blue plan's service area. The program links participating health care providers with independent Blue plans across the country, and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

Employees and their covered dependents receive in-network benefits even when they're out of state by using hospitals, doctors and other health care providers who are part of the local Blue Cross and Blue Shield Plan's BlueCard PPO network. Members can also take advantage of the discount and claim filing agreements other Blue plans have negotiated with the contracting providers in their area.

How the BlueCard Program works

If an employee or family member receives covered services outside Nebraska from a Blue Cross and Blue Shield BlueCard PPO network hospital or doctor, the provider will file claims directly with the local Blue plan. This Blue plan will then contact us electronically to verify the terms of the patient's coverage.

We will then process the claim and tell the local Blue plan to issue applicable payment to the provider. The employee will receive an Explanation of Benefits (EOB) form from us, detailing how the claim was processed.

How to locate BlueCard Program providers

Online: Go to **NebraskaBlue.com/Find-a-Doctor**.

By phone: Call the BlueCard Access Line at **800-810-BLUE (2583)**.

BlueCard Program claim filing

As long as your employees and their covered family members use hospitals, doctors and other providers who contract with the Blue plan in that area, claim filing will be handled for them.

If they use an out-of-network provider, they may have to file the claim themselves. Your employees should always present their member ID card when they receive health care services.

NOTE: Out-of-area dental and prescription drug claims are not processed through the BlueCard Program. These claims should be filed directly to us:

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, NE 68180-0001

WORLDWIDE NETWORK ACCESS

Blue Cross Blue Shield Global® Core

Blue Cross Blue Shield Global Core enables Blue Cross and Blue Shield Plan members traveling or living abroad to obtain medical assistance and inpatient, outpatient and professional services from a network of health care providers worldwide. Blue Cross Blue Shield Global Core currently includes hospitals and doctors in nearly 200 countries.

Blue Cross Blue Shield Global Core gives members access to available customer services 24 hours a day, seven days a week, at no additional cost. These include locating inpatient, outpatient and professional services, medical assessments and translators, and making doctor appointments and hospitalization arrangements – all by simply calling the Blue Cross Blue Shield Global Core Access Line.

Blue Cross Blue Shield Global Core World Access Line

800-810-BLUE (toll-free within U.S.)

804-673-1177 (call collect from outside U.S.)

Employees and their covered dependents should call the Blue Cross Blue Shield Global Core World Access Line if they are admitted to a hospital while out of the U.S. The Access Line operator will assist them in contacting us. Participating hospitals in various countries have agreed to file inpatient claims for Blue Cross and Blue Shield members. For these inpatient services, members will be responsible for paying an inpatient provider for any deductible, copay and/or coinsurance amounts, and charges for any non-covered services.

Claims for outpatient care, treatment at nonparticipating hospitals or other medical services should be sent to the Blue Cross Blue Shield Global Core Worldwide Service Center along with a completed international claim form. Members will be responsible for payment in full at the time services are received.

MEDICARE PART D

Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), individuals entitled to Medicare are able to purchase prescription drug coverage through Medicare on a voluntary basis.

Individuals entitled to Medicare who do not enroll in Medicare Part D when first eligible will be subject to a significant late enrollment penalty unless they are covered by other creditable drug coverage.

The late enrollment penalty for Part D eligible individuals that go without creditable prescription drug coverage for any continuous period of 63 days or longer after the end of their initial enrollment period in Part D will be an increase in the premium that would otherwise apply, of at least 1% for each month without creditable coverage.

As your employees reach retirement age, contact EHARetiree@NebraskaBlue.com for more information about our Medicare Supplement.

Creditable coverage

Under the MMA most entities that currently provide prescription drug coverage to Medicare Part D eligible individuals must disclose to the Centers for Medicare and Medicaid Services (CMS) and to individual members whether the coverage is creditable prescription drug coverage. Sending these notices is the group's responsibility.

