Group administrator guide

univera HEALTHCARE

Right here.
For you.

Welcome

to our 2025 spring edition of the group administrator guide.

At Univera Healthcare, we are committed to providing the best possible solutions and customer care to our groups, members, and brokers.

This guide is designed to assist in providing useful information related to:

- Our Customer Care and the support provided for our members
- How to submit Enrollment requests using a variety of methods
- Information related to Eligibility and Enrollment Opportunities

And so much more!

On behalf of all of us here at Univera Healthcare, thank you for the opportunity to provide you with the best possible solutions to your health care needs.

Best regards,
Your Enrollment Operations Leadership Team

Last revision: April 2025

Table of contents

How to contact us 4

Working with us in a virtual world 5

Customer care 7

- Help us help your eligible employees 7
- Setting up a member account online 8
- First-call resolution 8
- Submitting member documents 9

Monthly Health Summary Q&A 10

Membership enrollment options 11

- Electronic enrollment 11
- Web enrollment 11
- Paper enrollment 12
- Enrollment inquiry & support form 13
- Cancellation requests 14

Billing and payment information 16

Flexibility and simplicity with online bill pay 17

Eligibility 19

- Group eligibility 19
- Subscriber eligibility 20
- Active employees 20
- Eligible dependents 21
- Spouse 22
- Eligible child dependents of the subscriber 22
- Probationary period 29

Subscriber level activity 30

- How do I enroll, change or terminate employees or dependents? 30

Enrollment opportunities 33

- Initial enrollment 33
- Special enrollment period 33
- Annual open enrollment period information 34

Group level activity 35

Medicare 37

Medicare Advantage/Medicare supplement/ Simply Prescriptions group coverage 40

Medicare tip sheet 49

Continuation of coverage 54

Prior coverage information needs 58

Coordination of Benefits (COB) 58

Retroactive policy 59

Retroactivity – COBRA, NY State Continuation of Coverage & Young Adult Option (YAO) 60

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security rules 63

Frequently asked questions 65

Notes 66

How to contact us

Reason for call	Who to call
Commercial large group benefits, setup, updates, cancellations, billing, member enrollment or member cancellations	Call your Account Service Consultant or the sales line at 1-800-427-8490
Commercial small group benefits, setup, updates, cancellations, billing, member enrollment or member cancellations	Call your Account Service Consultant or the sales line at 1-800-427-8490
Technical issues	Members should call the number on their member cards. They can also contact us on the web through Online Chat or by submitting an email.
Member claims, benefits or authorizations for medical, dental or pharmacy plans	Members should call the number on their member cards. They can also contact us on the web through Online Chat or by submitting an email.

Before you call:

Due to Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, there are restrictions regarding the disclosure of health information to a third party without a Release of Information form on file with us. Account Service Consultant and Small Group Inquiry line phone numbers are for group administrators only. Each time a Group Administrator contacts their Account Service Consultant or the Small Group Inquiry Line, we require the following:

- Group number (if not available, group address is required)
- Group name
- Contact name

Our mailing address:

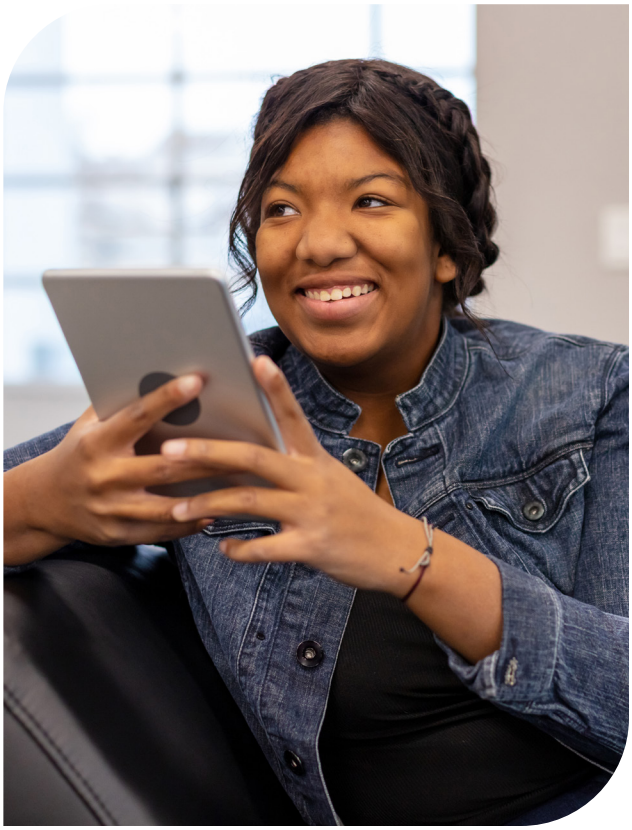
PO Box 211256
Eagan, MN 55121

Our billing/payment address:

Please refer to the address on your invoice.

Our email address:

Log in to UniveraHealthcare.com and scroll down to the Contact Us tab and follow instructions on the website for secure email process.



Working with us in a virtual world

Please see the following tips for doing business with us in a virtual world:

If you need to send packages to our offices, please advise your Account Managers prior to mailing. We have representatives assigned to sign for and scan items to the appropriate staff.

Member ID cards: paperwork, including enrollment changes must be received by 12/1 to ensure Member ID cards are mailed by 12/31 for a 1/1 effective date.

We encourage our groups and brokers to look at web and electronic enrollment options for submitting member activity. Please have conversations with your Account Managers regarding these options.

Member signatures in the event they are unattainable: eSignatures are permissible as long as the eSignature is on our application. We are allowing applications to be reviewed and processed without a signature if you are unable to obtain it. We will, however, need the signature either sent to us electronically or mailed when it is possible to do so.

Signature requirements: In most cases member signatures are required for: New Enrollment, COBRA Adds, Re-enrolls, Student Certification and anytime activity is processed that results in a contract change or benefit change. This includes re-instates if over 30 days from the cancellation date; a new enrollment transaction/paper application is needed to enroll. **NOTE:** For Self-Insured Plans a subscriber's signature is required for all activity unless it is a transfer to COBRA. In this case an enrollment application is not required, however, we do require a COBRA Election Form.

Electronic forms: To ensure you are using the most current forms, please download all forms from the Univera Healthcare site. From the **Employers page and Brokers page, click on Resources, then select Forms.**

Contact your Account Manager if you are interested in a Virtual Benefit Fair.

Integrated care for complete health at every phase of life

Our group plans are just a part of how Univera Healthcare is here to care for businesses and people in our community. We offer a complete range of plans including Medicare, Safety Net, individual and family Qualified Health Plans, dental plans, and more. That way, as members move through life and situations change, you can always count on our team to be there for them.

Here's a look at scenarios where Univera Healthcare can provide coverage when it's needed most:

If Anita retires,

we can offer **Medicare** plans if she's 65+.

If Jayden leaves her job to open a new business,

we can help her get individual coverage through **Safety Net, Essential Plan, Qualified Health Plans, Dental, or Medicare** options.

If Rachel has a baby,

we can offer a **Child Health Plus** plan through Univera Healthcare instead of adding them to their coverage through their employer or commercial group plan, which may result in a financial savings.

If Samir owns a company with employees working past 65,

we can offer a **Group Medicare** plan to help make the transition to Medicare easier.

If Jack loses his job,

– and group medical and dental coverage with it – we can provide individual plan options such as **Safety Net, Essential Plan, Qualified Health Plans, Dental, or Medicare options.**

If Calvin becomes physically disabled,

he may qualify for Medicaid and Univera Healthcare can help him understand his options and get enrolled.

To learn more about our plans contact your Sales Consultant, Broker, or visit **UniveraHealthcare.com**

Customer care

Questions specific to an individual employee's claims or benefits should be directed to our Customer Care department using the telephone number listed on the employee's member card.

Hours of operation: Monday - Thursday 8 a.m. - 8 p.m., Friday 9 a.m. - 6 p.m. EST

Help us help your eligible employees

We are always happy to speak with eligible employees and look forward to assisting them and answering their questions. For their convenience, please remind your eligible employees of the online options available to them.

When your eligible employees do call Customer Care, please remind them to:

- Call the number listed on their member card. Please note only some Customer Care numbers are open till 8 p.m. EST Monday through Thursday, and 6 p.m. on Friday
- Have their member card with them
- Have any bills or correspondence they are questioning with them
- Make sure they and everyone covered under their policy has completed an **Authorization To Share My Protected Health Information Form**

To comply with the federal Health Insurance Portability and Accountability Act (HIPAA) regulations, health plans must obtain a member's permission to share that member's protected health information with any other person. There are limited exceptions to this rule. Until a child reaches age 18, parents may access most of their child's health information without first obtaining the child's permission. However, regardless of the child's age, parents generally do not have access to diagnosis, treatment or payment information for sexually transmitted diseases, abortion, HIV/AIDs, and drug and alcohol use, unless the child specifically authorizes the release of such information.

The necessary forms can be completed online – or we can fax or mail copies to you.

To complete online the member must have an online account.

- Once the member is logged in, they would select "Manage Privacy" from the "My Account" dropdown menu
- They will click on the button "Enter or Update Authorizations". It will then show the member's active and inactive authorizations
- The member can also click on "learn more" to read about our privacy policy and look at frequent questions and answers
- They can then enter the required information to grant authorization
- Member's can stop an authorized person's access at any time

When your eligible employees submit information/correspondence to customer care, please remind them of the following:

- Complete all pertinent forms – do not leave anything blank
- Ensure that their member ID number is on the correspondence
- Include a contact phone number and/or email address we can use to reach them if needed

Important information about the eligible employee's address:

Many communications are sent directly to your eligible employee population, some of which include:

- New member packets
- Member cards
- Monthly health summaries
- Cancellation notices

Please make sure that we are always provided with the eligible employee's most current, correct and full address to ensure receipt of this important information.

To update or change their address, eligible employees should contact their group administrator to ensure you always have their most current address.

We also accept paper requests from groups and brokers to change an eligible employee's address.

Please complete one of our approved applications and mail it to us at P.O. Box 21146, Eagan MN 55121.

First-call resolution

First-call resolution is our goal. We are committed to resolving our member's inquiries during your initial call. We have established a number of initiatives and have empowered our Customer Care Advocates to do more than ever before. We will make calls on the eligible employee's behalf when necessary, set realistic expectations and follow-up in a timely manner. We are working hard to lessen the amount of work your members have to do in order to resolve their issues.

Feedback can be provided through our phone surveys. We appreciate any and all comments.

Setting up a member account online

It's easy for your eligible employees and eligible dependents on their policy to set up an account online and all they need is their Member ID number.

When eligible employees visit our website – **UniveraHealthcare.com** – they can select "Login–>Member–>Create an Account" and follow instructions to get set up.

There are a variety of options and services available for members online. Listed below are some of them:

View benefits & claims

- View benefits, copays and deductibles
- Review claim history
- Check the status of referrals and authorizations
- Obtain a copy of the monthly health summary

Print forms

- Claim forms
- HealthyRewards reimbursement forms (if applicable)
- Advance care planning
- Managing your privacy
- Membership and enrollment forms

Make changes

- Change and find a primary care physician
- Change address (not applicable to all groups)
- Find a doctor using our online directory
- Request (and print) a new ID card
- Find ways to save money on prescriptions
- Learn more about member Blue 365 discounts, including LASIK vision correction, glasses, massage therapy
- Contact Customer Care via email or through a live chat

For members age 18 years and older who wish to make available Protected Health Information (PHI) to someone other than themselves (including disclosure to parents), we recommend that they complete an authorization form for the disclosure of PHI. The completed form will allow us to disclose information to the person(s) named on the authorization and will eliminate delays in answering their questions should they need to contact us. On the member home page, the member can select Print Forms in the footer and then select Manage Your Privacy to access the form(s).

Submitting member documents

Need help? We're here for you.

- Information regarding a member's benefits and coverage, claims and options to pay their premium bill (e.g. COBRA) is available online
- Members can contact us at the phone number on their member card for personalized care

Do they need to send us documentation, including membership forms or correspondence?

At this time, electronic methods are preferred over mail:

- Advise them to use the appropriate form and attach to ensure proper handling
- Refer them to the Member Forms page for a downloadable PDF
- Go online to Email Us.
- Select "Submit Other Documentation" to electronically submit correspondence (login required), such as:
  - Grievance/appeal
  - HIPAA authorization
  - Medical records
  - Membership/enrollment application or documentation
  - Other letter/correspondence
- Submissions are limited to common file types: PDF, Word, TIFF, JPG, PNG
- Please allow up to 72 hours for a reply. Note: The 72-hour time frame does not include the time required to process their document

To submit a claim:

- Click on Contact Us > Email Us
- Click on Submit a Claim to complete a claim form and "Send to Us Electronically"

If they are unable to submit their documentation electronically, they may continue to submit the documentation via mail to the address on the back of their member card. Please note, there may be significant delays with the processing of documents received by mail at this time.

We recommend that you avoid setting up online accounts on behalf of your employees. If employees need assistance setting up their online accounts, please instruct them to call our Web Help Desk at 1-800-278-1247. Select prompt number 1.

Our Web Help Desk hours are: Monday - Thursday 8 a.m. to 4:30 p.m., Friday 9 a.m. to 4:30 p.m.

Did you know?

If you set up online accounts for your employees, be aware that you may be putting yourself at risk for unauthorized access to employees' protected health information, such as claims information.

Monthly Health Summary Q&A

When will members receive a Monthly Health Summary?

The Monthly Health Summary will be sent to the eligible employee's mailing address when one or more members on the contract have claim activity during the previous month.

Will protected health diagnosis information be on the Monthly Health Summaries?

Claims for protected diagnoses will appear on the Monthly Health Summary as a generic service (e.g. "office visit") – details of protected diagnoses will not be displayed.

A claim was paid but according to the code in the comments the benefit is exhausted. An eligible employee contacts us and insists they have not used that particular benefit this year and the claim is indicating that it is paid. So, why is the code in the comments section?

The code shows that the benefit is now exhausted with the newest claim or current claim that has processed and paid.

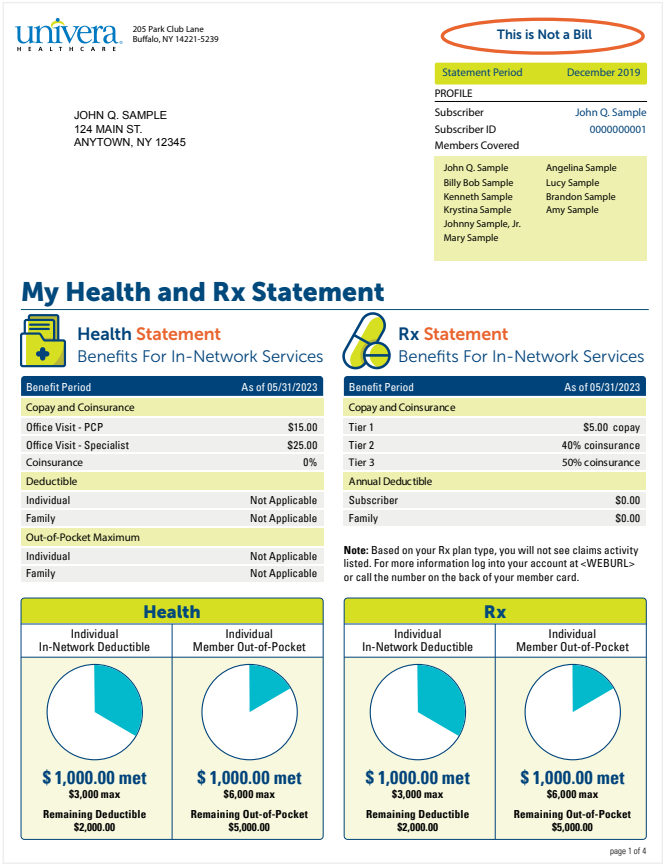
A member is in a High Deductible Health Plan (HDHP) and wants to know why his/her prescription drug claims don't show on the Monthly Health Summary.

