

Benefits Administrator Guide



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Welcome

Dear Benefits Administrator:

Thank you for selecting AmeriHealth for your organization's health plan. AmeriHealth is a customer driven organization that strives to understand and exceed our customer's expectations. We value our relationship with you, and we are committed to giving you and your employees high quality service.

As the Group Administrator of your AmeriHealth plan, you have the important job of understanding your program and assisting your employees with their questions and concerns. We have prepared this Benefits Administrator Guide to help you manage the day-to-day administration of your organization's AmeriHealth benefit program.

The guide describes AmeriHealth processes and procedures, such as enrollment procedures, billing and coordination with Medicare, and even includes sample forms for your use.

The guide and the forms referenced within are also available on our website, **www.amerhealth.com**.

ID Cards / Member Handbook

Each employee selecting an AmeriHealth plan will receive benefit information and AmeriHealth identification card(s). The third copy of the members' Enrollment/Change Form may be used as a Temporary ID Card until their permanent card is received.

Please take some time to review the material in this Guide. If you require additional information or if you have any questions about your AmeriHealth coverage, please contact your Broker or AmeriHealth Account Executive.

Thank you for choosing AmeriHealth!

Enrollment

Open Enrollments

Open enrollments are held at least once a year. During the open enrollment period, any eligible employee of the group may enroll in the AmeriHealth plans you've selected.

The effective date of coverage is listed on the face sheet of your Group Master Contract, or may be confirmed by your Broker or Account Executive.

Each newly eligible person who enrolls during the open enrollment must complete an Enrollment/Change Form. Employees who are already enrolled in AmeriHealth and who wish to remain a member (re-enroll) do not have to complete a new Enrollment/Change Form during the group's open enrollment period.

Your Broker or Account Executive will assist you in planning and determining the appropriate access for your group's open enrollment (employee meetings, mailing brochures to each employee's home, payroll announcement, etc.). However, employers who routinely encourage mandatory attendance at open enrollment meetings experience fewer difficulties and higher employee satisfaction with their choice of health plans.

Enrollment Procedures

Each new subscriber to AmeriHealth, whether joining as a new hire or through the open enrollment, must complete an Enrollment/Change Form. ALL information must be provided to avoid processing delays.

Timing of Enrollment. You may enroll new employees (new hires) and their dependents within 30 days of becoming eligible for health benefits. Your company establishes the eligibility date for health care benefits for new hires for your group.

For Large Groups (51+), if employees are not enrolled within 30 days, they generally cannot enroll until the new open enrollment period, which is generally a year later.

For Small Groups (1-50), employees may enroll at any time, subject to their employer's waiting period, if any.

Enrollment Forms

All HMO, POS and PPO members use the AmeriHealth Enrollment/Change Form. Be sure your employees carefully read the instructions for completing this form as specific information is required of HMO and POS members.

Any time you add a new member or submit a change, you will submit both the Enrollment/Change Form and an Enrollment Report. The Enrollment/Change Form records the change for each individual member, while the Enrollment Report summarizes all the changes being submitted at one time. Both forms need to be completed each time a change is made, even if only one change is being submitted.

Enrollment

Adding/Changing Information

To Add A New Member Using The Enrollment/Change Form:

The employee must complete all questions in sections 1, 2, 3, and 3B (if the member is selecting an HMO or POS plan).

Sections 4, 4A, 4B and 4C must be completed if the employee's dependents also will be covered. Please note that for an HMO or POS plan, each dependent must select a primary care physician in section 4A.

The member must also complete sections 5A, 5B and 5C, then sign and date all copies of the form.

As the group administrator, it is your responsibility to complete section 3A. If your organization has more than one group number be sure to indicate the correct group number on each Enrollment/Change Form.

To Change Information For An Existing Member Using The Enrollment/Change Form:

(Examples: adding or deleting a dependent or changing an address.) The member must complete sections 2 and 3.

Then, complete just the specific sections relating to the change on the Enrollment/Change Form, such as dependent information or primary care office information for HMO or POS members. The employee then should sign and date all copies of the form.

As the group administrator, it is your responsibility to complete section 3A. If your organization has more than one group number, be sure to indicate the correct group number on each Enrollment/Change Form.