Creditable prescription drug coverage is coverage that is at least as good as the Medicare drug benefit. BCBSNE will inform each of our groups whether or not their coverage is creditable.

Please see **NebraskaBlue.com/RxCreditability** for additional information.

Notice to individuals

The disclosure must be provided to all Part D eligible individuals who are covered under the entity's prescription drug coverage. This notice must be sent annually and in the other circumstances outlined below. Practically speaking, a group should consider sending the annual notice to all members of the group to ensure receipt by all eligible Part D individuals.

The notice must be sent at the following times:

1. Prior to the Medicare Part D Annual Coordinated Election Period – beginning Nov. 15 through Dec. 31 of each year.
2. Prior to an individual's Initial Enrollment Period (IEP) for Part D.
3. Prior to the effective date of coverage for any Medicare eligible individual that joins the plan.
4. Whenever prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable.
5. Upon a beneficiary's request.

For sample creditable coverage notices produced by CMS and additional guidance regarding the notice, refer to the CMS website at **CMS.HHS.Gov/CreditableCoverage.**

Notice to CMS

Groups must also disclose to CMS whether or not their prescription drug plan is creditable. Groups that contract with a Part D plan to provide qualified prescription drug coverage are exempt from this disclosure requirement. This disclosure may ONLY be made online.

The notice must be sent at the following times:

1. Within 60 days of the beginning date of the plan year for which the entity is providing the disclosure to CMS.
2. Within 30 days after the termination of the prescription drug plan.
3. Within 30 days after any change in the creditable coverage status of the prescription drug plan.

For the link to the online CMS disclosure form and additional guidance regarding this notice, refer to the CMS website at **CMS.HHS.Gov/CreditableCoverage.**

ELECTRONIC ENROLLMENT OPTIONS

BenefitFocus is a leading provider of cloud-based benefits software solutions

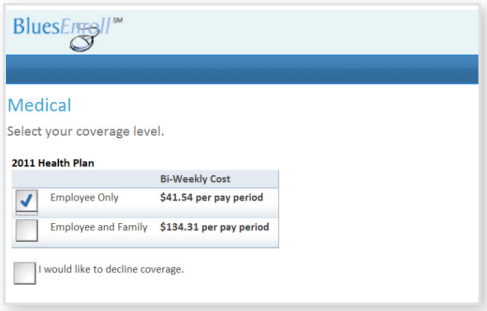
BenefitFocus®

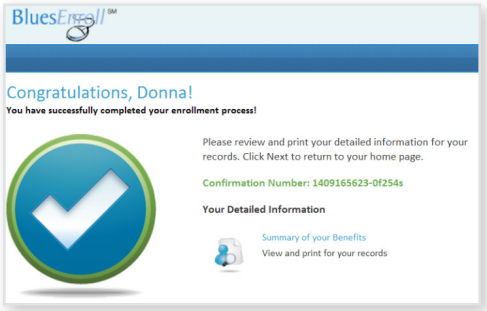
Managing membership enrollment using a manual, paper-based process can be extremely time-consuming and inefficient. That's why BCBSNE teamed with BenefitFocus, Inc., to offer electronic enrollment solutions that deliver effective open enrollment and membership management.

BenefitFocus is a leading provider of cloud-based benefits software solutions for consumers, employers, insurance companies and brokers. The BenefitFocus Platform consists of an integrated portfolio of products and services that enable employers to efficiently shop, enroll, manage and exchange benefits information.

BluesEnroll is provided by Benefitfocus. Benefitfocus is an independent company that has contracted with Blue Cross and Blue Shield of Nebraska to provide electronic health plan enrollment services.

Working together, BCBSNE and BenefitFocus offer multiple levels of electronic enrollment solutions designed to deliver effective management of open enrollment and membership.





01 Level One – BluesEnroll℠

BluesEnroll is a secure open enrollment system that allows you to complete eligibility transactions quickly and without paper. With BluesEnroll, you will have complete control of the open enrollment process and be able to view, change and approve employee elections with a few simple online steps.