Even though prescription drug claims do not appear on the medical Monthly Health Summary at this time, they are being calculated into the member's deductible and out-of-pocket maximum information that is shown on the cover page.

Members who have prescription drug coverage that has a deductible and/or coinsurance benefit design will receive a monthly My Rx Statement in addition to the Monthly Health Summary.

What column should a member be looking at and comparing to the bill they receive from their provider's office in order to make sure they are being billed the correct amount?

There is a section on the Monthly Health Summary titled Member Responsibility. This section consists of deductible, coinsurance, copay and non-covered expenses. The provider can bill the amounts listed in these columns. If members have any questions or concerns regarding how a claim processed, or believe the Member Responsibility is not correct, they can contact our Customer Care department at the phone number listed on the back of their member card.



univera HEALTHCARE
205 Park Club Lane
Buffalo, NY 14221-5239

This is Not a Bill

Statement Period	December 2019

PROFILE

Subscriber	John Q. Sample
Subscriber ID	0000000001
Members Covered	

John Q. Sample, Billy Bob Sample, Kenneth Sample, Krystina Sample, Johnny Sample, Jr., Mary Sample, Angelina Sample, Lucy Sample, Brandon Sample, Amy Sample

JOHN Q. SAMPLE
124 MAIN ST.
ANYTOWN, NY 12345

My Health and Rx Statement

Health Statement
Benefits For In-Network Services

Benefit Period	As of 05/31/2023
Copay and Coinsurance	
Office Visit - PCP	$15.00
Office Visit - Specialist	$25.00
Coinsurance	0%
Deductible	
Individual	Not Applicable
Family	Not Applicable
Out-of-Pocket Maximum	
Individual	Not Applicable
Family	Not Applicable

Rx Statement
Benefits For In-Network Services

Benefit Period	As of 05/31/2023
Copay and Coinsurance	
Tier 1	$5.00 copay
Tier 2	40% coinsurance
Tier 3	50% coinsurance
Annual Deductible	
Subscriber	$0.00
Family	$0.00

Note: Based on your Rx plan type, you will not see claims activity listed. For more information log into your account at <WEBURL> or call the number on the back of your member card.

Health

Individual In-Network Deductible	Individual Member Out-of-Pocket
$ 1,000.00 met	$ 1,000.00 met
$3,000 max	$6,000 max
Remaining Deductible $2,000.00	Remaining Out-of-Pocket $5,000.00

Rx

Individual In-Network Deductible	Individual Member Out-of-Pocket
$ 1,000.00 met	$ 1,000.00 met
$3,000 max	$6,000 max
Remaining Deductible $2,000.00	Remaining Out-of-Pocket $5,000.00

page 1 of 4

Membership enrollment options

We offer a variety of enrollment options, including web, electronic and paper. Select the option that meets your business needs.

Electronic enrollment

Electronic enrollment is a method of electronically submitting enrollment files and exchanging data that is compliant with the Health Insurance Portability and Accountability Act.

If you are currently submitting paper enrollment forms, and are interested, please contact us at Electronic. Enrollment@UniveraHealthcare.com for more information on this option.

Benefits of electronic enrollment

- Enjoy faster service
- Enrollment is submitted via a secure server
- Enrollment is submitted on one file rather than multiple paper applications or web transactions
- Decrease in manual interventions for additions, terminations or changes to current enrollment

When submitting files electronically there are some limitations with punctuation.

- We accept hyphens (-), apostrophes (') and forward slashes (/) in first names.
- We accept single-space, apostrophe (') or hyphen (-) in last names.
- We accept letters, numbers and a dash (-) in addresses.
- We do not accept periods (.), commas (,), accents (` or é), colons (:) , smart quotes and other special characters in names or addresses.

Please note

Valid Social Security numbers must be sent for eligible employees. A missing or invalid Social Security number will stop the transaction. It is also strongly recommended that valid Social Security numbers are sent for eligible dependents. We are required to ask for enrolled eligible employee and dependent Social Security numbers in order to meet our reporting obligations under the Affordable Care Act. If a valid Social Security number cannot be sent for an eligible dependent, then it must be omitted. This omission will not stop the enrollment process; however, a Social Security number solicitation letter will be sent to the employee. Do not send invalid Social Security numbers as they will impact eligibility.

Web enrollment

Web enrollment is available to all employer groups. This type of enrollment has two options:

1. Full access option: This option allows you to enter all employee applications and make updates to a member's coverage on our website.

   Another feature is that your employees may submit their own updates and enrollment requests. If you choose this option, we will notify you whenever you have an employee enrollment and change request pending for approval or denial.

2. View only access: This option allows you to view a real-time member roster and print/order member cards. Benefits of web enrollment:

   - Receive immediate confirmation that your request is received
   - View real-time member roster 24/7 (sort by subgroup, name, age, date of birth, active/terminated status)
   - Convert roster to a Microsoft Excel spreadsheet to make reconciliation of invoices easier
   - View and update a member's policy (change member address and/or phone)
   - Enjoy faster service
   - Print/order member cards

Social Security Inclusion

We are required to ask for a Social Security number in order to meet our reporting obligations under the Affordable Care Act. Also, it is strongly recommended that valid Social Security numbers are sent for all dependents.

To add or activate a new group number, or remove an old group number from your web account, an existing user can: Log on our website **UniveraHealthcare.com**, and follow the link for Employer, and go to the Quick Links section under the "Enroll and Update" tab.

To learn more about this convenient method of enrollment, simply go to our website at **UniveraHealthcare.com**, follow the link for "Employer" and select "Register," then complete the Group Web Access Request Form. Upon approval, we will send you an email with a username and password. Once you receive this, you may complete the registration process online.

If you are a Broker interested in web enrollment, please contact **BrokerContractsUnivera@UniveraHealthcare.com**

Paper enrollment

Paper enrollment is our traditional method of enrolling new members and making changes to a member's coverage. Updated fillable PDF forms with plan option drop-downs based on the plan design (PPO/EPO/ Indemnity, and HMO/ POS, etc.) are now available on the web. Our goal is to work with you to ensure that all required fields on the application are complete and accurate. This will reduce the number of applications returned to you for additional information/clarification and will speed up the process to enroll members.

Below are a few reminders to assist in the enrollment process:

✔	Complete all areas of the application. **Note**: If additional dependents need to be added that cannot be completed on the application, use the **Additional Dependent Addendum** form on the Resources > Forms page.
✔	Always provide an employee's hire date.
✔	Include all signatures.
✔	Check appropriate coverage boxes.
✔	We are required to ask for a valid Social Security number in order to meet our reporting obligations under the Affordable Care Act. Also, it is strongly recommended that valid Social Security numbers are sent for all dependents. **Please note:** Missing or invalid Social Security numbers will result in a Social Security number solicitation letter being sent to the employee. Missing or invalid Social Security numbers will not stop enrollment.
✔	Always use blue or black ink on the applications.
✔	If highlighting, only use yellow.
✔	Write legibly.
✔	Ensure a complete and legible subscriber address is included.
✔	Applications that have missing or illegible information may not be processed. If this is the case, we will notify the group with a letter.
✔	Activity must be submitted as it occurs to ensure timely enrollment or cancellation. Please do not send activity with your premium payment.
✔	Mail the completed application to: Membership Department, P.O. Box 21146 Eagan MN 55121, or visit our website to scan a secure request to us.
✔	Use only acceptable enrollment forms, which are available to print from the website at: **Employer.UniveraHealthcare.com**. Click on Print Forms at the bottom of the employer/benefit administrator's home page. If you submit an alternate group enrollment form, the form may not be processed.

Enrollment inquiry & support form

Why use this form?

The purpose of this web–based form is to streamline all of your enrollment and billing inquiries and requests. When you submit your inquiries and requests via this form, they are securely transmitted directly to the request management system that is utilized to assign and process requests within our Enrollment Operations department. Requests submitted via this online tool can be easily tracked, assigned and managed through completion. The process is simple; this document outlines how to use the form and what to expect once you submit an inquiry to Enrollment Operations.

Please note: You must have an active web account to use this feature.

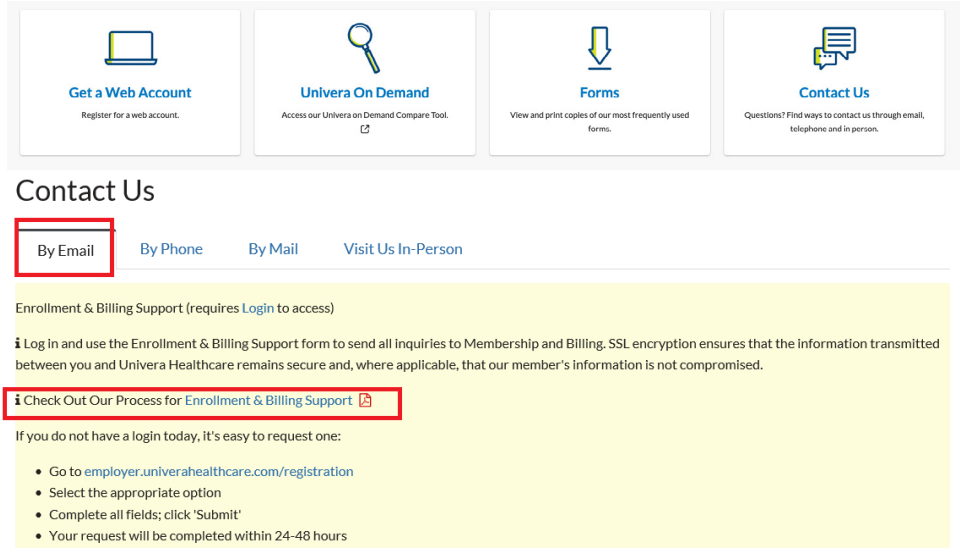
Accessing the form:

Employer home page

From the Employer home page of our website, click on the 'Contact Us' box on the right

Select the 'By Email' tab

Click on the link in 'Check Out Our Process for Enrollment & Billing Support'

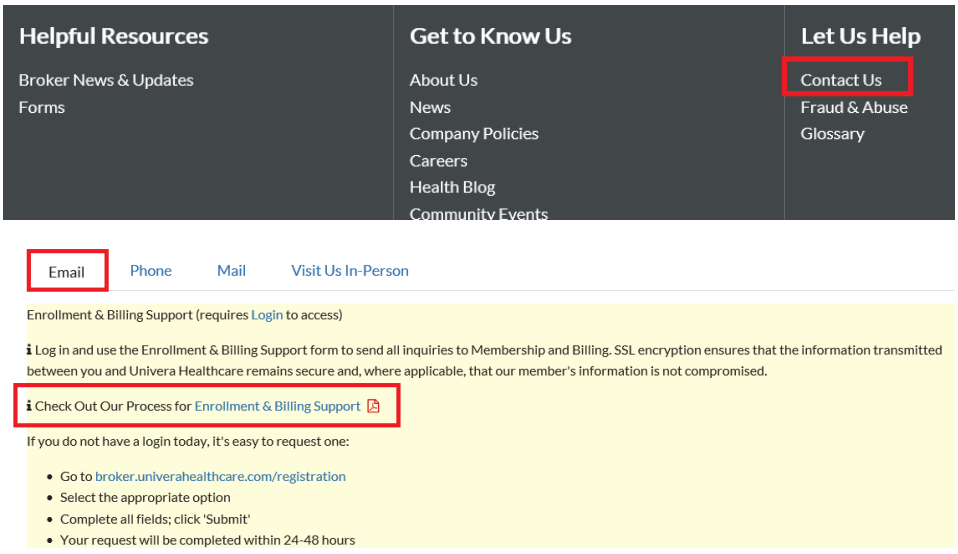


Broker home page

From the Broker home page of our website, click on the 'Contact Us' link in the bottom right hand side under 'Let Us Help'

Select the 'Email' tab

Click on the link in 'Check Out Our Process for Enrollment & Billing Support'



Using this form

The fields on the form are self-explanatory. To ensure your inquiry is routed appropriately, please review the below descriptions for the 'Reason for Inquiry' field.

- Billing – Use to request copies of invoices
- E-File – Only groups that have been pre-approved for our e-file enrollment may use this option
- Member card request/research – Use to submit a request for a new set of member cards or when requesting a mass reissue of member cards for an entire group
- Reconciliation – Use to request a research posting of funds or to request a history of payment activity
- Subscriber/member eligibility – Use for member activity, new enrollments (single or multiple enrollments), member additions to existing contracts, membership changes, terminations, general questions and research. All appropriate paperwork must accompany the request and required fields must be completed.

Tracking system and notifications

- You will be given a case ID immediately when your case is submitted on the web portal
- Your dashboard will be updated with the case ID in real-time with the latest status
- Upon completion, the secure email you receive will contain the case ID, company name, group number(s), subscriber name and subscriber ID if applicable and entered in the request. It will also contain resolution comments
- The case ID is used for tracking purposes. If you have any questions concerning status of a specific inquiry, please use the case ID to check status on your user dashboard
- If further assistance is required, contact your account service consultant or dedicated support line with this case number

Cancellation requests

Easy options for cancellations

Visit our website at **Employer.UniveraHealthcare.com** and select Resources then Forms. Under Additional Enrollment Forms, select Membership Cancellation Worksheet. This is a fillable PDF form which can be used instead of a full application being completed to cancel a policy. This one-page form can be used to cancel a subscriber or dependent. For privacy, please limit to one employee's information per form.

Visit the "Enroll and Update" tab to view "Online Enrollment & Account Maintenance" options.

For paper cancel submissions:

Cancellations can also be submitted on an application. Select from one of the approved application request forms, and complete the following sections of the form for a subscriber cancellation:

- Subscriber information
- Group/Employer information
- Subscriber/Employee status
- Cancellation information

The Group Representative signature must accompany these forms. For termination of a dependent, please complete the following sections of the approved application form:

- Subscriber information
- Group/Employer information
- Subscriber/Employee status
- Cancellation information (check the dependent information portion of this section)
- Dependent information (list the dependent that is cancelling off the policy)
- **The Group Representative signature must accompany these forms**

Please note: In order to streamline the process and eliminate numerous paper forms, we no longer accept any forms that were formerly used for individual or multiple subscriber/member cancellation requests.

Once the form is completed, it can be mailed to Membership Department, P.O. Box 211256, Eagan MN 55121.

Deceased members with dependents

Upon a Subscriber's death, coverage will terminate unless the Subscriber has coverage for dependents. If the Subscriber has coverage for dependents, then coverage will terminate as of the last day of the month for which the premium has been paid.

Cancellation reason codes

It is important to select the proper code when you submit a cancellation. Please refrain from using the same or a few codes for every transaction. These codes trigger certain activity in our systems, including whether or not an individual is:

- Offered a conversion policy upon termination
- Entitled to a special enrollment period

Once the form is completed, it can be mailed to Membership Department, P.O. Box 21146, Eagan MN 55121.

Subscriber				Dependent(s)			
Cancel Code	**Cancel Reason**	**Conversion Letter Issued**	**Cancel feed to LBS COBRA**	**Cancel Code**	**Cancel Reason**	**Conversion Letter Issued**	**Cancel feed to LBS COBRA**
SB02	Left employment	Yes	Yes	**M001**	Per group request	Yes	Yes
SB05	Per group request	Yes	Yes	**M002**	Deceased	No	No
SB06	Subscriber no longer wants Cov	Yes	No	**M003**	Sub does not want to cover dep	Yes	No
SB07	Deceased	No	Yes	**M004**	Enrolled in error	No	No
SB09	Enrolled in error	No	No	**M005**	Divorced	Yes	Yes
				M007	Dep no longer wants coverage	Yes	No
				M008	Moved out of area	Yes	No
				M010	Overage dependent	Yes	Yes
				M011	No longer a student	Yes	Yes
				M013	Ineligible dependent	Yes	Yes

Billing and payment information

Benefits of electronic enrollment

Your next billing statement will automatically generate at the same time each period. Delays in billing can be expected at renewal.

