AmeriHealth®

Welcome

Your *Benefits Administrator Guide*

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Welcome

Thank you for selecting AmeriHealth for your company's health plan. We are a customer-focused organization. We value our relationship with you, and we are committed to giving you and your employees the best possible service.

As the benefits administrator of your AmeriHealth insured or administered 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.

Using this Guide/Accessing Forms

This guide explains AmeriHealth's processes and procedures including enrollment, billing and coordination with Medicare.

The guide and forms are available on our web site: **www.amerihealth.com**

ID Cards/Member Handbook

Each employee selecting an AmeriHealth plan will receive benefit information and ID card(s). It will take a few weeks to process the member's Enrollment/Change Form. In the interim, a copy of the enrollment form may be used as a temporary ID card until the member receives a permanent card in the mail.

Please review this guide in its entirety. If you require more information or if you have any questions about your AmeriHealth coverage, please contact your independent broker or AmeriHealth Marketing Representative.

Thank you for choosing AmeriHealth!

Managing Benefits Online

Managing Your Company's Health Care Coverage Online

Now there's an even easier way to manage your company's health care benefits. AmeriHealth recently developed a web site—**www.amerihealthexpress.com**—which offers the most up-to-date information on your company's health care coverage. *AmeriHealth Express* was designed to reduce the amount of paperwork and time you need to perform enrollment transactions, including many of the functions outlined throughout this guide.

With *AmeriHealth Express* you can:

- **Add/delete new members**—simply add or terminate a new member by entering their information. The member application should be kept in your file for your records.
- **Find coverage information for your employees**—managing employee benefit information is easy—just enter the employee's name or member ID.
- **Request ID cards**—*AmeriHealth Express* allows you to choose ID cards for medical, dental, prescription and vision cards in just a few steps.

AmeriHealth Express is available 24 hours a day, Monday through Saturday. It is a simple, convenient and secure way for benefit administrators to manage your account at any time from any location.

Register online at **www.amerihealthexpress.com**

Enrollment

Open Enrollments

Open enrollments are held at least once a year. During the open enrollment period, eligible employees of the group may enroll in the AmeriHealth plan(s) you've selected based on their county of residence. AmeriHealth coverage is available for employees who reside in the following counties:

New Jersey: Cumberland, Cape May, Atlantic, Ocean, Monmouth, Middlesex, Somerset, Union, Hudson, Essex, Morris, Passaic, Bergen and Sussex

Delaware: Kent and Sussex

Maryland: Caroline, Harford, Kent, Wicomico and Worcester

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 currently enrolled in an AmeriHealth plan that wish to continue the same coverage, do not have to complete a new Enrollment/Change Form during the group's open enrollment period. However, a form must be completed if you are changing coverage.

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). Employers that routinely encourage mandatory attendance at open enrollment meetings often experience fewer difficulties and higher employee satisfaction with their choice of health plans.

Enrollment Procedure

Each new member 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.

In most cases, if employees are not enrolled within 30 days, they cannot enroll until your company's next enrollment period or if/until a change of life event occurs.

Enrollment Forms

All members must use the AmeriHealth Enrollment/Change Form. Be sure your employees carefully read the instructions before completing this form, as specific information is required.

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

Adding a New Member

To add a new member using the Enrollment/Change Form: The employee must answer all questions in the Subscriber Information section. The Dependent Information section must be completed if the employee's dependents will also be covered. Please note, each dependent must select a Primary Care Physician (PCP). If a PCP is not selected, the member will not receive an ID card. The member must review and complete, if applicable, other health coverage sections of the enrollment form. It is important for members to sign and date the form.

As the benefits administrator, it is your responsibility to complete information that pertains to the appropriate product and if applicable, copayment information. Please see the detailed instruction sheet attached to the enrollment form. Remember to include your account or group number. If your organization has more than one account or group number be sure to indicate the correct account or group number on each Enrollment/Change Form. If your billing is set up with divisions or payroll locations, the appropriate division code should be listed under site number. Remember to sign and date the Enrollment Form. It is important to make certain that the employee included their county designation located at the bottom of the Enrollment form.