Employer-only Option

During open enrollment, you enter employee benefit election information into BluesEnroll. Once data is submitted, it will be automatically downloaded into BCBSNE's membership system.

Throughout the year, you can enter eligibility information for new hires and member additions and/or deletions into the BluesEnroll system for automatic download to BCBSNE's eligibility system.

Custom Reporting

BluesEnroll offers customized reporting, which allows you to view enrollment information in the format of their choice.

BluesEnroll is Free of Charge!

The BluesEnroll system is available to all BCBSNE groups – regardless of size or funding method – and best of all; it's available at no charge. What's more, a BenefitFocus implementation consultant will provide full training and implementation set-up.

02 Level Two – eExchange (Electronic Data Interchange)

For organizations with 100+ enrolled subscribers, eExchange is another alternative for enrollment processing. A BenefitFocus service, eExchange converts your enrollment data into transactions, which are then processed by BCBSNE. This fast, secure and accurate method of transmitting membership data is available free of charge and may be utilized in lieu of the BluesEnroll and HR In Touch options.

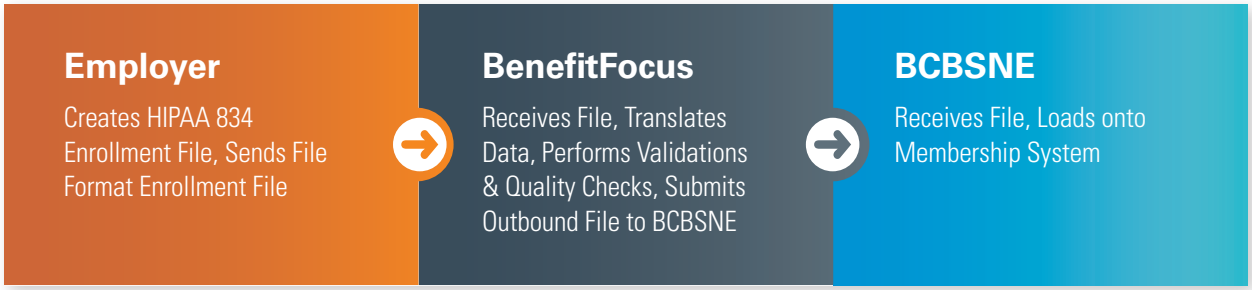
How eExchange Works

On a weekly basis, you send an electronic HIPAA 834 enrollment file to the BenefitFocus Secure File Transfer Protocol (SFTP) site.

During file processing, eExchange will translate the data, apply the appropriate business rules and perform detailed file validations. Data analysts will investigate any changes or exceptions uncovered during the validation process, and make updates as needed to ensure data accuracy.

An outgoing file is then submitted to the BCBSNE membership system. Once the file has been processed and loaded, employers receive a final report documenting all changes and exceptions applicable to the file submission.

BenefitFocus implementation consultants and BCBSNE work with employer's HR and IT departments to establish requirements and timelines, ensuring that the participating population is loaded accurately and on a timely basis.



Bottom Line

Two electronic enrollment options are available to ensure a good fit for every employer's needs:

Level 1 - BluesEnroll (free of charge)

Level 2 - eExchange (free of charge)

An advanced, simple-to-use, online enrollment system helps reduce costly and time-consuming enrollment maintenance and frees up valuable staff resources.

BluesEnroll: Benefit Administrator Quick Tips

How do I add new employees?

You can add new employees to the system by selecting the *Employees* tab and clicking the *Add New Employee* button.

Note that required fields are identified with an asterisk (*). The following fields are required to add a new employee to the system:

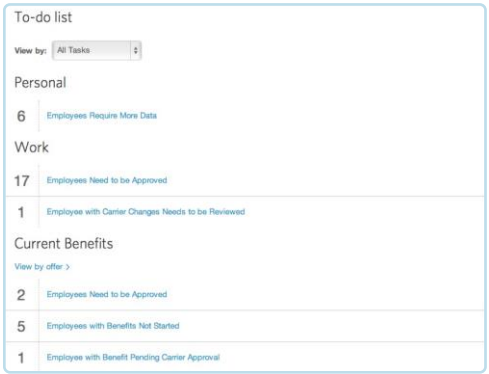
- First and Last Name
- Gender
- Date of Birth
- SSN
- Hire Date
- Address

Other fields may be required, depending on the settings established for your company.