Any time you change information for an existing member, we'll ask you to send us both the Enrollment/Change Form and an Enrollment Report. The Enrollment/Change Form records the change for each individual member, while the Enrollment Report summarizes all the changes being submitted at one time. Both forms need to be completed each time a change is made, even if only one change is being submitted.

Enrollment

Completing The Enrollment Report

The Enrollment Report summarizes all the additions and changes submitted at one time.

A completed Enrollment Report must be included anytime you request a change, even if you are submitting only one Enrollment/Change Form. The Enrollment Report must be filled out in its entirety, including: the group number, group name, current effective date, address and phone number, so we can contact you if there are any questions about the report.

Each numbered line should reflect the information on one of the Enrollment/Change forms included in the submission. Be sure to include the member's identification number, the effective date of the change, and indicate whether the change is an addition, a change, or a removal. If the change is a removal, be sure to include the removal code number, which can be found on the bottom of the form, and include the terminated member's address in the "Remarks" section. Once you've completed all the necessary lines, simply total the number of transactions by type, then enter the grand total of all transactions in the designated box.

Keep copies for your records, and mail the original documents to the address at the top of the form.

Because we prepare invoices in advance of the coverage date, changes may not appear on your invoice for one or two monthly billing cycles. To avoid any potential payment problems, ***you should always pay the billed amount.*** Any credits or additional premium due will "catch up" on subsequent bills.

Retroactive Adjustments

The effective date for additions, changes and/or removals can be retroactively dated two months from the current month. If the requested effective date is greater than two months prior to the current month, a written explanation is required and must be mailed with the Enrollment Report Form for consideration. If a written explanation is not received, the membership transaction will automatically be processed with an effective date that is two months prior from the current month. All effective date requests, "current and prior" are subject to a paid claim utilization review and will result in the effective date being altered for claims that are incurred. On these situations, the effective date will be processed using the next month following the most recent date of service.

Dependent Verifications

If a dependent is a full-time student over the dependent age limit specified in your contract, the Student Verification Form must be completed and attached to the Enrollment/Change Form.

If the dependent is overage and is dependent on the member for more than half of his or her support, the Application to Continue Coverage For Handicapped Dependent Child must be completed and attached to the Enrollment/Change Form. Dependent verification forms are also mailed out periodically to determine whether an overage dependent remains eligible for coverage. These forms are sent directly to members with dependents over the contract termination age. When your employees receive these forms, they must be completed and returned within 30 days, otherwise the dependent will not be eligible for coverage under the contract.

Enrollment

Temporary ID's

It is important that you retain a copy of the completed Enrollment/Change Form for your records and provide the employee with a copy for use as their Temporary ID. This copy of the enrollment form is the employee's Temporary ID Card. If any enrolled member requires care before they receive their Permanent ID Card, they simply present this form at their physician's office to receive all the benefits to which they are entitled.

Special Information For HMO And POS Members

Each member of the family must select a primary care physician from AmeriHealth's physician network. Female members do not have to pre-select an AmeriHealth OB/GYN.

Participating physician's names and Primary Care Office Code Numbers are listed in the AmeriHealth Directory, and are also available by calling the Health Resource Center physician referral line at 1-800-275-2583, or online under Providers at www.amerihealth.com.

If an HMO or POS member does not select a primary care physician, or selects a physician with a closed practice or one who is no longer participating with AmeriHealth, the member's Identification Card cannot be issued. The member will receive notification to select another primary care physician.

Members may change their primary care physician up to two times per calendar year. Members wishing to change their primary care physician may contact the Member Services Department at 1-800-444-6282 to make their selection.

Billing

Overview

Itemized invoices are sent on a monthly basis, approximately 15 days in advance of the month of coverage. Invoices for a given month of coverage are based on the actual group enrollment for the prior month. This enables billing and payment to occur in advance of the covered month.

To avoid payment problems, it is important to always pay the amount BILLED, even though it may not reflect your most recent additions and terminations. **DO NOT write enrollment or plan changes on your invoice.** These changes will not be made. The proper way to report enrollment changes is to use the Enrollment/Change Form and the Enrollment Report.

Enrollment changes made via the Enrollment Report will generally be processed within three (3) days of receipt. Premium adjustments for enrollment changes processed by the night of billing will appear on the bill. Changes made after the night of billing will appear on the next bill.