Selecting a Primary Care Physician (PCP)

Each member of the family must select a PCP from the AmeriHealth Physician Network. Female members do not have to pre-select an AmeriHealth OB/GYN.

Participating physicians and Primary Care Office Code Numbers are listed in the provider directory. They are also available by calling the Member Services Department at the number listed on the back of the Member's ID card, or online under "providers" at **www.amerihealth.com**

If a member does not select a PCP, selects a physician with a closed practice, or a doctor no longer participating with AmeriHealth, the member's ID card will not be issued. The member will receive notification to select another PCP.

Members may change their PCP up to twice per calendar year. Members wishing to change their PCP should contact the Member Services Department at **1-866-681-7373** to make their selection.

Temporary IDs

It is important that you retain a copy of the completed Enrollment/Change Form for your records and provide employees with a copy for use as their 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.

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To Change Information for an Existing Member Using the Enrollment/Change Form

The member must specify the type of change in Section 1 of the Enrollment Form. AmeriHealth members must review and complete the appropriate section of the enrollment form that describes the type of change (i.e., address or name). If changing or adding a dependent, the member must also complete the Dependent Information section. The employee must sign and date the form.

It is your responsibility to complete the product and copayment sections as appropriate. If your organization has more than one group or account number, be sure to indicate the correct group or account number on each Enrollment/Change Form. Remember to sign and date this form.

Any time you change information for an existing member, you can complete the Enrollment/Change Form for each member or summarize the changes on the Enrollment Report/Transmittal Form.

Completing the Enrollment Report/Transmittal Form

The Enrollment Report/Transmittal Form summarizes all additions and changes submitted at one time.

If you are not submitting an Enrollment/Change Form for each member, a completed Enrollment Report/Transmittal Form must be included when you request a change.

The Enrollment Report must be filled out in its entirety including Group or Account Number, Group Name, Current Effective Date of change, Address and Phone Number, so we can contact you if there are any questions about the report.

Keep copies for your records, and mail the original documents to AmeriHealth HMO, Inc., P.O. Box 8240, Philadelphia, PA 19101-8240.

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 potential payment problems, ***you should always pay the billed amount.*** Any credits or additional premiums due will be reflected 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/Transmittal Form for consideration. If a written explanation is not submitted, the membership transaction will automatically be processed with an effective date that is two months prior to the current month. Requests for effective dates beyond 60 days are subject to a Paid Claim Utilization Review and will result in a revised effective date for claims that are incurred. In 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 unmarried and a full-time student over the dependent age limit specified in your contract, a Student Verification Form must be completed and attached to the Enrollment/Change Form.

If the dependent is overage and dependent on the member for more then half of his or her support because of a handicap, an Application to Continue Coverage For Overage 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.

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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 group enrollment at the time of billing. 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. Submit enrollment activity online through our group portal.

Enrollment changes made via the Enrollment Report will be processed within five (5) days of receipt. Premium adjustments as a result of such changes will be reflected as follows:

- Enrollment changes processed by night of billing will appear on the bill.
- Groups effective the 1st of the month are billed on the 15th of the previous month.
- Groups effective the 15th of the month are billed on the last working day of the previous month.

The Enrollment Report should be mailed to the Enrollment Department along with the Enrollment/Change Form indicating the desired action. This may include adding dependents to a contract (due to birth, adoption or marriage), or making any changes to a member's coverage such as 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 a member's coverage, or deleting dependents, use the AmeriHealth Enrollment Report Form, but ***continue to remit the billed amount. Do not delete billed premium amounts from your remittance.*** Your next invoice will reflect the person(s) retroactively deleted and any corresponding change to your premium balance.

Enrollment adjustments made will appear in the "Summary of Changes" section of the invoice.

Simply detach the remittance coupon located at 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 account. The sum of all coupons must equal the full amount of the check you are remitting. This will ensure that your payment is properly credited to each account number.