How do I manage my daily tasks?

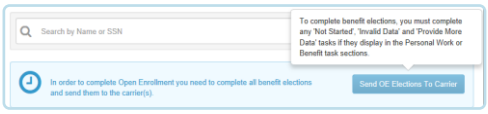
The *To-Do List* on your home page shows actions that you need to perform based on specific categories of information, such as an employee's benefits and tasks on the *Work or Personal* tabs.

Keeping up with the items in your *To-Do List* is vital in order to ensure that data is sent to insurance carriers quickly and your employees' benefits are processed in a timely fashion.



How do I manage Open Enrollment?

The Open Enrollment Manager supports additional options and displays specific messages in your *To-Do List* for quick and easy access to your company's Open Enrollment period.



Depending on settings established by the carrier, at the end of your Open Enrollment period, you can:

- Send elections to the carrier and close your Open Enrollment period.
- Review the appropriate tasks (such as benefit approvals and tasks not yet started) that must be completed before ending the Open Enrollment period.
- Receive email messages that indicate the Open Enrollment period has been successfully completed or, conversely, that attention is required because of outstanding tasks.

How do I change plans for an existing employee?

- Search for the employee.
- Select the *Benefit Details* link for the employee.
- Edit the benefit election.

  Note: You may be required to enter a life event, such as birth, marriage, etc. as a reason for changing the employee's benefit plan.
- Click the *Edit* button next to the *Plan* section to change the benefit plan.

- Select the new benefit plan and click **Next**.
- Continue with the enrollment flow and click *Save* when you have completed the plan change.

Benefits Adminstrator Quick Tips

How do I cancel a benefit policy without changing the employee's Active status?

When you cancel benefits for employees, they remain as *Active* employees.

- Search for the employee.
- Select the *Benefit Details* link for the employee.
- Edit the benefit election.
- Click the *Cancel Benefits for All* button.

- Click *OK* on the warning message that displays to confirm you want to cancel benefits.

  Note: You may be required to enter a life event, such as birth, marriage, etc. as a reason for changing the employee's benefit plan.
- Enter the date to cancel benefits and click *Next*.
- Review and *Save* the changes.

How do I terminate employment? What's the difference between terminating employment and canceling benefits?

When you cancel benefits for employees, the employee remains in an *Active* status.

Terminating employment changes the status of the employee from *Active to Terminated* and also cancels all benefits for the employee.

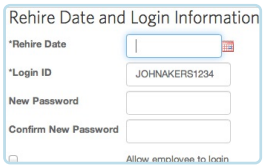
- Search for the employee.
- Select *Terminate Employment* from the *Manage Employee* drop-down menu.
- Enter the employment termination date for the employee.
- Select whether or not to disable the employee's login.
- Enter a *Termination Reason* and click Next.
- Review the benefit cancellation date for each benefit available. This date is pre-populated based on the employee's termination date and the benefit termination rule.
- *Save* the changes.

How do I rehire employees?

Once employment is terminated, employees can be rehired and their benefits can be reinstated. The system allows a rehiring strategy to be based on if the rehire date is within a certain number of days or more than a certain number of days past the termination date as defined in the *Rehire Rules*.

To rehire an employee:

- Search for the employee.
- Select *Rehire Employee* from the *Manage Employee* drop-down menu.
- Enter the employee's rehire date.
- (If applicable) Reset employee *Login* and *Password*.



Note: You can assign a new password for the rehired employee. If you allow your employees to make their own changes, create a new password and select the *Allow employee to login* checkbox. Else, leave the fields blank.