The Enrollment Report should be mailed to the Enrollment Department along with the Enrollment/Change Forms indicating the desired action. This could include adding dependents to a contract (due to birth, adoption or marriage), or making any changes to an individual's coverage i.e. marriage, divorce, legal separation, death of a spouse or dependent, loss of eligibility for coverage or moving out of the AmeriHealth service area.

Similarly, if you are terminating an individual's coverage, or deleting dependents, use the AmeriHealth Enrollment Report, but *continue to remit the billed amount. Do not delete billed premium amounts or add the additional premium due in your remittance.* The next invoice will reflect the person(s) retroactively added or deleted and any corresponding change to your premium balance.

Adjustments made will appear in the "Retroactive Adjustments" section of the invoice. Simply detach the remittance coupon from the bottom of the first page of your invoice and return it with your payment to the address indicated on your bill. *If you are including multiple payments in one envelope, please be sure to indicate on each coupon the amount to be applied to each group.* The sum of all coupons must equal the full amount of the check you are remitting. This will ensure that your payment is credited to the proper account.

Billing

Notes on Coverage and Billing Cycle

If your group's effective date is the 1st of the month:

- If members are added from the 1st to the 15th day of your billing cycle, **you will be billed for that month.**
- If members are added from the 16th to the last day of your billing cycle, **you will not be billed for that month.**
- If members are dropped from the 1st to the 15th day of your billing cycle, **you will not be billed for coverage from that month.**
- If members are dropped from the 16th to the last day of your billing cycle, **you will be billed for coverage for that month.**

If your group's effective date is the 15th of the month:

- If members are added from the 1st to the 14th day of your billing cycle, **you will not be billed for that month.**
- If members are added from the 15th to the last day of your billing cycle, **you will be billed for that month.**
- If members are dropped from the 1st to the 14th day of your billing cycle, **you will be billed for coverage from that month.**
- If members are dropped from the 15th to the last day of your billing cycle, **you will not be billed for coverage for that month.**

For assistance with billing reconciliations, please call the phone number that appears in the upper right hand corner of your bill.

Continuation of Coverage

Termination Or Cancellation Of Membership

Termination of membership occurs when an employee's employment is terminated and he or she loses group eligibility in such instances.

AmeriHealth will work with the employees entitled to continuation coverage under COBRA or through an extension of benefits through conversion coverage.

AmeriHealth will also work with small employers with between one and 19 employees who offer employees the option to continue their group health coverage, at the expense of the employee, when an employee is terminated for reasons other than cause, when he or she goes to part-time status, or if an employee ends employment. An employee on continuation would pay his or her premium to you, which you would remit as part of your regular premium payment.

Cancellation occurs when a member who remains eligible for group health benefits chooses to cancel AmeriHealth membership entirely.

The employer must complete an Enrollment Report in order to terminate an employee's coverage. The form must provide all the required information and must be dated and signed by the employer.

The employer is responsible for submitting the Enrollment Report within 60 days of the termination date to AmeriHealth at the address on the form.

Continuation of Coverage

The policy or contract issued to you and the certificate or evidence of coverage issued to the covered employees outlines the procedures that the employer and employee must follow for continuation of coverage. Small employers with 20 or more employees must also offer an option of continuation of coverage under a federal law, commonly referred to as COBRA.

Continuation of Coverage

Medicare As Secondary Payer

We hope to simplify a complex subject—when Medicare is the primary payer for Medicare eligible members of your employee group. If your company has 19 or fewer full and part-time employees, Medicare is almost always primary. If your firm is larger, various rules apply to determine whether your group plan is the primary or secondary payer.

The following information provides a summary of the Medicare Secondary Payer (MSP) requirements. This information may help you to correctly target benefits for your Medicare-eligible participants and to avoid potentially costly penalties and litigation. You should, of course, also refer to the actual laws and regulations with the assistance of your own legal counsel.

Information Regarding The Medicare as Secondary Payer Statute

Employers, group health plans (“GHPs”) and entities that sponsor or contribute to GHPs, as well as insurers, have certain obligations under the Medicare Secondary Payer (“MSP”) provisions of the Social Security Act, commonly known as the “MSP statute.”¹ As an employer² or administrator of a GHP you need to know the requirements of the statute, for among other reasons, to avoid potentially costly penalties and litigation. This guide is designed to provide you with a general overview regarding operation of the MSP statute and the enrollment and membership information system that is being developed to obtain information necessary to detect instances in which the MSP statute applies.