All enrollments processed before the bill run date will appear on the current month's invoice. If activity is processed after the bill run date, it will appear on the next month's invoice. Paying as billed will reduce disruption of members' coverage.

It is important that you reconcile the billing statements each month to ensure that all members being billed are still active and enrolled in the correct tier/enrollment type. This will ensure that our records are up to date, allow timely claim payments and prevent denials of activity requests due to our retroactivity guidelines. If preferred, an enrollment listing can be downloaded from our website at **Employer.UniveraHealthcare.com.**

Upon receipt of your invoice each month, please check the activity changes listed on the invoice. If you find a discrepancy, please contact your Account Service Consultant. As most activity is subject to a 30–day retroactive period, taking the proactive step of checking your invoice will help avoid retroactive requests.

Payment information

- Premium is due by the due date on your bill
- Pay as billed by paying the "Total Premium Due" on your billing statement
- Submit your payment with the remittance stub to the address listed on the reverse side of the stub or pay your bill online. Allow seven business days from the mailing date for payment to be credited to your account
  - Please note, we cannot accept automatic payments on the last two days and first two days of each month in order for us to reconcile our files.
- Payments should include all applicable group numbers
- Premium payment backup is needed at the time the payment is submitted but should not be mailed to our bank lock box.
  Please send separately using one of the following options:
  - Secure email via Univera Healthcare
  - Mail to: Membership Department, P.O. Box 21146 Eagan MN 55121
- If you are paying for more than one group number, provide a breakdown of how much you are paying for each group number. This will ensure that your account is properly credited.
- Do not send any activity or correspondence with your payment to our bank lock box. Please follow instructions listed above to forward payment backup.

Flexibility and simplicity with online bill pay

Employer bill pay & invoice updates

We improved the group bill payment and invoice experience.

- New and enhanced features
- Simpler user experience
- Redesigned invoice

Payment – improved payment options and simpler user experience

- View current and past invoices or download (PDF or .XLS)
- Make a full or partial payment
  - Ability to correspond with our reconciliation team and note reason for partial payment
- Setup automatic payments
  - Please note, we cannot accept automatic payments on the last two days and first two days of each month in order for us to reconcile our files.
- Pay invoices with different bank accounts
- Add bank account info to a digital wallet to easily make future payments optional)
- View payment history (mail, online, EFT/automatic payments)
- Get real-time payment status and balance updates
- Receive confirmation of payment or share receipts via email

And, you can manage settings and update them any time!

- Invoice delivery – paperless or paper and online
- Email notifications – invoice is available

Invoice – making it easier!

A redesigned invoice that is even easier to understand and use! The redesign includes changes such as:

- Cleaner, simpler design
- Addition of enrollment code
- Upgraded summary section, including previous payment info
- Visual cues for retroactivity
- Addition of number of contracts and total number of members

Get started at **Employer.UniveraHealthcare.com/Billing**

Delinquency

- Delinquency is based on date billed, due date and payment dates
- If payment is not posted to the group's account by the 10th of the month, a delinquent notice is automatically generated and mailed
- If after 20 days the bill is not paid, a cancellation notice is generated and mailed to the group advising that payment is needed within 10 days, or the group will be cancelled retroactively 30 days

Example:

A group is billed for its June premium on May 15. The group bill has a due date of June 1

If not paid, the delinquent notice will generate and mail on or around June 10

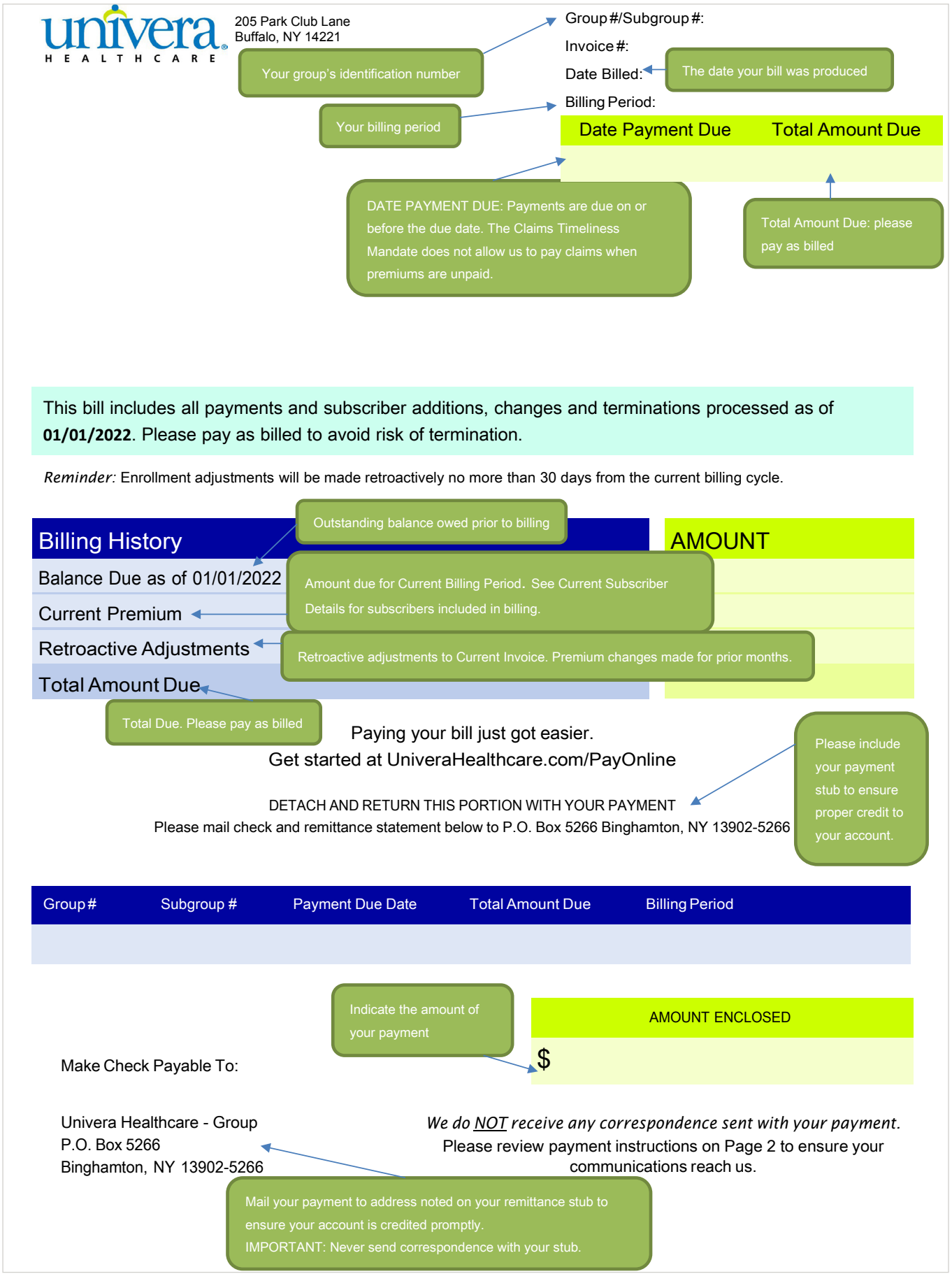
If no payment is posted, the cancellation notice will generate and mail on or about June 20

If no payment is received 10 days from the cancellation notice, the group cancellation will be processed for a termination date of June 1 on or around July 5

For questions: Call the Corporate Accounts Receivable at 1-877-208-4163.

Sample bill statement

Please view the attached statement to help familiarize yourself with your billing statement.



Eligibility

Group eligibility

New York state law has limitations regarding which types of employer groups qualify for group health insurance coverage. These requirements vary by type of entity (e.g., employer). In addition, we have certain underwriting guidelines, as permitted by law, that govern whether a group may be accepted for coverage or may maintain coverage. The most common of these guidelines are shown below:

- The group must have a worksite in our service area
- The group must meet the definition of an insurable group, or have an exception from the NYS Department of Financial Services
- A small group must be community rated. A large group may be experience rated. Definitions of these terms are below
- The group must have at least one common-law employee enrolled in the health insurance coverage. The sole owner of a business, regardless of business structure (e.g., C-corporation) is not a common-law employee

Group size

A small group is one in which:

- The group has one to 100 full-time equivalent employees
- If the sole owner of a business or the spouse of a sole owner is enrolled, at least one other common-law employee must be enrolled

A large group is one which has 101 or more full-time equivalent employees.

See the Annual Group Information Form for assistance in calculating full-time equivalent employees.

For further information, see the following website:

FAQs for small group expansion to 1-100 employees:

dfs.ny.gov/consumers/small_businesses/small_group_expansion_faqs

Community rating

The premium for all persons covered by a policy are the same, based on the experience of the entire pool of risks, without regard to age, sex, health status, occupation or any other demographic factors. The rates may vary by geographic location, product type (e.g., PPO), product features (e.g., copayments) and network (e.g., open).

Experience rating

The premium for the policy selected by the group is determined partially or in full by the group's claims experience and/or demographics, depending on the group's size.

If you have further questions regarding our underwriting guidelines or these terms, please contact your Broker or Account Manager.

Subscriber eligibility

The subscriber is the person to whom we issue the policy. In order to enroll in our insurance programs, subscribers must meet the criteria outlined in this section. Except as otherwise specified, we rely on you for verification of subscriber eligibility. We may request information to support enrollment of a subscriber at any time, so please maintain these records as long as the individual remains enrolled in our coverage, regardless of how many years he or she remains enrolled. Once the individual terminates coverage, you must retain these records for 10 years. Please note this 10-year requirement applies for paper, web and electronically submitted requests.

Eligible subscribers must be citizens of the United States, permanent residents or non-immigrants whose authorization status permits employment. Products that require a gatekeeper in the form of a primary care physician (e.g., HMO, POS) or certain products with limited networks require that the subscriber live, work or reside in the service area of our plan. A few gatekeeper products allow the subscriber to live in a contiguous county.

If you have questions about the type of product purchased by your group, please contact your Account Manager or Broker.

Active employees

Full-time employees

If the group is an applicable large employer (see definition below), a full-time employee must work on average 30 hours per week.

If the group is not an applicable large employer, it may establish the number of hours required to classify its employees as full-time, anywhere between 30-40 hours. For example, the group may establish the threshold at 35 hours.

Generally, an applicable large employer under the Affordable Care Act is any company that has an average of at least 101 full-time employees or full-time employee equivalents.

Part-time employees

Part-time employees for a small group or a sole proprietor must work 20 hours or more per week in order to qualify for health coverage. Large employers may include employees who work 17.5 hours or more per week.

Retired employees

Retirees are eligible for coverage if your group includes retiree coverage as a formal employee benefit as part of a written program. The retiree must fulfill the age and years of service requirements of the written retiree program.

The retiree, and all eligible dependents, must enroll in our products prior to the retirement date. The retiree and dependents must also maintain coverage continuously throughout retirement to remain eligible. If a spouse or dependent requires enrollment in a different product than the employee (e.g., employee is over 65 and spouse is under 65), the spouse and/or dependents must complete the appropriate application(s) for coverage to enroll in coverage.

Continuants

Individuals entitled to coverage through COBRA, NYS Continuation or the Young Adult Option are entitled to enroll as the subscriber if the individual received all appropriate notices, the election and first premium payments were timely and we receive the application on time.

For further information, see the Continuance section, later in this guide.

Ineligible subscribers

The following individuals are not eligible for enrollment in your health insurance programs:

- Employees working fewer than the required hours listed in the eligible employees section
- An employee in the employer's probationary period
- Individuals paid for periodic services, such as consultants
- Contract employees
- Temporary employees
- Volunteers
- Any individual who is not a bona fide employee or former employee

Check with your Account Manager or legal counsel regarding 1099 or seasonal employees.

What happens when a subscriber loses eligibility?

You must process a cancellation transaction immediately when a subscriber becomes ineligible, or we may not be able to honor your cancellation transaction for the requested date. You must notify us within 30 days from the date the subscriber loses eligibility. Please see the Retroactive Policy section for further information.

Those who become ineligible as a subscriber include:

- An employee whose employment is terminated
- A COBRA or NYS continuant who does not pay premium on time
- An employee or retiree who dies

Eligible dependents

The dependent must have an existing relationship with the subscriber, and must meet criteria as defined below, and as contained in the subscriber certificate or plan document. Except as otherwise required by law (e.g., COBRA, NYS Continuation), coverage of dependents is based on the employee or member being the primary person covered under the policy.

Similar to the eligible subscribers section, eligible dependents must meet certain criteria in order to obtain and maintain coverage. In the past, we may have requested certain information to verify eligibility. In today's world of electronic and web enrollment, we generally rely on you to verify dependent eligibility and do not request these documents. We may request information to support enrollment of any dependent at any time, so please maintain these records for as long as the individual remains enrolled in our coverage, regardless of how many years he or she remains enrolled. Once the individual terminates coverage, you must retain these records for 10 years. We have included helpful information regarding the types of acceptable documentation normally expected immediately following the definition of each type of eligible dependent.

Eligible dependents must be citizens of the United States, permanent residents or non-immigrants whose authorization status permits an extended stay in the United States. The dependent must have an existing relationship with the subscriber, and must meet criteria as defined below, and as contained in the subscriber certificate. Univera Healthcare HMO coverage requires the dependents to live or reside in the service area.

If you have questions about the type of product purchased by your group, please contact your Account Manager or Broker. If you have questions regarding the eligibility of a dependent, please contact Enrollment Processing.

Spouse

A spouse is eligible whenever the couple is legally married in a state or country that recognizes the type of marriage. The definition of spouse includes opposite sex and same-sex spouses, as well as common-law spouses.

As the group administrator, you must permit enrollment for all spouses who qualify and properly apply for coverage.

Same sex marriage is legal in all states in the United States. If the same sex marriage occurred in another country, e.g., Canada, please seek advice from your legal advisors regarding whether the marriage is valid. Common law marriage is a legal form of marriage in certain states and the District of Columbia. For questions on common law marriage and eligibility, please seek counsel with your own legal advisors.

For information regarding domestic partners, please see the information under Other Adult Dependents of the Subscriber on subsequent pages.

Eligible child dependents of the subscriber

A dependent child must meet criteria related to the relationship with the subscriber, as well as age and, in some cases, financial dependency. Please review the following sections for more detail.

Age

The standard dependent age limitation for medical contracts is to the age of 26. New York state insurance law mandates that a group either add a rider to cover dependents through age 29 or offer a special type of continuation called the Young Adult Option (YAO).

For further information regarding the Young Adult Option, please see the Continuation of Coverage section, later in this manual.

If your group's present policy only covers dependents to age 26 and you are interested in coverage for dependents to age 30, contact your broker or Account Manager for a proposal. This change is available only at renewal.

Please note that these rules affect medical plans only. Freestanding dental and vision plans are not affected and may have different types of eligible dependents and age requirements than the health plan and include eligibility provisions (e.g., the dependent must be a full-time college student) to obtain the higher age limitations.