- Click *Next*.
- Select the appropriate *Benefit Reinstatement* radio button.
- (If applicable) Specify how to reinstate benefits. Review the rehire information and click *Save*.

What reports can I access?

You can create numerous group reports, including *Benefit Detail, Employee Census* and *Dependent Census* reports. From the *Data & Reporting tab*, you can:

- Generate reports in multiple file formats, including PDF, Excel or CSV.
- Sort report data by employee name or SSN.
- Group and/or filter report data.

You can also generate employee-specific reports from the *Employee Reports* section of the employee's record.

SAMPLE EXPLANATION OF BENEFITS (PAGE 1)

Below is a sample Explanation of Benefits (EOB). Each time a claim is processed, we send an EOB. The EOB shows how we processed available benefits according to the terms of your group's coverage.

If the claims are for a spouse or other adult member, the EOB is sent to that person. The EOBs for minor dependents (under 18) are generally sent to the subscriber (the person who is the primary insured).

Members may also view their EOBs online with their myNebraskaBlue account. To learn more, view the tool as a guest by selecting "Guest" on the myNebraskaBlue.com home page.

BlueCross BlueShield Nebraska

PO Box 3248 | Omaha, NE 68180-0001

We're here to help.

Member Services: 877-721-2583
Member ID: EHN123456789

Jane Doe
12345 Washington Street
Omaha, NE 68000

January 12, 2021

This is not a bill.

This is an Explanation of Benefits (EOB) for health insurance claim(s) processed 01/07/2021.

It is your personal record of what we paid and what you may still owe to a doctor or facility. Below is a breakdown of each claim. See the following page(s) for information to help manage your plan.

Jane Doe

Claim Number: 12345678910
Provider: John Doe MD

				Your Responsibility to the Provider				
Date of Care and Care Received	Charged by Provider	Allowed Amount	Paid by BCBSNE	Not Covered	Copay	Deductible	Coinsurance	You Owe
01/05/2021 Specimen collect	39.00	16.58	16.58	0.00	0.00	0.00	0.00	0.00
Total:	**39.00**	**16.58**	**16.58**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

Your responsibility is $0.00

SAMPLE EXPLANATION OF BENEFITS (PAGE 2)

Additional Resources

Year-to-date costs (as of this mailing)

$0.00 / $1,200

In-network Deductible (Individual)

The amount you pay for covered care before BCBSNE pays. Once your deductible is met, we share payment, which is called coinsurance.

Out-of-network: $0 / $2,400

$0.00 / $5,000

In-network Out-of-pocket Max (Individual)

The most you could pay for covered care, including copays, deductibles and coiunsurance. Once your maximum is met, BCBSNE pays the rest.

Out-of-network: $0 / $10,000

$0.00 / $2,400

In-network Deductible (Family)

The amount your family pays for covered care before BCBSNE pays. Once your deductible is met, we share payment, which is called coinsurance.

Out-of-network: $108.00 / $4,800

$0.00 / $10,000

In-network Out-of-pocket Max (Family)

The most your family could pay for covered care, including copays, deductibles and coiunsurance. Once your maximum is met, BCBSNE pays the rest.

Out-of-network: $108.00 / $20,000

Manage your plan at myNebraskaBlue.com

Go Paperless

Sign up for email notifications

Estimate Costs

Compare costs for upcoming procedures

See Claims History

View your current claims history

Do you have any questions or concerns about this claim?

For additional details regarding your claim, including specific policy provisions and the provider's diagnosis and procedure codes, contact Member Services at **877-721-2583**.

If you disagree with the claim decision, you may request an appeal within six months of the date it was processed, or as otherwise required by your plan. To access an appeal form, go to **NebraskaBlue.com/Appeal** or call Member Services at the number above. Submit the completed form by secure email at myNebraskaBlue.com or mail it to Appeals Department, Blue Cross and Blue Shield of Nebraska, P.O. Box 3248, Omaha NE 68180.