I. The MSP Law

A Coordination of Benefits Approach: During the first 15 years of the Medicare program, Medicare was the primary payer of all services provided to Medicare beneficiaries, with the sole exception of services covered under a workers’ compensation policy or program. As a result, where a Medicare beneficiary had dual health care coverage, Medicare paid first, and the employer, GHP or insurer paid all or a portion of the remainder of the bill for the health care item or service at issue, depending on the terms of the relevant plan or contract. In an effort to save scarce Medicare resources, Congress enacted a series of amendments to the Social Security Act, beginning in 1981, which made GHPs responsible in certain instances for making primary payment in connection with medical items or services provided to specific Medicare beneficiaries with dual health care coverage.

1. The MSP provisions are set forth at 42 U.S.C. §1395y(b). The regulations the Health Care Financing Administration has issued implementing the statute are located at 42 C.F.R. Part 411. It is important that you and your counsel review the statute and regulations periodically to ensure compliance with your statutory obligations. This information is provided for informational purposes, and is not offered or intended as legal advice.

2. In this material, the term “employer” includes a plan sponsor or entity that contributes to a GHP.

The MSP statute is essentially a coordination of benefits statute. It requires, in discrete instances, that a GHP make primary payment where dual coverage exists for a particular health care item or service. Employers are constrained in the benefits they can offer employees and other individuals covered under the plan. The statute specifically prohibits employers and GHPs from differentiating between benefits offered to certain Medicare beneficiaries and their counterparts not enrolled in Medicare. The anti-discrimination provisions of the statute are explained more fully below.

Scope of the Statute: The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and GHP coverage, as well as certain other factors, including the size of the employers sponsoring the GHP. In general, Medicare pays secondary to the following:

1. GHPs that cover participants with end-stage renal disease (“ESRD”) during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees employed by the employer or whether the individual has “current employment status.”
2. In the case of a covered participant or his or her covered spouse age 65 or over, a GHP of an employer that employs 20 or more employees, if that participant has “current employment status.” If the GHP is a multi-employer or multiple employer plan the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).
3. In the case of a covered participant or his or her covered family member who is disabled and under age 65, GHPs of employers that employ 100 or more employees, if participant has “current employment status.” If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees. (There is no small employer exception under the statute).

In determining whether the size threshold has been met in any given case, the statute and regulations must be consulted.

Application of the statute depends not only on the size of the employer but also, in certain cases, on whether the coverage is provided under the GHP based on “current employment status.” Thus, generally the age-based and disability-based MSP provisions apply when the GHP participant (not necessarily the covered person with Medicare) has “current employment status.” (By contrast, the MSP provisions relating to individuals who have ESRD apply regardless of whether the beneficiary has GHP coverage as a result of “current employment status” and regardless of the number of employees which an employer employs.) Under HCFA regulations, an individual has “current employment status” if the individual: (1) is “actively working as an employee, [is] the employer...or [is] associated with the employer in a business relationship;” (2) is “not actively working” but is “receiving disability benefits from an employer for up to 6 months;” or (3) is “not actively working” but “retains employment rights in the industry” and other specific requirements are met. For additional information, we again direct your attention to the statute and regulations.

The Non-discrimination Provisions - Age and Disability: The MSP statute prohibits GHPs from “take[ing] into account” that an individual covered by virtue of “current employment status” is entitled to receive Medicare benefits as a result of age or disability. The statute expressly requires GHPs to furnish to Medicare beneficiaries the same benefits, under the same conditions, that they furnish to employees and spouses not entitled to Medicare. Thus, GHPs may not offer coverage that is secondary to Medicare under a provision that “carves out” Medicare coverage (commonly known as a “carve-out” policy), or which supplements the available Medicare coverage (commonly known as “Medicare supplemental” or “Medigap” policies), to individuals covered by the provisions of the MSP statute relating to the working aged and the disabled. By contrast, “Medigap” and secondary health care coverage may appropriately be offered to retirees in this context because the GHP coverage is not based on “current employment status.”