For further information, see the following website:

Dependent to 26: healthcare.gov/ law/features/choices/young-adult-coverage/index.html

Dependent through 29: dfs.ny.gov/ consumers/health_insurance/faqs_ age29_young_adult_option

The following comparison provides eligibility information regarding the age thresholds under these important laws:

General Provision	ACA	NYS Dependent through 29
Age limit	Under age 26	Under age 30
Children subject to the provision	Children (natural and adopted), legal guardian, stepchildren	Any covered dependent child
Children not subject to the provision	Dependents not listed above	N/A
Financial dependency	Not required for affected children, is required for all other children	Not required
Residency with the parent, stepparent, adoptive or proposed adoptive parent	Not required	Not required
Residency within NYS or the insurer's service area	Not required	Required
Marital status	May be married	Unmarried
Student status	Not required	Not required
Child is eligible for, or covered by their employer's plan	Eligible	Not eligible
Child is covered by Medicaid	Eligible	Not eligible

Financial dependency

Unless specifically included in the exemption for dependency under ACA or New York state dependent through 29, as shown in the table above, the dependent (e.g., children of a domestic partner) must be financially dependent upon the subscriber for support.

Documentation

When financial dependency is a requirement of coverage, we recommend the group maintain the following documentation, as applicable, in the member file:

- A sworn and notarized statement certifying that the subscriber and/or covered spouse is responsible for the medical expenses of the child, or a sworn and notarized statement certifying that the subscriber is responsible for at least 50 percent of the support of the child
- A copy of the last tax statement indicating that the child was the subscriber's dependent
- Other evidence (e.g., divorce decree) indicating the subscriber has responsibility for the child's medical expenses or new responsibility for at least 50 percent of the support of the child

Child of the subscriber

The natural children of the subscriber are eligible for coverage, if the children meet the relationship and other requirements, such as age, as described in this section.

Children are eligible from the moment of birth, if the subscriber adds the child within 30 days of the birth. Please advise employees not to wait to enroll their newborns. The parent does not need to wait for a newborn's Social Security number to add the newborn to coverage.

In the event a child is eligible for coverage due to a Qualified Medical Child Support Order (QMCSO), the child is eligible as of the date the court order is final, provided that the order meets the definition of "qualified." Your group is responsible to certify that the QMCSO is qualified by using the Qualified Medical Child Support Order Certification Form, which is on our website. This form and a copy of the court order must accompany a paper application in all cases.

Please note, we will accept an application without a subscriber signature in the case where a QMCSO is issued and the subscriber is not cooperative in adding the child.

If a covered dependent child of the subscriber gives birth, the newborn grandchild is not eligible unless the subscriber adopts the child or obtains legal guardianship. See requirements for adopted child or legal guardianship in the appropriate sections below.

Documentation

We recommend the group maintain the following documentation in the member file:

- A birth certificate
- A sworn and notarized statement that the subscriber is the natural parent of the child
- A QMCSO Certification Form and a copy of the court order, when applicable

Stepchild

The stepchildren of the subscriber are eligible for coverage as of the date the subscriber marries the child's parent. Coverage is effective on the date of the marriage, as long as the subscriber applies for coverage within 30 days of the marriage.

In the event a stepchild is eligible for coverage due to a QMCSO, the child is eligible as of the date the court order is final, if the order meets the definition of "qualified." A QMCSO Certification Form and a copy of the court order are necessary, when applicable.

Documentation

We recommend the group maintain the following documentation in the member file:

- Copy of the child's birth certificate and a copy of the marriage license to establish the relationship to the subscriber as a stepparent
- The QMCSO Certification Form and a copy of the court order, when applicable

Proposed adoptive child

A child who the subscriber has consented to adopt and for whom the subscriber has entered into an agreement to support, is eligible for coverage, even though the adoption is not final. Proposed adoptive children are either newborns or older children. The requirements for each are as follows:

Newborn proposed adoptive child

Newborn proposed adoptive children are eligible for coverage from the moment of birth, if the subscriber:

- Takes physical custody of the child upon discharge from the hospital or birthing center
- Files a petition under section 115-c of the New York Domestic Relations Law within 30 days of the birth

If the circumstances do not meet both of these conditions, the child is eligible on the date the subscriber meets the requirements to add the child as a non-newborn proposed adoptive child or the adoption is final.

Non-newborn proposed adoptive child

These children are eligible during the waiting period prior to finalization of adoption, if the subscriber has entered into an agreement to support the child.

Foreign proposed adoptive child

If the parent requests coverage for a foreign adoption that has not reached the final stage or the child is not physically in the United States at the time the application for coverage is submitted, please contact your Account Service Consultant for guidance, prior to acceptance of the application or enrollment of the proposed adoptive child.

Documentation:

Documentation requirements for a newborn proposed adoptive child include both of the following:

- Proof that the subscriber has physical custody of the child upon discharge from the hospital or birthing center
- A copy of the 115-c petition

Documentation requirement for a non-newborn proposed adoptive child, include both of the following:

- A statement from the adoption agency or, in the case of a private adoption, other appropriate documentation indicating that the subscriber is the proposed adoptive parent and the approximate or target date of adoption
- Proof that demonstrates the proposed adoptive child is dependent upon the subscriber during the waiting period prior to the adoption becoming final

Documentation requirements for a foreign proposed adoption include documentation similar to the above, and a copy of both the original and translated documents.

Legal guardianship

A child for whom the subscriber is the legal guardian. Please note that custody alone is not sufficient. A court must specifically confer legal guardianship. The child is eligible for coverage on the date of the court order.

Documentation requirements include of the following:

- A copy of the court order that conveys legal guardianship of the child to the subscriber or spouse. Custody agreements or orders do not convey legal guardianship

Adopted child

When an adoption is final, the child is eligible for coverage under the same terms and conditions as a natural child.

Foreign adoptions

If a parent requests coverage for a child adopted from a foreign country and the child is not physically in the United States at the time the application for coverage is submitted, please contact your Account Service Consultant, before you accept the enrollment application for the adopted child. If the adoption is not final, the child must meet the criteria for a proposed adoptive child. See the previous section regarding the requirements for coverage of a proposed adoptive child.

Documentation:

Documentation requirements for an adoptive child include both of the following:

- If the adoption occurs in a foreign country, obtain a copy of both the original and translated documents
- A copy of the 115-c petition

Full-time student

For products not subject to federal or New York state age limit requirements (e.g., stand alone dental/vision), the age limits and eligibility requirements may vary and may include a full-time student status requirement. Please review the subscriber certificate or applicable plan documents for details.

If the product includes a full-time student status as a requirement of eligibility, a full-time student must enroll in 12 or more credit hours per semester at an accredited institution of higher learning. Students are not required to attend college during the summer months, but must enroll for the fall semester in the spring, with the intent to return to college in the fall.

We require the group to maintain the following documentation in the member file:

- Same as established for any other type of dependent based on the relationship between the subscriber and the dependent; plus
- Proof that the dependent is attending school on a full-time basis; and
- Subscriber needs to confirm student status on an annual basis

Student medical leave

Dependent students who are medically unable to attend full time classes may be eligible for Student Medical Leave for up to six months or to the maximum dependent age limit. A request must be submitted for review to determine if the dependent is eligible to continue coverage on student medical leave.

The following requirements must be met:

- Dependent must be an active member under the policy, under the age requirement
- Dependent has prior approval for coverage as a full-time student
- A 'Continued Student Coverage Request for Medically Necessary Leave of Absence' form, must be completed and signed by the subscriber and the child's physician

Other adult dependents of the subscriber

Domestic partner

We cover domestic partners in most, but not all of our benefit programs. Please review the language in the subscriber certificate to determine whether the coverage your group has purchased includes coverage for domestic partners. Our standard domestic partner language includes coverage for both same and opposite-sex partners. Your group may not limit coverage to just one of the two categories, if the language in the certificate includes both types of partnership.

A Domestic Partnership must meet the criteria specified in the subscriber certificate for relationship and financial interdependency.

To qualify as domestic partners, members must demonstrate that they have been living together in a committed relationship for a minimum of six months and are:

- Not married to any other party
- A couple of the same sex or opposite sex
- 18 years of age or older
- Not related by blood or otherwise barred from marriage to each other

If the domestic partner meets the criteria as specified in the subscriber certificate, his or her children are also eligible for enrollment in your group's coverage.

Your group must maintain the following documentation in your records:

- Affidavit attesting to the domestic partnership
- Certificate of Domestic Partnership or Declaration of Domestic Partnership
- Materials supporting cohabitation and financial interdependency, per the affidavit

Adult child incapable of self-sustaining employment

A child who is incapable of self-sustaining employment may be eligible to remain on a parent's policy beyond the age (e.g., 26) where coverage would otherwise terminate. The parent's coverage must be a type of coverage that includes dependent coverage. The parent must apply for coverage and provide proof of incapacity within 31 days of the time the child ages off the policy.

The child must meet all of the following conditions:

- The condition occurred before the dependent reached the maximum age under the certificate
- The child was covered under the parent's policy at the time he or she would have otherwise reached the maximum age under the certificate
- The condition continues to exist
- The child is unmarried
- The child is dependent upon the subscriber for support

Our Medical Director reviews all applications for coverage of an adult disabled dependent. The Medical Director will determine whether the condition is permanent or temporary. If the condition is temporary, we will periodically request the recertification of the dependent's eligibility, through the submission of a new Adult Dependent Disabled Form. If the child loses eligibility, (e.g., marries), the child may not re-enter coverage under the parent's policy at any future point.

Documentation must accompany the application, and include:

- A completed Adult Dependent Disabled Form
- Proof of financial dependency

Dependent Form:

To obtain an Adult Dependent Disabled Form please go to our website at **UniveraHealthcare.com**:

- Select the Broker or Employer tab
- Select Resources then select Forms
- Select Adult Disabled Dependent Form under Eligibility Certification Forms

You may also contact your Account Manager to obtain the form.

Ineligible dependents

Unless specifically included above as eligible, the dependent is not eligible for coverage. Examples of ineligible dependents include:

- Children who are older than the age limit or who do not meet the definition of an eligible dependent specified in the subscriber certificate, e.g., a child who:
  - turns 30 when enrolled in a product where the group has purchased the dependent through 29 rider
  - turns 26 when enrolled in a product where the group has not purchased the dependent to 29 rider
  - is 26 to 30 years old and marries, moves out of state, becomes eligible for or enrolls in his or her employer's coverage or is no longer dependent upon the subscriber for support
  - is no longer a student for products such as freestanding dental that may include such limitations
- Former spouses from the date that the marriage is annulled or ends in divorce
- Adults who merely live together and do not qualify as domestic partners (when coverage includes domestic partners)
- Grandchildren, unless the grandparent adopts or becomes the legal guardian of the grandchild
- Foster children placed in the care of foster parents
- Parents, grandparents, aunts, uncles, brothers, sisters, nieces, nephews and other relatives
- Foreign exchange students who live with the host family

What happens when a dependent loses eligibility?

You must process a cancellation transaction immediately when you learn that a dependent is ineligible, or we may not be able to honor your cancellation transaction for the requested date. You should ensure that your employees understand that they need to notify you within a few days, but never more than 30 days, after the date the dependent loses eligibility.

Those who become ineligible under a subscriber's contract include:

- Divorced spouse
- A member who no longer meets the eligibility requirements in the Eligibility Section of this guide
- Deceased dependent
- QMCSO Disenrollment - If a child is enrolled in a Group Health Plan under a QMCSO, the following is required from the group in order to process the cancellation:
  - A court order; and
  - A completed QMCSO disenrollment form

Please see the Retroactive Policy section for further information.

Enrollment and maintenance procedures

We have compiled the information in this section to assist you with enrollment procedures. Our goal is to help you enroll your members quickly and accurately.

We cannot emphasize strongly enough that you must review and reconcile your bill each month to ensure that our membership records for your group are accurate. If you find any discrepancies, please contact the Enrollment Processing Inquiry Unit immediately.

If you are an administrator for an employer group, you are entitled to establish certain policies for your group, by class of employee, at what point a new employee or rehire may apply for coverage and/or which products are available to each class of employee. The following are important decisions you must make and communicate to us, so we can properly create and maintain your group on our system.

Class of employee

Although the employer has a choice in classifying employees, there are limitations based upon NYS insurance law and regulations. To comply with these limitations, we are providing you with the following list of characteristics to take into consideration when determining employee classifications:

- Geographic location of employment (e.g., New York, Ohio, Pennsylvania). This does not pertain to the employee's address or minor differences in geographic location, such as by ZIP code
- Earnings (e.g., commissioned, non-commissioned)
- Method of compensation (e.g., hourly, salary)
- Hours (e.g., full-time, part-time)
- Occupational duties (e.g., management, non-management)
- Family status of the employee (e.g., single, family)

An employer may not establish employee classifications that do not conform to federal or state labor laws, are discriminatory, patently unfair or that create adverse selection.

Common employee classifications include:

- Active/retiree
- Hourly/salary
- Management/ non-management
- Union/non-union

Please note that our systems include COBRA and Young Adult Options (Dependent through 29) as standard employee classifications. Although these individuals were not generally the subscriber when enrolled as a non-continuant, we must include these employee classifications in order to enroll these individuals as the subscriber once enrolled in continuation.

Your group may request a change to its employee classifications throughout the year, provided you submit the request in writing at least 30 days in advance. These changes apply prospectively. To request a change to your group's employee classifications, please contact your group's Account Manager or Broker.

Probationary period

A probationary period is the period of time an employee must wait after the hire date before enrollment in the employer's group coverage. This is also referred to as the employer waiting period. An employer may establish probationary periods that vary for its employee classifications, but may have only one probationary period for each employee classification.

It is recommended for the employer group to break up their classes to offer at least two different active classes. This will allow a group to offer two different probationary periods, which will eliminate the need to request a waiver of probationary period.

For example:

- Non-management: the first of the month 30 days from the date of hire
- Management: no waiting period; effective date is date of hire

For example, an employer may establish a probationary period of 30 days from date of hire for salaried staff and the first of the month following the date of hire for hourly staff. Other common probationary periods are:

- Date of hire
- 60 or 90 days from the date of hire
- The first of the month 30 or 60 days from the date of hire

Employees must meet the probationary period before enrollment, even if the employee experiences an event that would otherwise entitle the employee to a special enrollment opportunity.

An employer's probationary period for health products, may not exceed 90 days from the date the employee became eligible for coverage.

Change an existing probationary period

Your group may request a change in probationary period for a class of employee once per year, provided you submit the request, in writing, at least 30 days in advance. The changed probationary period applies to any employee hired after the effective date of the change. To request a probationary period change, please contact your group's Account Manager or Broker.

Rehired employee

Your group may establish a policy that the probationary period does not apply to rehired employees. A rehired employee is one who has a break in employment of at least one day, but not more than six months.

Our default policy is that rehired employees must meet the probationary period. If your group wants to waive the probationary period for rehires, it must establish this policy by notifying us at least 30 days in advance of the effective date. The changed rehire policy applies to employees rehired after the effective date of the change. To change the rehire policy, please contact your group's Account Manager. For some large employers, there are additional regulatory rules for which you may want to consult with your advisors (e.g., legal counsel) and determine if/how they may impact your eligibility policy.

Key employees:

A fully insured group may request to waive the established waiting period for an employee who is a key employee. It is recommended that approval for the Key Employee be obtained prior to offering to the candidate. We define a key employee as one who is in:

- An advanced level of management; or
- A highly skilled professional or technical position; and
- A position that is extremely difficult to recruit for and fill; and
- The inability to fill that position could cause the organization to fail or go out of business

Typically, this definition applies to CEOs, CFOs, medical doctors (particularly in rural settings) and certain IT positions.

If your company wishes to request a waiver of the probationary period, send a letter on company letterhead explaining the full details of the situation, including the impact if the position remains unfilled, along with any other supporting documentation that may be appropriate and relevant. This waiver is on a case-by-case basis. If we grant a waiver for one employee, it does not guarantee that we will grant any future waivers.

Subscriber level activity

How do I enroll, change or terminate employees or dependents?

Submission of application, web transaction, or electronic file submission

You must submit the request directly to the Enrollment Processing department in accordance with our retroactivity policy, as shown later in this guide. This is true, regardless of whether the application is on paper, submitted through the Web or in an electronic format.