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 through the 15th day of the month, **you will be billed for that month.**
- If members are added from the 16th to the last day of the month, **you will not be billed for that month.**
- If members are dropped from the 1st through the 15th day of the month, **you will not be billed for coverage for that month.**
- If members are dropped from the 16th through the last day of the month, **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 through the 14th day of the month, **you will not be billed for that billing period.**
- If members are added from the 15th to the last day of the month, **you will be billed for that billing period.**
- If members are dropped from the 1st through the 14th day of the month, **you will be billed for coverage for that billing period.**
- If members are dropped from the 15th through the last day of the month, **you will not be billed for coverage for that billing period.**

For billing inquiries, please call the telephone number that appears on your invoice.

Payment Reminders

When paying your group's invoice, please keep the following points in mind. They will help us in promptly and accurately crediting your account and reduce the chances of any record-keeping confusion.

- Submit all payments with the coupon from Page 1 of your invoice. If you have more than one account, please be sure to submit all required coupons with your payment(s).
- Submit all payments to the Post Office Box noted on the invoice.
- Do not send enrollment activity (member adds, changes, deletions) with your premium payments. Send them with the appropriate forms to the Enrollment Department.
- Review/verify all adds, changes and deletions processed since the last invoice. If they are incorrect or incomplete, contact the Enrollment Department using the telephone number listed on the invoice.
- Verify with your bank that your checks have been cashed before making a call regarding payments not yet posted on an invoice.
- **Please note, payments received after the due date noted on invoices can cause claim processing delays or rejections.**
- Making "partial" payment can also result in claim processing delays or rejections. If the members listed on your bill are incorrect, contact the Enrollment Department using the telephone number listed on the invoice to have the adjustments noted on your next premium statement. **Always pay the amount noted on the invoice to prevent claims problems.**

Continuation of Coverage and Conversion Privilege

Termination or Cancellation of Memberships

Termination of membership occurs when employment has been terminated and the employee will lose group eligibility in such instances.

AmeriHealth will work with employees entitled to continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or through an extension of benefits.

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

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

The policy or contract issued to you outlines the procedures that the employer and employee must follow for continuation of coverage or conversion.

Continuation of Coverage

Small employers with 20 or more employees are required to offer eligible employees the option of continuation of coverage under a federal law, commonly referred to as COBRA.

Conversion Privilege

If the employee's coverage or the coverage of an eligible dependent terminates because of the employee's death, change in employment status, divorce of a dependent spouse, or change in a dependent's eligibility status, the terminated person will be eligible to apply within the required time period (or termination of continuation privilege under COBRA) for conversion coverage (subject to the terms and conditions of the applicable group contract).

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Information Regarding the Medicare as a Secondary Payor Statue

We hope to simplify a complex subject—when Medicare is the primary payor 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 payor.

The following information provides a summary of the Medicare Secondary Payor (MSP) requirements. This information may help you to correctly target benefit 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.

Employers, Group Health Plans ("GHPs") and entities that sponsor or contribute to GHPs, as well as insurers, have certain obligations under the Medicare Secondary Payor ("MSP") provisions of the Social Security Act, commonly known as the "MSP statute."[1] As an employer[2] or administrator of a GHP, you need to know the requirements of the statue to remain in compliance and to avoid potentially costly penalties and litigation. This guide is designed to provide you with a general overview regarding operation of the MSP statue and the enrollment and membership information system that is being developed to obtain information necessary to detect instances in which the MSP statue applies.

I. The MSP Law

A Coordination of Benefits Approach: During the first 15 years of the Medicare program, Medicare was the primary payor 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 amendments to the Social Security Act, beginning 1981, which made employers and GHPs, as well as their insurers, responsible in certain instances for making primary payment in connection with medical items or services provided to specified Medicare beneficiaries with dual health care coverage.

The MSP statute is essentially a coordination of benefits statute. Thus, it does not dictate the benefits an employer or GHP must offer, but instead simply 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, however, in one important respect: 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 on the following pages.