You may have the right to have our decision reviewed by independent health care professionals who have no association with us. Specific information regarding the external review process, if applicable, will be included with your final appeal response.

You may be required to exhaust your appeals prior to filing a lawsuit. If your health plan is subject to ERISA (Employee Retirement Income Security Act of 1974), you have the right to bring a civil action under Section 502(a) of the Act.

If you suspect fraud, call 877-632-2583 or write to Special Investigations, Blue Cross and Blue Shield of Nebraska, P.O. Box 3248, Omaha, NE 68180.

ANSWERS TO YOUR FREQUENTLY ASKED QUESTIONS

How do I terminate an employee's coverage?

Whenever an employee or dependent loses eligibility, BCBSNE should be notified as soon as possible. Terminations can only be submitted for 60 days retroactive. If you are a BluesEnroll user, please submit cancellations through BluesEnroll.

How do I add a new employee to the group plan?

New employees may apply for coverage immediately upon being hired. The effective date of coverage will be assigned according to your group's probationary period, generally the first of the month following the probationary period. To be considered a timely enrollee, sections A and B of the enrollment form must be completed and received within 31 days of the end of the employee's probationary period.

How long does it take for a new hire to be loaded into the BCBSNE membership system?

If the new hire is added via a paper application, the turnaround time is seven to 10 business days. If added via BluesEnroll, turnaround time is 24 hours.

How is coverage handled for a newborn dependent child?

Nebraska law requires automatic coverage for newborns for a period of 31 days. Coverage will begin at birth for a newborn child of a subscriber or eligible dependent for a period of 31 days. To continue coverage, the newborn must meet the definition of an eligible dependent and be enrolled as a special enrollee within the 31-day period.

At what age does a dependent child terminate from their parent's coverage?

Eligible dependent children are covered to age 26 regardless of student status, residency or financial dependency.

An eligible dependent may continue coverage when they reache age 26 if certain requirements are met, the subscriber elects to continue coverage for the dependent, and pays an additional premium. Coverage will continue until the dependent reaches age 30. BCBSNE must receive a completed Extension of Coverage Request for Extended Eligibility to Age 30 Form within 31 days from the date the dependent would otherwise lose coverage.

What qualifies someone for special enrollment?

A 31-day special enrollment period may be available if an employee or dependent loses other coverage due to: (1) death, divorce, legal separation or loss of dependent status; (2) the individual experiences a reduction in the number of hours of employment or termination from employment other than for cause; (3) the employer ceased to make a contribution for other coverage; (4) the individual had coverage through an HMO or other group arrangement that requires individuals to live or work in the service area; or (5) the individual had coverage through COBRA continuation which has now been exhausted. Special enrollment is also available if an individual becomes qualified as a dependent because of marriage, or in the case of a dependent child, through birth, adoption or placement for adoption.

A special enrollment period of 60 days may be available if: (1), the individual becomes eligible for premium assistance under Medicaid or a State Child Health Insurance Program (SCHIP), with respect to coverage under the group health plan (2) is terminated as a loss of eligibility from Medicaid or a State Child Health Program (SCHIP).

How are claims handled for an employee who has Medicare?

For employees who are actively employed, BCBSNE will generally be the primary payer and Medicare will pay benefits second. Federal Medicare Secondary Payer rules will apply, based on the size of the employer group and the reasons for Medicare eligibility.

Medicare may be the primary payer in certain situations under these rules, such as in cases involving endstage renal disease, long-term disability, active employees over age 65 working in companies with fewer than 20 employees and for certain COBRA beneficiaries.

For more information about all of the FAQs on this page, refer to the section titled Administering Your Coverage.

How do I reconcile the monthly billings if I am terming, adding or upgrading an employee's coverage?

Terminating employees: If using BluesEnroll, please make those adjustments online, which should reflect on a future billing. It is very important that you pay the invoice as billed.

We encourage all groups to **PAY AS BILLED**.