Please submit applications when received, up to 90 days in advance, to ensure the best possible service and to comply with the retroactivity policy below. Do not hold the applications until the end of the month.

You should not wait to terminate an employee or dependent while the individual is in the election period for COBRA, NYS Continuation or the Young Adult Option. If the individual elects continuation of coverage, the individual is entitled to reinstatement of coverage, within the guidelines that pertain to those options.

All transactions require a completed application, electronic file submission or transaction through the web. It is important for the person completing the application or submitting the transaction to acknowledge the fraud statement.

Requests should be submitted within 30 days of an event. If you do not submit requests on time we will deny the request and the subscriber or dependent must reapply at the next open enrollment period or special enrollment.

Re-enrolling an employee vs. reinstating an employee: this is how we define the two –

- Re-enroll (break in coverage): Subscriber had prior coverage under the employer and this coverage has ended. Employee is resuming coverage under the employer but there is a break in coverage from the cancel date to the re-enroll date
- Reinstate (no break in coverage): Subscriber had prior coverage under the employer group and is being reinstated back to the termination date of that coverage with no break in coverage

Re-enrolls:	As a standard process, if the subscriber is re-enrolling within two months (less than 63 day break in coverage) the same Member ID will be kept, and accumulators/limits will carryover. Re-Enroll transactions may be submitted through the web portal as a new add transaction.
Reinstates:	Requesting that a subscriber's cancelled or terminated policy be made active again. Reinstating the cancelled or terminated policy back to the cancellation date is subject to the standard retroactivity policy, as described further in this guide. The Member ID remains the same. Reinstate requests may be submitted through the web portal as an eForm. To request that a subscriber's cancelled or terminated policy be made active again: **Step 1:** Lookup the subscriber's cancelled policy using View/Update Policy **Step 2:** On the View/Update Policy page, under the Policy Information section, select the Reinstate Terminated Policy button and complete the eForm **NOTE:** A policy can only be reinstated via the web eForm within 30 days of termination, so if there is no Reinstate Terminated Policy button, you will need to re-enroll the member in a new policy via the web or submit the application to be processed manually. If outside the standard retroactivity timeframe, user will need to initiate the standard retroactive review process. Reinstate transactions may also be submitted via paper enrollment form or another approved electronic enrollment method (ANSI 834 file, eFile, etc.) The reinstate date is equal to the day after the policy's cancellation date.

Important information on the application

While every field is important, the following sections of the application require special attention to ensure timely processing of the application and accurate claims processing.

Other coverage

Although pre-existing condition provisions cannot be included in medical products since the enactment of the Affordable Care Act in 2014, it is possible that other types of products (e.g., standalone dental/vision) will contain pre-existing condition provisions.

If the benefits for your group are subject to pre-existing condition provisions, it is critical that this section is complete and accurate. If there is a gap in creditable coverage of 63 or more days, the subscriber and/or dependent(s) may be subject to waiting periods.

If the individual checked the box indicating prior coverage, please ensure that all fields in this section of the group enrollment form are complete.

You are responsible to obtain the Certificate of Coverage (COC) issued by the prior carrier or other proof of creditable coverage from the member. You must maintain this information as part of the subscriber or dependent's records, as specified in the eligibility section. We may request the information from you at any time.

If the group enrollment form indicates that other coverage existed, but the section is incomplete, we will send a "portability" letter to the member, requesting the information above.

Proper information regarding other coverage that remains in effect is crucial to the proper administration of coordination of benefits. This important insurer function helps us ensure a claim is not overpaid and keeps our premiums as low as possible. See the Coordination of Benefits section, later in this manual.

Cancellation reason codes

It is important to select the proper code when you submit a cancellation. Please refrain from using the same or a few codes for every transaction. These codes trigger certain activity in our systems, including whether or not an individual is:

- Offered a conversion policy upon termination
- Entitled to a special enrollment period

Primary Care Physician (PCP) enrollment requirements

The primary care physician information is a requirement for enrollment in HMO products. Please note, we will return enrollment requests for HMO products that do not have PCP information completed.

Primary Care Physician change request

Due to requirements in the Health Insurance Portability Accountability Act (HIPAA), group administrators, brokers and Account Managers may not update the PCP information on the member's behalf. Members must contact Customer Care, or visit our website to make PCP changes.

Add a subscriber or dependent(s)

Examples of when your group may add a subscriber or dependent are:

- Employee has fulfilled the probationary period and elected coverage
- Spouse or dependent is newly eligible

If you do not submit an addition in accordance with the retroactivity policy, we will deny your request and the subscriber or dependent must reapply at the next open enrollment period or special enrollment opportunity.

Exceptions to the 30-day retroactivity period:

Adding a subscriber to COBRA continuation of coverage. The COBRA law provides for an extensive notice and election period. We will honor a request to reinstate a member to coverage as a COBRA continuant for a period of up to 179 days for a subscriber related event and 239 days for a dependent related event. We encourage you to wait until the continuant pays his or her first premium before you reinstate the coverage or you may be liable for the premium. Please note that you must still submit the original transaction to terminate the individual within the standard 30 days. The reinstatement to coverage as a COBRA continuant is the only portion that is an exception.

See the COBRA timeline table in the continuation of coverage section

Adding a subscriber to NYS continuation of coverage. The notice and election period for NYS continuation is much shorter than COBRA. We will honor a request to reinstate a member to this coverage for a period of up to 95 days for a subscriber event and 125 days for a dependent event. Please Note: The subscriber/dependent must pay the premium at the time he or she elects NYS Continuation. **Please note:** The subscriber/dependent must pay the premium at the time he or she elects NYS Continuation

- See the NYS Continuation Timeline in the Continuation of Coverage section

Adding a former dependent under the Young Adult Option (YAO). The election period for initial enrollment allows for retroactive enrollment. We will honor a request to enroll a Young Adult if we receive the request within 60 days of the termination date. **Please note:** The subscriber/dependent must pay the premium at the time he or she elects the Young Adult Option.

Change a subscriber or dependent(s)

Benefit changes

Benefit changes are generally restricted to the open enrollment period. An exception to this rule is if your group has different products for members when Medicare is primary. If your group has these products and you provide timely notice, we permit product changes at the point when Medicare changes status from secondary to primary or the reverse. We also allow product changes during certain Special Enrollment Periods, such as when there is a newly eligible dependent.

Demographic changes

We refer to the following and other similar changes to the member's information as demographic changes:

- Address
- Phone number
- Last name or corrections to the spelling of names

You may submit demographic changes at any time. The change is effective the date we enter the information into our system. For a name change, please submit the request in writing or via our website. We suggest you request and maintain a marriage certificate, divorce decree or other records to support a name change.

Change a subscriber or dependent(s)

The ACA placed restrictions on cancellation transactions that it defined as rescissions. Please be certain you read the information under Rescissions in the Retroactive Policy section carefully, as you may be required to provide advance notice of termination to your employees or dependents, and it may restrict your ability to terminate coverage as of the requested date.

A subscriber may voluntarily terminate coverage entirely or remove a dependent at any time during the year. The subscriber does not have to wait until open enrollment. Voluntary terminations must be submitted 30 days in advance. Once terminated, the subscriber must wait until open enrollment or a special enrollment opportunity to rejoin group coverage or add the dependent to his or her coverage.

Enrollment opportunities

There are three times when employees or dependents may enroll. The first is at the point of initial eligibility (e.g., new hire, birth). The second opportunity is when an event occurs (e.g., divorce, loss of coverage) that qualifies the employee or dependent for a special enrollment period. The third opportunity is at the annual open enrollment period. The following sections explain these three periods.

Initial enrollment

If an employee does not enroll himself/herself or dependents when initially eligible, he or she will not have a second opportunity until open enrollment or a special enrollment event.

New hire

A new employee is eligible to enroll at the end of the probationary period established for his/her class of employee.

Rehire

In accordance with the rehire policy selected by your group, the rehire is eligible either from the date of hire or at the end of the probationary period. See the Probationary Period section for further information.

Newly eligible dependent

The following events qualify a dependent for addition to the subscriber's coverage:

- Marriage (the spouse and any qualified stepchildren)
- Adoption of a child, spouse and employee or a qualified proposed adoptive child (the adoptive or proposed adoptive child)
- Birth (the newborn)
- A Qualified Medical Child Support Order (QMCSO) is issued

If the employee has certain newly eligible qualified dependents and the employee has not enrolled in coverage, the employee and his or her spouse may qualify to enter coverage along with the new dependents and spouse, due to a special enrollment event. See below.

Special enrollment period

Certain events qualify employees and/or dependents for enrollment opportunities during the plan year, rather than at open enrollment. These events typically are major life events that affect coverage decisions. However, these events do not supersede the probationary period. An employee is not entitled to enroll until the end of his/her applicable probationary period.

If the employee does not currently have coverage because the employee previously waived coverage and experiences certain special enrollment events, the employee may be qualified to enroll in coverage outside open enrollment and add some or all qualified dependents, depending on the event and the type of dependent.

If a member submits an application on a timely basis, it is your obligation to accept and forward applications for enrollment, whenever one or more of the following events occur.

Involuntary loss of coverage

Loss of coverage under another employer's or spouse's plan due to:

- Change in working hours
- Termination of employment
- Other employer terminates coverage or ceases to contribute to the cost of coverage
- Divorce
- COBRA or other continuation maximum period is reached

New dependent

A new dependent due to:

- Marriage
- Birth
- Adoption or qualified proposed adoption
- Legal guardianship

Former dependent regains eligibility for coverage

- Dependent through 29 – for example: a dependent who is 27 years old moves back into New York state
- Dependent to 26 – for example: a 21-year-old dependent returns to college and regains eligibility for a freestanding dental product with 19/23 coverage for dependents

Medicare status changes

- Medicare eligibility or Medicare primary/secondary status change, which necessitates a change of product
- When a subscriber becomes Medicare eligible and the group offers a Medicare policy, dependents of his/her family may remain eligible on the group policy. That family member will be allowed to become the subscriber on their own policy within the group, if the dependent was active on the subscriber's plan at the time of Medicare eligibility
  - The dependent will be allowed this coverage for the remainder of time that the subscriber carries their Medicare primary plan with the group, or they age off the coverage before then
  - If you have further questions on this, please contact your Account Manager

Network limitations

- The subscriber moves out of the service area of a limited network health plan (e.g., HMO), and your group offers other coverage without a limited network

Eligibility for government-sponsored program or premium assistance

- Loss of eligibility for a government-sponsored program, such as Medicaid
- The employee or children become eligible for premium assistance through Medicaid or Child Health Plus in an eligible state, such as New York state or Pennsylvania

If you have questions regarding whether an event qualifies the employee for a special enrollment period, please contact your Account Service Consultant for assistance.

Events that do not create a special enrollment:

- Voluntary loss of coverage
- Early termination of COBRA due to nonpayment
- The spouse's employer raised employee contribution, but did not cease contributions

Annual open enrollment period information

Once per year, an employer must offer employees the opportunity to participate in open enrollment.

Open enrollment does not supersede the probationary period. An employee is not entitled to enroll until the end of his/her applicable probationary period.

Employee options at open enrollment

Open enrollment is the time when employees may:

- Change benefits if the employer offers more than one product to the employee's class of employee (e.g., union employees)
- Enroll in coverage, if the eligible employee declined enrollment when initially eligible or subsequently disenrolled
- Add eligible dependents who:
  - did not enroll at initial eligibility or a subsequent special enrollment opportunity
  - were previously disenrolled from coverage or who lost eligibility and have subsequently regained eligibility
- Voluntarily disenroll existing dependents

Group level activity

Group level activity is a change that affects all or a defined portion (e.g., a particular employee classification) of the group, rather than activity that affects a particular subscriber or dependent.

We have designed this section to help you understand and follow the requirements which allow us to administer your overall group benefits in the most accurate and efficient manner possible.

In general, your group may add a new benefit or change benefits only at your group's renewal date. You may terminate an existing benefit at any time.

You should advise us of any group level activity at least 30 days in advance, to ensure that we can process the change well in advance of the effective date for the following reasons:

- Ensures that new member cards and benefit certificates are in the member's hands before the changes go into effect
- Provides time for the member and providers, if applicable, to follow product protocols, such as preauthorization, to avoid penalties
- Allows the member to take full advantage of any rewards programs built into the product
- Enhances member satisfaction

If you need a quote for alternate benefits, please contact your Account Manager or Broker. We suggest you request a quote at least 60 days in advance of your renewal date, to allow time to review the quotes and make a decision. If you are adding a new benefit and employees will have to review the selections and make choices, you may want to request a quote 90 days in advance of your renewal date.

Please submit new benefit, change to benefit, and termination of benefits requests to the Sales department.

Please submit new benefit, change to benefit, and termination of benefits requests to the Sales department.

Group activity transactions

Adding a new benefit

This transaction is to add an entirely new product offering (e.g., a second health plan option to your existing package of benefits, such as a high deductible health plan).

You must provide:

- A signed rate sheet for the new plan offering
- A memo or similar document to indicate that you are adding a new plan and not replacing an existing offering. Include whether you have web access
- New applications (either paper or electronically) for all members who are not presently enrolled with us and who:
  - Elect the new benefit(s), or
  - Change to the new offering

If you perform subscriber maintenance via our website, you must wait until we add the new benefit to your group before submitting subscriber requests.

Change an existing benefit

This transaction is to change everyone enrolled in existing Product A to a new Product B (e.g., from a PPO with a $20 copay to a PPO with a $25 copay).

You must provide:

- A signed rate sheet for the new plan offering
- A memo or similar document that indicates you are replacing your current plan with the selected option and instructions
  - Requesting us to transfer all membership from Product A to Product B, or
  - That you will perform the maintenance electronically

Terminate an existing benefit

This transaction is to terminate an existing benefit. For example, your group no longer provides coverage for gym memberships.

Please provide us with a memo or similar document that includes:

- The specific package you wish to terminate
- The effective date of termination
- Instructions regarding the treatment of terminated members. For example, transfer members from Product C to Product D

Terminate a subgroup

This transaction is to terminate all coverage for one or more subgroups. For example, your group no longer provides coverage for retirees or has closed a location.

Please provide us with a memo or similar document that includes:

- The specific subgroup you wish to terminate
- The effective date of termination
- Instructions regarding the treatment of terminated members. For example, please advise us:
  - To terminate the member(s) from the subgroup without transfer, or
  - Transfer the member to another subgroup that your group offers. Provide the destination subgroup and benefit plan for these members, or indicate that you will initiate the transaction electronically

Terminate a group

This transaction is to terminate all coverage for a group. Please provide your Account Manager with a memo or similar document that includes the group number you wish to terminate.

Medicare

Employer group watch list

Member transition to medicare coverage and how to prevent impacting the members' coverage:

- Any group size changes where the number of employees fall above or below 20 total employed
- Any group size changes where the number of employees fall above or below 100 total employed
- All Medicare information for subscribers and their dependent(s) as they become Medicare eligible
- Any change in working status of employees where the subscriber or their dependent are Medicare eligible
- Supply all health and/or drug coverage you are aware the subscriber and/or their dependent are currently enrolled in and are Medicare eligible. This is to ensure coordination of payment

Medicare is a federal health benefits program available to people based on age (65 or over), disability or condition (e.g., end-stage renal disease).

There are different types of medicare fee-for-service coverage

1. **Part A** – Covers institutional services, such as hospital or skilled nursing facility when followed by an inpatient hospital stay, subject to Part A deductibles and copayments.
2. **Part B** – Covers professional medical services, outpatient hospital services, ambulance services, durable medical equipment, medical supplies, services of other qualified health care professionals such as physical therapists. These services are subject to Part B deductibles and coinsurance.
3. **Part C** – Covers services under Part A and Part B, referred to as a Medicare Advantage Plan (like an HMO or PPO) may also include additional benefits, as well as prescription coverage. Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are offered by private companies approved by Medicare.
4. **Part D** – Covers prescription drug benefit as a voluntary benefit for people with Medicare provided through private plans that contract with the federal government.