1. The MSP revisions are set forth at 42 U.S.C. §1395y(b). The regulations the Centers for Medicare and Medicaid Services has issued implementing the statute are located 42 C.F.R. Part 411. It is important that you and your counsel review the statute and regulations to ensure compliance with your statutory obligations. The 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.

I. The MSP Law (continued)

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 individuals 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 individuals age 65 or over, GHPs of employers that employ 20 or more employees, if that individual or the individual's spouse (on any age) has "current employment status." If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 20 or more employees, the MSP rules apply even with respect to employers of fewer than 20 employees (unless that plan elects the small employer exception under the statute).
3. In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual's family 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.)

Application of the statue 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 CMS 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 current 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 result of age or disability. The statute expressly requires GHPs to furnish to aged employees and spouses the same benefits, under the same conditions, that they furnish to employees and spouses under 65. 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 GHP coverage is not based on "current employment status" and thus the MSP provisions do not apply.

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 end 30 months later. During this period, the GHP must pay primary for all covered health care items or services, while Medicare serves as the secondary payor. **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 of 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.

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 payor for that individual due to a "carve out" provision, the GHP may continue to offer such coverage and is not required to pay primary during the 30-month coordination period. By contrast, where a GHP was providing primary benefits immediately before the onset of the disease, the GHP is responsible to continue providing primary benefits for that individual for 30 more months. This is because a change from primary to secondary or supplemental coverage would improperly "take into account" Medicare eligibility based on ESRD.

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 payor, 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.** 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 spouse of an employee is free to refuse the health plan offered by an employer or GHP, in which case Medicare will be the primary payor. It is unlawful; however, for an employer (or any one else for that matter) 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. This is so even if the incentive is offered universally to all individuals who are eligible for coverage under 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. **Where an employee or spouse of an employee chooses to reject the employer-sponsored health plan, the employer and GHP are prohibited from offering or sponsoring that individual's health coverage or contributing to the premium for that coverage.**

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. Under CMS regulations, a non-conforming group health plan is a plan that: (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 provide requested information, fails to pay correctly, or fails to refund to CMS 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 CMS for mistaken primary payments may result in ultimate liability double the amount at issue. The law also establishes a private right of individuals to collect double damages from any GHP that fails to make primary payments in accordance with the MSP provisions.

The Need for Your Active Participation: Our ability to make accurate primary/secondary determinations involving individuals enrolled in your GHP, and thus to assist CMS in processing MSP claims properly in the first instance, depends entirely on the breadth and accuracy of our files concerning individuals covered by your GHP. We depend on you to provide us with this information. Accordingly, it is important that you respond promptly and accurately to our requests for information.

Moreover, to ensure the continuing accuracy of our files, it is your responsibility to notify us promptly of any changes in the size of your work force or the status of your employees that might affect the order of payment under the MSP statute, such as information regarding working-aged persons who retire (and thus for whom Medicare makes primary payment) and changes in the size of your work force that place you in, or take you out of, the scope of the MSP statute. **If we do not receive such information from you, we will assume that all relevant factors remain unchanged and will process claims accordingly.**

We will be using the information you provide us to update our files, and will also forward this information to CMS on a quarterly basis so that CMS can revise its file to reflect relevant changes in primary/secondary status.

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 in meeting your statutory obligations by providing general information about the statute, and gathering information that will detect potential problems in enrollment, it is ultimately your responsibility to ensure your company's compliance with the MSP statute.

Contacting AmeriHealth

Important Phone Numbers

Communications 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 phone numbers shown below.

Member Services	
HMO/POS	866-681-7373
AmeriHealth 65®	800-645-3965
STAR Group Services	215-241-2123
Billing	866-681-7374
Enrollment	215-241-2123
Pre-Certification	215-567-3070 Press 1
Baby FootSteps®	800-598-BABY
Health Resource Center	800-275-2588
Network Physician Referral	Press 1
Healthy Lifestyles℠	Press 2
Radiology Providers/ Mammography Program	Press 3
Magellan (Mental Health)	800-220-1570
Caremark Member Services	**877-252-3485**

Thank you for choosing AmeriHealth!

AmeriHealth
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Notes

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