Adding employees: If you are adding an employee to your group's coverage, a completed enrollment form must be submitted to our Membership department. If you are a BluesEnroll user, additions of employees should be submitted through BluesEnroll.

Change in coverage: To request a change in coverage, a completed enrollment form must be submitted to our Membership department. If you are a BluesEnroll user, employee changes in coverage should be submitted through BluesEnroll. For more information, refer to the section titled HIPAA.

What is necessary to help an employee with questions in terms of authorization to use or disclose PHI?

We are not able to discuss with you questions pertaining to the employee's personal health information unless they have submitted an Authorization for Release of Protected Health Information to us. This form is available from our Member Services department or may be downloaded at **NebraskaBlue.com/Forms.**

For more information on this topic, refer to the section titled HIPAA.

How do I locate providers in Nebraska?

Visit **NebraskaBlue.com/Find-a-Doctor** or call the Member Services number on the back of your BCBSNE member ID card.

How do I locate BlueCard Program providers?

Online: For providers within the U.S., Puerto Rico, and U.S. Virgin Islands, go to **NebraskaBlue.com/Find-a-Doctor.**

For international providers, go to **BCBSGlobalCore.com.** You will be asked to accept the terms of the site and to add your three-character alpha prefix. Select "Login" and you will then be able to select the applicable country to locate Blue Cross Blue Shield Global Core providers.

By phone: For domestic and international providers, call the BlueCard Access Line at 800-810-BLUE (2583). Members located outside the U.S. may call collect by dialing 804-673-1177.

For more information, refer to the section titled The BlueCard Program.

What are the employer's responsibilities for offering COBRA?

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that requires a group health and/or dental plan to allow a covered person to continue their group coverage under certain circumstances when coverage would otherwise terminate.

What if a member wants to appeal a denied claim?

Internal appeal request: A request for an internal appeal must be submitted by the claimant within six months of the date the claim was processed or adverse benefit determination was made.

Expedited internal appeal: For urgent care claims, an expedited appeal may be requested orally or in writing.

External review request: The claimant may request a review by an independent review organization (IRO) of an adverse benefit determination or final internal adverse benefit determination which was based on a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment; a determination that a treatment is investigative; or a rescission coverage.

Expedited external review: An expedited external review may be requested at the same time a claimant requests an expedited internal appeal of an adverse benefit determination concerning an urgent care claim. Please see your policy for details on the appeal options.

GLOSSARY OF TERMS

Aggregate deductible: This protects against higher than expected claim activity for the plan as a whole.

Allowable charge: Payment is based on the allowable charge for a covered service. Generally, the allowable charge for services by in-network providers will be the contracted amount. The allowable charge for services by out-of-network providers will generally be the lesser of the billed charge or the Reasonable Allowance for the service.

BlueCard Program: The BlueCard Program links contracting health care providers and Blue Cross and Blue Shield Plans across the country through a single electronic network for claims processing and reimbursement. Employees and their covered dependents receive in-network benefits even when they're out of town by using hospitals, doctors and other health care providers who are part of the local Blue Cross and Blue Shield Plan's BlueCard PPO network.

COBRA: The acronym "COBRA" stands for "Consolidated Omnibus Budget Reconciliation Act." COBRA provides for an extension of group coverage for employees and their covered family members after a "qualifying event," such as termination of employment, divorce and death. Not all employers are subject to COBRA, but generally those with 20 or more employees are.

Coinsurance: The percentage amount the covered person must pay for covered services, after satisfaction of the applicable calendar year deductible. Coinsurance is based on the lesser of the allowable charge or the billed charge.

Contract: The agreement between BCBSNE and the group applicant includes the master group benefit contract and any endorsements, the master group application, any subgroup application, attachments, any financial agreements and the individual employee enrollment forms.

Contracted amount: The allowable charge for a covered service agreed to by BCBSNE or the local Blue Cross and Blue Shield Plan and their network providers.

Deductible: An amount that the covered person must pay each calendar year for covered services before benefits are payable under the contract.