The Centers for Medicare and Medicaid Services (CMS) administers Parts A and B. Parts C and D are administered by private insurance companies under the supervision of CMS.

Coordination of benefits for Medicare members

Medicare Secondary Payer (MSP) is coordination of benefits specific to Medicare. Medicare has rules that specify when it is the primary or secondary payer of benefits. You, as the group administrator, are responsible for understanding how these MSP rules and regulations apply to your group and to report your group's size accurately as well as supply the members' working status when the account has a Medicare Beneficiary.

MSP coordination does apply to all Medical and RX coverage including Commercial policies and any Medicare Advantage or Prescription drug coverage the member may have to determine which policy pays primary.

It is important to know how Medicare works with other kinds of health or drug coverage and who should pay the members bills first. This is called "coordination of benefits."

If a member has Medicare and other health or drug coverage, each type of coverage is called a "payer." When there's more than one potential payer, there are coordination rules to decide who pays first.

The first or "primary payer" pays what it owes on the members bills, and then sends the remainder of the bill to the second or "secondary payer." In some cases, there may also be a third (tertiary) payer.

As the group we ask that you notify the health plan about all of the health and/or drug coverage you are aware your members have to make sure their coordination to pay bills are sent to the right payers, in the right order.

Working aged rules

These rules apply to employees who are over 65, eligible for either Medicare Part A or B, actively working during the specified time frame and who receive a health benefit as a condition of employment.

- If the company has 19 or fewer employees, Medicare is primary and we are secondary
- If the company has 20 or more employees, Medicare is secondary and we are primary

Retiree rules

Medicare is the primary payer for retired employees who are over 65, regardless of the group's size.

Disability rules

These rules apply to employees who are under age 65 and eligible for Medicare due to disability.

- If the company has fewer than 100 employees, Medicare is primary regardless of whether the employee is in active employee status or not. We are the secondary payer
- If company has 100 or more employees during the specified time frame and subscriber is actively working, Medicare is the secondary payer and we are primary
- If a subscriber is not in active employee status, regardless of company size, Medicare is primary to subscriber's plan for Medicare eligible members
- In cases of Medicare eligibility due to a disability and the disability ends, we require the letter from CMS indicating when this ended.

Health reimbursement arrangement rules

If the subscriber has an active HRA (Health Reimbursement Arrangement) in which the employer has provided an annual benefit of $5000.00 or more or due to carry-over options in an HRA, the value of the HRA starts at less than $5,000 but grows to meet or exceed $5,000, Medicare is secondary and we are primary.

Health savings account rules

Medicare beneficiaries should not make a current year contribution to an HSA (Health Savings Account) or make a contribution during the time he/she becomes a Medicare beneficiary. Medicare beneficiaries who continue to contribute funds to an HSA may face IRS penalties including payment of back taxes on their tax-free contributions and account interest.

End-Stage Renal Disease (ESRD)

These rules apply to all participants enrolled in the group's coverage, if

- The employee is in active status (regardless of age) or the employee is disabled and under 65
- The member is diagnosed with permanent kidney failure, based on a diagnosis consistent with ESRD, such as chronic renal failure

If the member has dialysis:

- A 30-month coordination period applies where the group's health insurer is the primary payer before Medicare
- After 30 months, Medicare is primary and the group's health plan is secondary

If the member receives a transplant:

- At the end of the coordination period, Medicare becomes primary
- If a member receives a successful kidney transplant, Medicare eligibility ends 36 months after the successful kidney transplant
- The Centers for Medicare & Medicaid Services (CMS) sends the member a letter once Medicare ends. The member must provide this letter to us, so that we may process claims accordingly

We correspond directly with members who are eligible for Medicare due to ESRD to obtain the effective dates for Medicare Part A and B and to ensure we are processing claims in accordance with Medicare Secondary Payment rules.

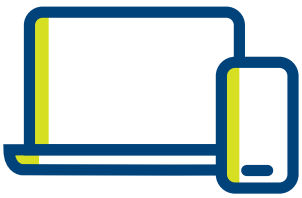
Note that we cannot provide the group with any information or ask for anything from the group regarding ESRD due to HIPAA.

As described on the previous page, whether Medicare pays first depends on a number of things. The following chart supplies a quick guide to coordination for the more common scenarios:

Working aged rules	
If 65 or older, currently employed, and the employer has **20 or more employees...**	Group health plan pays first.
If 65 or older, currently employed, and the employer has **fewer than 20 employees...**	Medicare pays first.
Retiree rules	
If member has retiree insurance (insurance from former employment)...	Medicare pays first.
Disability rules	
If under 65 and have a disability, currently employed, and the employer has **100 or more employees...**	Group health plan pays first.
If under 65 and have a disability, currently employed, and the employer has **fewer than 100 employees...**	Medicare pays first.
End-Stage Renal Disease (ESRD) rules	
If member has group health plan coverage based on their current employment, and they are eligible for Medicare because of End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant)...	Group health plan will pay first for the first 30 months after they become eligible to join Medicare. Medicare will pay first after this 30-month period.

Remember these important facts about coordination of benefits:

- The insurance that pays first (primary payer) pays up to the limits of its coverage
- The one that pays second (secondary payer) only pays if there are costs the first payer didn't cover
- The secondary payer (which could be Medicare) might not pay all of the uncovered costs
- If Medicare is the primary payer and the employer is the secondary payer, the Beneficiary will need to join Medicare Part B (Medical Insurance) before the employer insurance will pay for Part B services
- Medicaid and TRICARE never pay first for services that Medicare covers. They only pay after Medicare, employer group health plans, and/or Medicare Supplement Insurance (Medigap) have paid



This is a simplified explanation, and there are many exceptions to the above rules and regulations. Special rules apply to owners of companies, association-type groups, clergy/religious order members, part-time employees, domestic partners and same-sex spouses.

Please visit **Medicare.gov** for additional Medicare information.

Medicare Advantage/Medicare supplement/ Simply Prescriptions group coverage

Our mailing address

Medicare Division, P.O. Box 211316, Eagan, MN 55121

Customer Care – contact information

Questions specific to an individual member's claims or benefits should be directed to our Medicare Customer Care advocates at **1-877-883-9577.**
TTY phone number:**1-800-662-1220.**

Hours of operation:

October 1 through March 31 8:00 a.m. to 8:00 p.m. seven days a week
April 1 through September 30 8:00 a.m. to 8:00 p.m. Monday through Friday

Enrollment – contact information

Enrollment – employer group email:
Medicare.Group.Inquiries@UniveraHealthcare.com

Questions regarding the enrollment status or eligibility of a Medicare member can be directed to your Account Service consultant.

Eligibility

Members must meet the following eligibility requirements to enroll in a Medicare Advantage (MA) or Medicare Advantage – Prescription Drug (MA-PD) Plan:

- Simply Prescriptions enrolled in Part A and/or B with D
- MA-PD enrolled in Parts A, B and D
- Permanent resident of the plan service area

All enrollments in MA, MA-PD and Simply Prescriptions are processed as single contracts. Any dependents of eligible members must qualify for Medicare individually in order to be eligible to enroll in a MA, MA-PD or Simply Prescriptions Plan. For those members with a spouse or dependent who is not Medicare eligible, the spouse or dependent may enroll in a non-Medicare plan if offered, commonly referred to as "commercial" coverage. Commercial enrollments are handled separately and may have different eligibility guidelines.

Plan service area

The approved plan service area for MA and MA-PD Plans is listed below.

Covered counties in New York state:
Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming.

Univera SeniorChoice HMO-POS Plans

- The Employer Group must be headquartered in one of our eight counties listed above.
- The Employer Group members must live in above Plan service area in order to enroll in.
- When submitting application, we must know the member's permanent residence within the service area. If that is missing, or the member is outside of the service area, they may not be enrolled.

Univera Medicare PPO Plans

- The Employer Group must be headquartered in one of our eight counties listed above.
- The Employer Group members can live anywhere in the United States and Puerto Rico.

Enrollment

Univera Healthcare must receive a signed paper application from each member who is enrolling in a MA, MA-PD, PDP and Simply Prescriptions Plan.

New group enrollment applications

- It is important that the correct employer group enrollment forms are used. If a member completes an "Individual" enrollment form, he/she will be enrolled in an individual plan
- Please review all enrollment forms for completeness to ensure proper processing
- When new enrollment is submitted the plan must receive a member signed application from each member who is enrolling in a Simply Prescriptions, MA, MA-PD and PDP plan unless the group is utilizing an electronic enrollment option
- The group representative cannot sign enrollment on behalf of the member
- The group enrollment form needs to include the correct current group structure information including: group number, subgroup number, class, plan and enrollment code
- If we determine that the group enrollment form is incomplete, we will send a request to the member in order to obtain the additional information

Medicare Advantage benefit changes

Mandated benefit changes

During the year, Congress may mandate Medicare to provide coverage for specific items. These changes generally are effective the first of the year; however, effective dates may vary. Centers for Medicare & Medicaid Services (CMS) requires that each member receive notification of these benefit enhancements, as well as any other plan benefit changes.

We will notify members and groups directly of any mandated Medicare benefit changes.

Voluntary group benefit changes

Voluntary benefit changes may be requested on renewal and must be received by us no less than 30 calendar days prior to the requested effective date.

In addition, group MA and MA-PD members must be provided with written notice of any change in benefits, contributions or service areas at least 30 days prior to the effective date of the change. Employer groups that voluntarily make changes to its plan offering are responsible for mailing this notice to their members. Records of the notification and the dates should be retained in the event of any CMS audit(s).

Individual notification of changes

Annual Notice of Change (ANOC)/Evidence of Coverage (EOC)

Each September, CMS requires MA and MA-PD organizations to provide written notification to each MA or MA-PD member detailing all the benefit changes or enhancements, as well as any service area changes that affect all members.

- This annual mailing is sent to members based on the active benefit package as of August 1

Miscellaneous

Reinstatements

If a member unintentionally disenrolls from the employer group MA or MA-PD Plan due to enrollment in another similar plan he/she may be reinstated under certain circumstances.

Deliberate and intentional disenrollments made by the member are only eligible for reinstatement if the member directly contacts the other plan to cancel his/her enrollment prior to the effective date of a deliberate disenrollment. This request is the responsibility of the member and cannot be performed by the employer representative.

Enrollment cancellation

Cancellations may be necessary in cases of mistaken enrollment made by a member. A member may cancel his/her enrollment only by contacting us prior to the effective date of the enrollment. Cancellations properly made to the plan sponsor prior to the effective date of the enrollment request being cancelled are also acceptable. Plan sponsors must submit appropriate documentation showing that the member contacted the plan sponsor prior to the effective date of coverage in order to cancel the enrollment.

Requests to cancel an enrollment that are made after the effective date of coverage will be considered for disenrollment effective the first of the following month.

Address changes

When an address for a member has changed, it is the responsibility of the member to notify us by contacting Customer Care at the phone number listed on their member card. If it is determined that the member resides outside of our plan service area as a result of the move, then the member will no longer be eligible to stay in one of our MA or MA-PD plans and must be disenrolled.

Individuals' demographic changes

Includes name changes and date of birth changes.

For updates to personal information due to typographical errors by us, notifications can be made to Customer Care for correction. However, other updates to personal information must be initiated by the member through the Social Security Administration. We will be notified of these changes electronically by CMS daily. Once the change is processed, the member's information will be updated and a new member card will be issued if necessary.

Electronic enrollment options

Electronic enrollment options for Medicare Employer Groups are now available. There are two file types available for use.

Group electronic application file – This file is utilized for new enrollment into the employer group or enrolling into a new plan contract type, e.g., HMO, PPO, PDP Medicare Plans.

Member to member file – This file is utilized for benefit changes to existing members within the same contract type, e.g., HMO, PPO, PDP Medicare Plans within the same employer group number.

There is the companion document to assist with electronic files for Medicare Advantage Employer Group member level processing. To obtain a copy of the companion document reach out to your Account Service Consultant. The process is to provide Groups that offer Medicare Advantage (MA) coverage to their eligible subscribers an electronic means of application submission for the individuals enrolling into or changing Medicare Advantage enrollment within their Employer Groups through an electronic file submission.

There are two types of files that can be used:

New file template (Medicare formatted electronic file)

- If templates are being utilized for both HMO & PPO products, two different enrollment files must be submitted for the group. One for HMO and another for PPO. The two cannot be combined on one file
- The OEC file will be used for those new to MA plan as well as those that are changing from one contract to another
  - Ex: use this file type when an existing member is changing from HMO to PPO
- When moving from one contract to the other, member will automatically be termed from current contract; a separate disenrollment is not necessary
  - Ex: member is moving from HMO to PPO. Once HMO enrollment is processed PPO will auto-term for the day prior to the HMO effective date.

Existing group plan changes

- This file should be used for existing groups making plan changes or benefit changes within the same contract line – PPO to PPO or HMO to HMO
  - For example, do not use this file type for HMO to PPO even for existing groups

Disenrollments, cancellations, or terminations of coverage cannot be accepted through this mechanism

Any group that wishes to utilize the alternative enrollment method contact your Account Consultant for further information regarding group requirements and responsibilities

The group must retain and be able to provide to the plan the source of the member's election to the plan being requested for 11 years, in the event CMS requests such documentation within an enrollment audit

Effective date of enrollment

All enrollment forms must be signed prior to the requested effective date and must also have the requested effective date listed on the enrollment form. In no event can the requested effective date be prior to the date the member signed the application.

The enrollment process

After an enrollment form is entered into the Univera Healthcare membership system, an electronic file is sent to CMS to verify eligibility for each member. If the enrollment is accepted, each member will be mailed a letter that acknowledges and confirms their enrollment and includes the effective date of coverage. If the enrollment is denied, the applicant will receive a denial letter; and he or she will be individually responsible for paying the cost of all medical or pharmacy services received while the enrollment application was pending.

If the enrollment form is incomplete or eligibility cannot be verified, a letter is mailed to the member requesting the additional information needed to complete the enrollment. The enrollment process will not continue until the additional information is received and Medicare eligibility is verified. If the needed information is not provided by the member within 21 calendar days or the end of the month, whichever is later, the application will be rejected as it is assumed the member is no longer interested in enrolling in the MA or MA-PD Plan.

NOTE - member contact

With regard to member eligibility for MA and MA-PD Plans, we may need to contact the member directly for additional information. It is important that we ensure that the member is making a fully informed decision in regard to his/her enrollment choices. While the plan sponsor may be able to provide particular information specific to a member's enrollment request, we may need to contact the member directly over-the-phone or by mail to verify information.

Disenrollment

Disenrollment process – entire group

If the plan sponsor wishes to terminate the group MA or MA-PD Plan, a written request must be received by us 45 days prior to the requested termination date.

We must notify a member at least 21 days prior to a plan sponsor termination that he/she has the option to enroll in a MA or MA-PD Plan as a direct pay individual. We will provide affected plan sponsor's members with this notice at least 21 days prior to the plan termination. If we receive written notice of plan termination less than 45 days before the requested termination date, we will extend the termination date of the group contract by one month in order to meet the CMS required time frames for this member notification. Retroactive disenrollments will not be processed and are not allowed due to notification requirements for the member per CMS guidance.