ESRD: The MSP statute also prohibits a GHP from taking into account that an individual is entitled to Medicare benefits as a result of ESRD during a coordination period specified in the statute. This coordination period begins with the first month the individual becomes eligible for or entitled to Medicare based on ESRD and ends 30 months later. During this period, the GHP generally must pay primary for all covered health care items or services, while Medicare serves as the secondary payer. **GHPs are prohibited from offering secondary (i.e., “carve-out”) and “Medigap” coverage in this context.** After the coordination period has expired, however, the GHP is free to offer “carve-out” and “Medigap” coverage to ESRD Medicare beneficiaries, but may not otherwise differentiate between the benefits provided to these individuals and all others on the basis of the existence of ESRD, the need for renal dialysis, or in any other manner. (Important Note: Special rules apply to persons eligible for or entitled to Medicare based on ESRD and one or more other reasons.)

Special rules apply regarding retired individuals and members of their families who receive Medicare benefits on the basis of age or disability immediately before the onset of ESRD. Where immediately prior to contracting the disease, the GHP was lawfully providing only “Medigap” coverage, or was otherwise a secondary payer for that individual, the GHP may continue to offer such coverage and is not required to pay primary during the 30 month coordination period.

***Employer Obligations:* It is your obligation to ensure that beneficiaries who are covered by the MSP statute are not improperly enrolled in “carve-out” or “Medigap” coverage under your Plan. If an individual is improperly enrolled in a supplemental or secondary policy or contract when the individual should be enrolled in a plan that makes the GHP the primary payer, it is Medicare’s position that Medicare pays secondary and the plan is required to pay primary regardless of contrary language contained in the plan or contract.**

These individuals may choose to purchase and pay for “Medigap” insurance on their own, but neither the employer nor the GHP may sponsor, contribute to, or finance such coverage.

Prohibition of Financial or Other Incentives Not to Enroll in a GHP: An employee or family member of an employee who is entitled to Medicare is free to refuse the health plan offered by an employer or GHP, in which case Medicare will be the primary payer. It is unlawful, however, for an employer to offer any financial or other incentive for a Medicare beneficiary not to enroll, or to terminate enrollment, in a GHP which would be primary to Medicare if the individual enrolled in the GHP. Any entity violating this prohibition is subject to a civil monetary penalty under the MSP statute of up to \$5,000 for each violation.

Other consequences of Non-compliance: Non-compliance with the statute can result in serious consequences. Thus, a significant excise tax in the amount of 25 percent of the employer's or employee organization's GHP expenses for the relevant year may be assessed under the Internal Revenue Code against a private employer or employee organization contributing to a "non-conforming" group health plan. Under HCFA Regulations, a non-conforming group health plan is a plan that, for example: (1) improperly takes into account that an individual is entitled to Medicare; (2) fails to provide the same benefits under the same conditions to employees (and spouses) age 65 or over, as it provides to younger employees and spouses; (3) improperly differentiates between individuals with ESRD and others; or (4) fails to refund to HCFA conditional Medicare payments mistakenly made by the agency. It is Medicare's position that, in addition to the possible imposition of an excise tax, failure to reimburse HCFA for mistaken primary payments may result in ultimate liability double the amount at issue. The law also establishes a private cause of action to collect double damages from any GHP that fails to make primary payments in accordance with the MSP provisions.

Amendments to the MSP Statute and Regulations: The MSP statute and regulations are frequently amended. As a result, it is important that you and your counsel continue to monitor changes in the law and assess the impact of such changes on your company. While we can assist you by providing general information about the statute, it is ultimately your responsibility to ensure your company's compliance with MSP statute.

Contacting AmeriHealth

Important Phone Numbers

Communication is a priority for us here at AmeriHealth. If you have any questions regarding the administration of your group insurance plan, please call your AmeriHealth Service Team at the appropriate number shown below.

Member Services

HMO/POS	800-444-6282
PPO/CMM	800-422-2457

Employer Services

HMO/POS	800-893-7827
PPO/CMM	800-487-7739

Accounts Receivable

HMO/POS	800-893-7827
PPO/CMM	800-487-7739

Pre-Certification

800-227-3116	
HMO/POS	Prompt 1
PPO/CMM	Prompt 2

Baby FootStepsSM

800-598-BABY

Health Resource Center

800-275-2583

Network Physician Referral	Prompt 3
AmeriHealth Healthy Lifestyles SM	Prompt 4

Megellan (Mental Health)

800-688-1911

Caremark Member Services

877-252-3485

AmeriHealth Enrollment
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Thank you for choosing AmeriHealth!



AmeriHealth[®]

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AmeriHealth HMO, Inc.

QCC Insurance Company d/b/a AmeriHealth Insurance Company