Forms: There are a variety of forms and documents such as the Summary of Benefits Coverage, Certificates of Coverage and Schedule of Benefits available at EHAPlan.org. You may also order forms by contacting the Group Leader Line.

International Travel Health Insurance: A provider for health insurance for short-term and frequent leisure, study, mission, marine and business travel. For more information, please visit **NebraskaBlue.com/BCBSGlobal**.

Local (onsite) Plan: A Blue Cross and Blue Shield Plan in another geographic service area that administers claims through the BlueCard Program for people receiving care in that area who are covered by another Blue Cross and Blue Shield Plan.

Maximum benefit amount: A maximum amount determined to be reasonable by BCBSNE or the local Blue Cross and Blue Shield Plan via the BlueCard Program. If no maximum benefit amount has been established for a particular covered service, BCBSNE may consider the charges submitted by providers for like procedures, a relative value scale that compares the complexity of services provided or any other factors deemed necessary.

Medically necessary: Health care services ordered by a treating physician exercising prudent clinical judgment, provided to a covered person for the purposes of prevention, evaluation, diagnosis or treatment of that covered person's illness, injury or pregnancy that are:

1. consistent with the prevailing professionally recognized standards of medical practice and known to be effective in improving health care outcomes for the condition for which it is recommended or prescribed. Effectiveness will be determined by validation based on scientific evidence, professional standards and consideration of expert opinion, and
2. clinically appropriate in terms of type, frequency, extent, site and duration for the prevention, diagnosis or treatment of the covered person's illness, injury or pregnancy. The most appropriate setting and the most appropriate level of service is that setting and that level of service which is the most cost effective, considering the potential benefits and harms to the patient. When this test is applied to the care of an inpatient, the covered person's medical symptoms and conditions must require that treatment cannot be safely provided in a less intensive medical setting; and

3. not more costly than alternative interventions, including no intervention, and are at least as likely to produce equivalent therapeutic or diagnostic results as to the prevention, diagnosis or treatment of the patient's illness, injury or pregnancy, without adversely affecting the covered person's medical condition; and
4. not provided primarily for the convenience of the following:
   - the covered person
   - the physician
   - the covered person's family
   - any other person or health care provider; and
   - not considered unnecessarily repetitive when performed in combination with other prevention, evaluation, diagnoses or treatment procedures.

BCBSNE will determine whether services are medically necessary. Services will not automatically be considered medically necessary because they have been ordered or provided by a treating physician.

Networks: We offer several networks. For further information regarding these networks, call Group Leader at 888-232-0942 or visit **NebraskaBlue.com/Find-a-Doctor**.

Out of Pocket Limit: The maximum amount of cost-share each covered person must pay in a calendar year before benefits are payable without application of a cost-share amount. The out-of-pocket limit includes deductible, coinsurance and copayment amounts for medical and pharmacy services.

Pre-authorization: Pre-authorization of benefits is prior written approval of benefits for certain services, such as organ transplants, subsequent purchases of home medical equipment and home health services. This pre-authorization is based on the terms of your group's contract and the information submitted to BCBSNE. It may be effective for a limited period of time.

Preferred Provider Organization (PPO): PPOs are special arrangements between insurers and a network of hospitals, doctors and other types of providers to pay for health care services. As a result of these special arrangements, you and your employees save money, because in most cases, less is paid in deductible and coinsurance when PPO network providers are used.

Reasonable charge: The amount determined by BCBSNE to be payable to out-of-network providers for a covered service.

Schedule of Benefits: A brief overview of the member's deductible and coinsurance responsibilities; also includes the member's ID cards.

Schedule of Benefits Summary: A more detailed description of the member's coverage.

Telehealth: Telehealth allows for video chat with a doctor and is available 24/7, 365 days a year, over your computer, tablet or smartphone in all 50 states. For more information, visit **NebraskaBlue.com/Telehealth**.

NOTES

NOTES

NOTES

4962-1 (04-02-21)