Disenrollment process – specific individual

The plan sponsor will establish its own criteria for member eligibility in its plan. If it is determined that a member no longer qualifies for the group status, the plan sponsor must submit appropriate documentation to request the involuntary disenrollment of the member. This documentation must clearly state the reason why the member is no longer eligible and provide a minimum of 30 day notification prior to disenrollment. If 30 days notification is not provided by the plan sponsor, we will extend the disenrollment date of the member by one additional month in order to meet the CMS required time frames for member notification. The plan sponsor should maintain records of the notification and the dates in the event of any CMS audit(s).

Disenrollment process – individual initiated

If a member requests to voluntarily disenroll from the employer-sponsored plan, he/she may submit his/her own written request to us to do so. CMS requires that these requests be processed regardless of the member's enrollment in an employer-sponsored plan. These types of requests are processed for the first of the following month after the written disenrollment request is received. In addition to this form of disenrollment, if a member enrolls in another MA or MA-PD Plan he/she will be automatically disenrolled from his/her current plan. In order to re-enroll, a new enrollment application will need to be submitted.

Disenrollment process – Medicare Supplement plans

Disenrollment requests are processed for the first of the following month after the written disenrollment request is received or for a specific date as long as the effective date is written on the request and there has been no claims utilization.

Upon notification to the Plan, a group may disenroll a member from a Medicare Supplement plan for:

- Loss of eligibility
- Non-payment of premiums
- Death (The group must send the Plan written notification of a member's passing along with date of death)

A group may also disenroll a member if he or she is moving to a MA plan. Enrollment into a MA plan does not automatically terminate the Medicare Supplement plan. The termination date will be determined by the receipt date of the disenrollment request. The request should be received prior to the effective date of the MA plan in order to prevent the member from having overlapping coverage.

Disenrollment process – Medicare initiated

In certain cases, a member may be involuntarily disenrolled from an MA or MA-PD plan due to loss of eligibility for continued enrollment. We are notified of these eligibility changes electronically each week by CMS. The list below provides examples of when a member may be involuntarily disenrolled:

- Loss of entitlement to Medicare Part A
- Termination of enrollment in Medicare Part B
- Permanent move outside of the plan service area
- Enrollment in another MA and/or MA-PD Plan
- Death

When we complete an involuntary disenrollment for one of the above reasons, we will send written notification directly to the member or his/her estate.

Low Income Subsidy (LIS)

Medicare also provides extra help (a subsidy) with Part D prescription drug costs and premiums for eligible individuals whose income and resources are limited. This help takes the form of subsidies paid by the federal government to the Medicare Prescription Drug Plan in which the eligible individual enrolls. The subsidy provides financial assistance with the premium, deductible and copayments/coinsurance of the program.

Further information on the low income subsidy can be found on the Social Security Administration (SSA) Web site at SSA.gov.

Low Income Subsidy eligibility

- Individuals become LIS eligible either by being deemed eligible by CMS or through application to the SSA
- Individuals are eligible when they receive Medicaid benefits either as a full dual eligible or a partial dual eligible or if they are a Supplemental Security Income (SSI) recipient. Individuals are often deemed retroactively and are always deemed through the end of the calendar year
- Individuals that apply for LIS through SSA may gain, lose or have a change to their LIS status at any point during a calendar year

Low Income Subsidy enrollment process

We are notified of LIS status changes on a regular basis by CMS and by individual members. If it is determined that a member is eligible for this subsidy, the member's enrollment will be updated accordingly once our Medicare Enrollment Department receives notification.

Low Income Premium Subsidy pass through requirement

Plan sponsors are required to comply with the same requirements related to the low income premium subsidy amount that applies to Medicare Prescription Drug plan sponsors offering Part D plans to individual beneficiaries. Any low income premium subsidy amount paid on behalf of a member who is LIS eligible must first be used to reduce any portion of MA-PD or PDP Plan premiums paid by the member. Any remainder may then be used to reduce any portion of the plan sponsor's MA-PD or PDP premium contribution.

For plan sponsors with a community rated or prospective experience rated MA-PD or PDP Plan, we will reduce the monthly premium charged to the plan sponsor for the LIS beneficiary. It is the responsibility of the plan sponsor to reduce the LIS eligible member's contribution to premiums or refund the appropriate amounts directly to him/her within 45 days from the date we receive the subsidy payment from CMS.

For plan sponsors with a claims-based billing arrangement or self-funded arrangement, we will issue a refund check directly to the plan sponsor for the premium subsidy amounts received on behalf of the LIS eligible member. It is the responsibility of the plan sponsor to reduce the LIS eligible member's contribution to premiums or refund the appropriate amounts directly to the LIS eligible member within 45 days from the date we receive the subsidy payment from CMS.

Medicare creditable coverage

Plan sponsors who offer prescription drug coverage are required to notify Medicare eligible policyholders whether their prescription drug coverage is creditable coverage. Creditable coverage is coverage that is expected to pay on average as much as the standard Medicare prescription drug coverage. Please visit CMS.gov/CreditableCoverage for more information.

Medicare late enrollment penalty

Individuals eligible for Medicare who do not join a Medicare Prescription Drug Plan (Part D) when they are first eligible, and who do not have prescription drug coverage that is at least as good as standard Medicare prescription drug coverage (creditable drug coverage) may pay a late enrollment penalty if they later join a Medicare Prescription Drug Plan. Individuals must pay the late enrollment penalty if they join a Medicare Prescription Drug Plan after having a period of 63 days or longer without Medicare prescription drug coverage or other creditable prescription drug coverage after they are first eligible to join. This period will start three months after they are eligible to join a Medicare Prescription Drug Plan. Individuals are eligible to join a Medicare Prescription Drug Plan once they are entitled to Medicare Part A and/or enrolled in Medicare Part B.

Individuals will have to pay a penalty for every month he/she was eligible to join a Medicare Prescription Drug Plan and was not enrolled in one. They will have to pay this penalty in addition to his/her monthly premium for as long as they are enrolled in a Medicare.

Prescription Drug Plan.

The late enrollment penalty amount is at least 1% of the Part D national average premium for each full uncovered month that an individual was eligible to join a Medicare Prescription Drug Plan and did not.

Upon application for enrollment in a MA-PD Plan, the Medicare Enrollment Department will consult CMS eligibility systems and our internal eligibility systems for the following information.

- The date the member was first eligible to enroll in a Medicare Prescription Drug Plan
- The start and end dates of any period in which the member was previously enrolled in a Medicare Prescription Drug Plan
- The start and end dates of any period in which the member was enrolled in a creditable drug plan for which a former employer or union was receiving the retiree drug subsidy from CMS
- The start and end dates of any period in which the member was enrolled in a creditable drug plan offered by the same plan sponsor through Univera Healthcare

If we determine that the member had a period of 63 days or longer without Medicare prescription drug coverage or other creditable prescription drug coverage, we will calculate the number of full months that the member did not have coverage.

The late enrollment penalty will appear on the plan sponsor's monthly bill for any member that is subject to the late enrollment penalty. The plan sponsor has the discretion to pay the penalty amount on behalf of their members or to bill the member for the penalty amount. Regardless of which option is chosen, the plan sponsor is responsible for remitting the entire amount due to Univera Healthcare each month.

How to determine if a member will have a gap in creditable drug coverage:

- The Part D plan sponsor shall determine, at the time of enrollment, whether a beneficiary who enrolls in Medicare drug plan will have or had a break in creditable prescription drug coverage for a continuous period of 63 days or more any time after they were first eligible to enroll in a Medicare prescription drug plan
- In general, the Part D plan sponsor shall follow the steps described below to determine whether there has been a qualifying break in creditable prescription drug coverage since the end of the Part D Initial Enrollment Period (IEP), subsequent IEP, or Part D/RDS enrollment

1. Following Part D/Retiree Drug Subsidy (RDS or Employer Subsidy) disenrollment: The period in question begins on the effective date of the member's disenrollment from the prior Part D or RDS plan and ends on the day before the beneficiary's enrollment becomes effective with the current Part D plan sponsor.
2. The end of the Part D Initial Enrollment Period (IEP) (Original Medicare Part D): For individuals who did not have a prior MAPD plan or RDS/Employer Subsidy enrollment and are not in their subsequent IEP (when the member turns 65), the period in question begins the 1st day of the 4th month out following the Original Part D and ends on the day before the beneficiary's enrollment becomes effective with the MAPD plan sponsor.
3. The end of the subsequent IEP (when the members turn 65): An individual who is entitled to Medicare prior to turning age 65 (e.g., those who were entitled based on disability), will have a new or subsequent Part D IEP when they become entitled to Medicare based on age.
4. Creditable coverage period determinations for Low-Income Subsidy (LIS) eligible: The Part D plan sponsor shall make a creditable coverage period determination only if the individual loses his/her LIS-eligibility, disenrolls from Part D plan sponsor, incurs a qualifying gap in creditable prescription drug coverage, and is not LIS-eligible at the time of reenrollment or at the time the enrollment is effective in a Medicare prescription drug plan.

Please note:

Once the plan has researched the prior coverage we will only send out the letters and forms to members who we either could not find any creditable drug coverage or deemed the commercial coverage that they were under as "Non-creditable".

What to do if member has gap in coverage:

- Inform the member that if the plan determines they have a gap in creditable drug coverage, they will be receiving a letter in the mail with a form. The letter will indicate the time frame of the gap in coverage. The form provided will state "Declaration of Prior Prescription Drug Coverage"
- Please do not take the member's creditable drug coverage information when you are with them or helping fill out the application. If needed, we will reach out to the member
- Please tell the member that they must either return this form filled out by mail or fax, or they can call into our Customer Care call center and provide a representative with their prior creditable drug coverage information
- The member will need to provide us with whom they had the prior creditable drug coverage through (ex: prior Insurance company, drug company, or Employer group)
- They will also need to inform us of the start and end dates of that Prior Creditable Drug Coverage

Please note:

The Employer Group is responsible for sending out Creditable Drug Coverage letters to members of their employer group coverage.

Medicare employer group billing and payment information

Billing

It is important that you reconcile your billing statement each month to ensure that all members being billed are still active and enrolled in the correct MA or MA-PD plan. This will ensure that our records are up-to-date, allow timely claim payments and prevent denials of activity requests due to CMS retroactivity guidelines.

Payments.

- Submit the payment with the payment remittance stub to the address shown on the reverse side of the remittance stub
- Do not send any activity with your premium payment to our bank lock box. Activity such as new adds, cancellations or changes will not be processed with your payment

Top communications where responses are needed

Regulatory or needed response communications that may be sent to members:

- Reaching Age 65 Letter
- Medicare Advantage Survey C and D (Annual) – survey sent to our Medicare Advantage members asking them to validate our COB for Part C and D information
- Coordination of Benefits (COB)/Workers Compensation/Motor Vehicle questionnaires
- Request for Information (RFI) – request for information to complete Enrollment
- Late Enrollment Penalty (LEP) survey
- Retiree Drug Subsidy (RDS) – in the Direct (Broker) section

The following information is for when a member is transitioning to Direct pay – Medicare Advantage – A tip sheet for employer groups that do not offer Medicare Advantage plans to their members:

Medicare tip sheet

The Medicare Beneficiary will have to make several important decisions about their Medicare Coverage.

If they don't enroll in Medicare when first eligible, there could be some long-term financial consequences, including late enrollment penalties or a delay in effective date. We are here to help. Call us at 1-888-841-5604 (TTY: 1-800-662-1220).

There are four parts to Medicare

PART A – Hospital coverage (original Medicare)

- Helps cover inpatient hospital and skilled nursing, hospice care, and home health care
- No monthly premium applies for most people
- Penalties may apply if they don't enroll when first eligible

PART B – Medical insurance (original Medicare)

- Helps cover medically-necessary services like doctor services, outpatient care, and other medical services
- Monthly premium applies
- Penalties may apply if they don't enroll when first eligible

PART C – Medicare Advantage plans

- Offers an alternative way to receive their Medicare Part A and Part B benefits that typically includes additional benefits and lower out-of pocket cost when using services
- Can include Part D prescription drug coverage
- Offered through private health insurance companies
- Monthly premium may apply

PART D – Prescription Drug Coverage

- Helps cover the cost of prescription drugs
- Offered through private health insurance companies as a stand-alone plan or as part of Medicare Advantage (Part C) plan
- Monthly premium may apply
- Penalties may apply if they don't enroll when first eligible and don't have creditable drug coverage

When is a Medicare beneficiary eligible to enroll in Medicare?

There are several reasons a beneficiary may be eligible:

- Turning age 65
- Disability
- End Stage Renal Disease (ESRD)

If the beneficiary is turning age 65, they have a seven-month window to enroll in Medicare...

- Three months before the month they turn 65 (recommended to enroll at this time)
- The month they turn 65
- Three months after they turn 65

How does a Medicare beneficiary enroll in Medicare?

Call Social Security at **1-800-772-1213** (TTY users 1-800-325-0778), Monday through Friday, from 7 a.m. to 7 p.m.

Go in-person to their local Social Security office.

Online visit **SocialSecurity.gov**

Common scenarios to help guide the Medicare beneficiary in deciding which parts of Medicare they need to enroll

If they....	Consider...	Keep in mind...
Are turning 65 and are working full time (or covered by a spouse working full time)	**Part A** They should enroll in Part A when first eligible unless they are on a HDHP and intend on contributing to an HSA.	Once they enroll in any part of Medicare, they won't be able to contribute to their HSA. Consult a tax professional for more information about HSAs and Medicare.
	Part B They can delay signing up for Part B if they are working full time at a company with 20 or more employees. If their employer has less than 20 employees or they are self-employed, then they should enroll in Part B when first eligible to avoid penalties.	They will NOT pay a penalty for delaying Part B, as long as they enroll within eight months of losing their coverage or stopping work, whichever happens first. To clarify, the only time the member won't pay a penalty is if they are working for an employer with more than 20 employees, so it would be recommended that they talk to their employer group's benefits administrator before deciding to delay enrollment in Medicare.
	Part C Enrolling in a Medicare Advantage plan is optional. Talk with an Univera Healthcare Advisor to see if enrolling in a Medicare Advantage plan is a good fit for them.	They must have Medicare Parts A and B and live in the plan service area to enroll in a Medicare Advantage (Part C) plan.
	Part D If they have drug coverage through their employer that is considered creditable*, they do not have to enroll in a Part D plan.	If they lose creditable coverage*, they will need to enroll in a Part D plan. If they do not have creditable drug coverage for more than 63 consecutive days, they will have to pay a late enrollment penalty if they decide to get Part D coverage at a later date.

*Creditable drug coverage means:

- Coverage is expected to pay on average as much as the standard Medicare prescription drug coverage
- They should receive a yearly notice notifying them if the coverage is considered creditable

If they...	Consider...	Keep in mind...
Are turning 65 and NOT actively working or working part time (and not currently enrolled in Social Security)	**Part A and Part B** They should enroll in Medicare Parts A and B when first eligible to avoid paying late enrollment penalties	For each 12-month period they delay enrollment in Part B, the federal government requires then to pay a 10% monthly premium penalty.
	Part C Enrolling in a Medicare Advantage plan is optional. Talk with an Univera Healthcare Advisor to see if enrolling in a Medicare Advantage plan is a good fit for them.	They must have Medicare Parts A and B and live in the plan service area to enroll in a Medicare Advantage (Part C) plan.
	Part D They should enroll in a Part D plan when first eligible to avoid penalties.	If they have drug coverage from another source that is considered creditable, they do not have to enroll in a Part D plan. If they do not have creditable drug coverage for more than 63 consecutive days, they will have to pay a late enrollment penalty if they decide to get Part D coverage at a later date.
Are currently collecting Social Security	**Part A and Part B** They will be automatically enrolled in Medicare Parts A and B if they have been receiving these benefits for at least 24 months.	If they choose to decline Parts A and B when first eligible, they may have to pay a late enrollment penalty if they decide to enroll in the future.
	Part C Enrolling in a Medicare Advantage plan is optional. Talk with an Univera Healthcare Advisor to see if enrolling in a Medicare Advantage plan is a good fit for them.	They must have Medicare Parts A and B and live in the plan service area to enroll in a Medicare Advantage (Part C) plan.
	Part D They should enroll in a Part D plan when first eligible to avoid penalties.	If they have drug coverage from another source that is considered creditable, they do not have to enroll in a Part D plan. If they do not have creditable drug coverage for more than 63 consecutive days, they will have to pay a late enrollment penalty if they decide to get Part D coverage at a later date.

What's next?

What's next for Medicare Eligible members will depend on the current type of health insurance (employer group or Individual) they are enrolled in. Here are a few situations that are critical in determining next steps:

Employer group coverage

- Is the Medicare eligible member currently employed and the policy holder on their employer group plan?
- Is the Medicare eligible member a dependent on their spouse's employer group plan where the spouse is currently employed?
- Is the Medicare eligible member retired and have insurance offered through an employer group?
  - If any of the above scenarios apply to the Medicare eligible member, have them contact their employer group representative

Individual market coverage

- If the Medicare eligible member is retired or not working and does not have an employer group option:
  - Send completed Medicare Advantage or Medicare Supplement application to: Medicare Enrollment Processing, PO Box 31790, Rochester, NY 14603
  - Once the application is processed and approved by CMS, members will then receive their confirmation of enrollment letter. If they need to obtain services prior to receiving their ID card, their insurance information is provided in this letter
  - ID cards will be sent 7-10 business days after the enrollment has been processed.
  - If they are enrolling during the Annual Enrollment Period (AEP) (October 1st through December 7th) for a January 1st effective date, Member ID cards are issued in December prior to their effective date
  - After their initial enrollment, members will not receive a Member ID card annually unless they make any changes to their plan, benefits are altered, or any of the key resources displayed on the card changes in anyway. For example: Customer Care phone number update

Things to ensure are included or correct on the application

The purpose of this section is to make the members aware that there are times the health plan will have to suspend the process of an application for missing or validation of information. If all data is included, it will assist with a timely and accurate enrollment process. Below are some frequently missed data that causes the delay in enrollment processing.

Once they enroll with Social Security, they'll be assigned a Medicare Beneficiary Identification Number (MBI). This number should be provided to us on the Medicare Advantage application.

- What is a member beneficiary identifier?
  - A member's personal identification number issued by Social Security once they are entitled to Medicare. This number can be found on their Social Security supplied red, white, and blue Medicare ID card. The MBI is confidential like the Social Security Number and should be protected as Personally Identifiable Information

When adding the PCP to the application please use first and last name only with no prefix, title, or suffix.

- When do members need to provide a Primary Care Physician?
  - When electing to enroll in HMO coverage, please ensure provider's (PCP) full first and last name is spelled correctly. Do not include a prefix of Dr., Doctor, NP

What happens if there is missing information on the application?

- The member will receive a request for information (RFI) letter asking to provide the required missing information to the Plan
- If this information is not received by the date on the letter, the application will not be processed
- It is very important to respond back timely to ensure the member is still within a valid election period to enroll

What happens if there is missing information on the application?

Enroll with their elected broker

Enroll by phone

1-800-659-1986 (TTY: 1-800-662-1220)

Enroll online

Members can quickly and easily complete their application online, 24/7! Simply by visiting UniveraHealthcare.com/Medicare-Coverage/Medicare-plans and click on the Enroll link

Enroll in person

Visit one of our Univera Healthcare Resource Centers at:

205 Park Club Lane, Buffalo, NY 14221

Enroll by mail

Send completed Medicare Advantage or Medicare Supplement application to:

Medicare Enrollment Processing,
PO Box 31790, Rochester, NY 14603

Where can members go to get help?

- Call us at 1-800-844-0345 (TTY: 1-800-662-1220). Monday to Friday 8 a.m. to 8 p.m.
- Attend an educational seminar to learn more about Medicare and their coverage options. To find a seminar in their area, call 1-800-844-0345 or visit UniveraHealthcare.com/Medicare-Coverage/Learn to register online
- Visit the Univera Healthcare Resource Center at 205 Park Club Lane, Buffalo, NY 14221

For accommodations of persons with special needs at meetings call 1-888-841-5604 (TTY: 1-800-662-1220).

Univera Healthcare contracts with the Federal Government and is an HMO and a PPO plan with a Medicare contract. Enrollment in Univera Healthcare depends on contract renewal.

Our Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-883-9577 (TTY: 1-800-662-1220).

Continuation of coverage

There are two types of continuation: COBRA and NYS Continuation. In addition, a NYS law allows dependents to be covered to age 30. If your group does not add the rider to extend the age limit on your policy through age 29, it must offer a special type of continuation, known as the Young Adult Option (YAO). For further information on all three programs, see below.

Your group is responsible for properly administering these programs. We provide some general information below and links to additional resources. We recommend that you consult with your advisors (e.g., legal counsel) if you have specific questions or unique situations, as these laws and regulations are quite complex.

Please note: The employer group must be in active status in order to offer continuation of coverage.

COBRA

COBRA (Consolidated Omnibus Budget Reconciliation Act) is a federal law. It applies to employers with 20 or more employees who provide group health plans. It applies regardless of whether the plan is insured or self-insured. It does not apply to groups who are not employers.

COBRA provides your employees, or their dependents, with the right to keep the group health insurance benefits they would otherwise lose, on the occurrence of specified events. The member preserves his or her rights, if the member makes the election and pays premium on a timely basis.

Eligibility

Qualified individual

- Enrolled in a product that is subject to COBRA the day before a qualifying event
- An employee, the spouse of an employee or the qualified dependent child

Qualifying events and length of COBRA employee and qualified dependents

Up to 18 months of continued group coverage must be offered to the qualified employee and dependents for the following qualifying events:

- Termination of employment
- Reduction in hours

Dependent

A qualified dependent may elect COBRA independently of the employee when the qualifying event causes the dependent to lose coverage. Up to 36 months of continued group coverage must be offered for these qualifying events:

- Death of the covered employee
- Medicare entitlement of employee
- Divorce/legal separation from the covered employee
- Loss of "dependent child" status under the plan (e.g., age-off)

Termination of coverage

COBRA continuation of coverage terminates at the earliest of the following:

- Reaching the maximum continuation period
- Non-payment of premium
- First entitlement to Medicare, if the first entitlement is after the COBRA election

For additional information on COBRA, please review the information at the following website:
dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra/

COBRA timeline

Below is a chart to reference that will assist with avoiding retroactive request;

	Employee loses eligibility for employer's health plan	Dependent loses eligibility for employer's health plan
Employee must notify employer of event	Not applicable	Within 60 days of event that causes ineligibility
Employer must notify employee of COBRA rights	Within 44 days from the date of the qualifying event*	Within 44 days of the date employee notified the employer of the qualifying event
Employee's election period	Within 60 days from date employer notifies employee of COBRA rights	Within 60 days from date employer notifies employee of COBRA rights
Employee pays 1st premium	Within 45 days of COBRA election	Within 45 days of COBRA election
Employer submits application to EHP	Within 30 days of initial premium payment	Within 30 days of initial premium payment
Max days elapsed	179 days	239 days

** If your group has a Plan Administrator, you must notify the Plan Administrator within 30 days. The Plan Administrator has 14 days to notify the employee. If you are the Plan Administrator, you have the entire 44 days to provide notification*

There may be times when the COBRA enrollment process reaches the maximum period. It should however, be unusual. There are steps that you can take to keep the timeline to a shorter, more manageable period. Here is an example of a COBRA election for a terminated employee:

Activity	Time elapsed
Employee is terminated and employer provides notice at exit interview	1 day
Employee elects coverage and pays first premium with election	5 days
Employer submits the application to insurer	11 days
Total time elapsed	17 days

New York State continuation

New York state continuation applies to any insured health plan, regardless of the group's size and whether or not the group is an employer. It does not apply to self-insured plans unless the self-insured plan voluntarily subjects itself to these provisions. It does not apply to free-standing dental or vision plans.

New York state requires the availability of a total of 36 months of continuation for any individual who is entitled to continuation. The 36 months is in combination with any continuation already utilized under COBRA (where applicable); it is not in addition to COBRA. COBRA does not apply in certain situations (e.g., loss of coverage for a non-employee). New York state insurance law expands the availability of continuation to dependents who are not otherwise included under COBRA (e.g., same-sex spouse). A domestic partner who loses eligibility due to termination of the domestic partnership is not eligible for NYS Continuation.

Unlike COBRA, the member must include the initial premium with the continuation election. The termination reasons for NYS continuation are similar to COBRA.

For additional information on New York state's continuation requirements, please review the information at the following website: **dfs.ny.gov/consumers/health_insurance/cobra_faqs**

NYS continuation timeline

Below is a chart to reference that will assist with avoiding retroactive requests:

	Employee or member loses eligibility for health plan	Dependent loses eligibility for health plan
Employee must notify Employer of event	Not applicable	Within 60 days of event that causes ineligibility
Employer must notify employee of continuation rights	5 business days, per NYS Labor Law, Section 195	Within 44 days of the date employee notified the employer of the qualifying event
Employee or member's election period	Within 60 days of date: 1. Employer notifies employee of continuation rights, or 2. The actual termination date, whichever is later	Within 60 days of date: 1. Employer notifies employee of continuation rights, or 2. The actual termination date, whichever is later
Employee pays 1st premium	Simultaneously with election	Simultaneously with election
Employer submits application to EHP	With in 30 days of election	With in 30 days of election
Max days elapsed	95 days	125 days

There may be times when the process reaches the maximum period. It should however, be unusual. There are steps that you can take to keep the timeline to a shorter, more manageable period. Here is an example of a State Continuation election for a terminated employee:

Activity	Time elapsed
Employer provides notice two weeks prior to the employee's last day of employment	0 days
Employee elects coverage and pays first premium with election	30 days after last day of employment employer submits application to insurer
Employer submits application	11 days
Total time elapsed	41 days

Young Adult Option (YAO)

This law applies to all insured medical coverage, including Healthy New York and self-insured coverage under a municipal cooperative health benefit plan, when the group does not add the rider to extend the age limit under the family policy to include dependents through age 29. It does not apply to other self-insured groups. The law does not apply to free-standing dental-only, vision-only or drug-only coverage.

The subscriber or member may continue coverage for a young adult from 26 to 30 years of age, under group coverage, if enrolled in a type of policy that includes coverage for dependents. The young adult may not enroll without the parent's current and continued enrollment as an employee, member of the group or due to a right to continuation under either COBRA or NYS continuation.

Eligibility:

A young adult is eligible, if:

- Unmarried
- At least 26 years of age, but not yet 30
- Not insured by or eligible for, coverage through an employer
- Lives, works or resides in our service area
- Not eligible for Medicare

Enrollment:

There are three times when a young adult may enroll:

- At the time the young adult initially ages off the policy
- At each annual open enrollment period
- When the young adult experiences a change in circumstance and regains eligibility as a young adult (e.g., a married young adult divorces)

Coverage is effective the date of the loss of coverage, if the young adult applies for coverage within 60 days of the initial loss of coverage due to aging off the parent's policy. Coverage is prospective, and starts no later than 30 days from the receipt date of the election and premium for any other time the Young Adult re-enrolls.

Termination of coverage:

A young adult loses eligibility if:

- Coverage is voluntarily terminated by the young adult or parent
- The parent is no longer enrolled in the group
- The policy is cancelled for nonpayment
- You cancel the group policy and do not replace it
- The young adult turns 30, becomes eligible for or enrolls in coverage through his or her employer, marries or moves outside our service area

A young adult who continues coverage under the YAO is not eligible for either COBRA or NYS continuation when the young adult loses coverage under this option. The YAO is in lieu of COBRA or NYS continuation, not in addition to those programs.

Helpful hints:

Please ensure that a subscriber or young adult signs the Young Adult Certification form prior to submission. Please submit forms no more than 60 days prior to the eligibility date of the Young Adult option. The premium is required when the subscriber or dependent elects the YAO, so do not activate coverage until the premium is paid.

If your employees have questions regarding a Young Adult Certification form, they can contact our Customer Care department by calling the phone number on their member card.

Prior coverage information needs

Prior coverage information needed when adding a member

A Certificate of Coverage is not required upon a member's initial enrollment. However, the applicant must complete the other coverage information section on the group enrollment form with the following information:

- Previous coverage effective date
- Previous coverage termination date
- Previous coverage enrollment (family, individual, etc.)
- Name of previous insurance carrier
- Type of coverage (medical, dental, etc.)
- Identification number of policy
  - If enrolling via the web, all of the above information must be provided. We are providing general information as you may receive questions from members covered under your policy

Coordination of Benefits (COB)

What is Coordination of Benefits?

- Most health insurance contracts or certificates have a clause that allows the benefits of one policy to be coordinated with those of another. This clause, referred to as coordination of benefits, describes which policy is considered first, or "primary," for claims payment
- Please refer to your member certificate to review the COB clause
- A plan that does not contain a COB clause consistent with these rules is always primary

NOTE:

- Be sure that subscribers complete the "Other Coverage" section of the group enrollment form
- These rules do not always apply when one policy is Medicare
- Please notify us if there is a change to an employee's other coverage information. We want to be certain our records are accurate so we process the claims correctly

Rules to determine which plan pays first:

- If a person is covered under one medical plan as an employee and under another plan as a dependent, the plan under which he/she is an employee is primary
- If a child is covered under both plans, the birthday rule is applied to determine which contract is primary. Under this rule, the plan of the parent whose birthday (month and day) falls earlier in the year is primary
- If both parents have the same birthday, the plan that covered the parent longer is primary
- If a plan uses a rule based on gender of the parent, then the plan of the male parent is primary

NOTE:

Most insurance plans use the birthday rule to determine which plan pays first when the member has more than one active insurance policy. TPAs (Third Party Administrators) may use the male primary rule to determine which policy is primary for self-insured plans. Insurance policies issued in New York state must use the birthday rule.

Rules for children of separated or divorced parents

- The policy of the parent who the court has made responsible for health care insurance is primary
- The policy of the parent who has custody of the child is primary
- If the court has not placed responsibility on one parent to insure the children and the parents have joint custody, the birthday rule applies
- If the natural parent elects to have coverage under the policy of the stepparent, we will consider the policy to be that of the natural parent

NOTE: In some instances, we may ask for a copy of a member's court decree.

Rules for an active and non-active employee

- The plan that covers the policyholder as an active employee is primary
- If the policyholder has the same employment status (active/retired) under both plans, the plan with the earliest effective date is primary

Retroactive policy

The retroactive policy governs the length of time you have to submit transactions to us. It allows us to review and make possible exceptions to membership additions, terminations and changes in group benefits beyond the (30 day) event date.

There are many reasons why we have established this policy, but most important are:

- Prevent adverse selection
- Subscriber and group satisfaction
- Reimburse our providers on time and accurately for the services rendered to our members
- Limitations regarding the ability to retract claims
- Reduce administrative and provider costs when we must adjust or retract claims
- Comply with Federal and NYS requirements
  - Rescission law and regulation
  - Ensure that only eligible persons are covered per NYS insurance law and our subscriber certificates

Rescission

The rescission provisions of ACA apply regardless of whether the product is grandfathered or non-grandfathered. The provisions apply to all group health plans including HMOs, Healthy New York group products and Medicare Complementary products. The rescission provisions do not apply to HIPAA excepted products, such as freestanding dental and vision, Medicare Advantage and Medicare Supplement products.

If you do not comply with the rescission limitations in ACA, the federal government may assess fines on your group or the issuer of coverage. You may find more details at **Healthcare.gov** and at **HHS.gov**.

The information provided in this document does not provide regulatory compliance or legal advice. The intent is to raise your awareness of important issues so that you may seek guidance from your own legal counsel or tax advisor, as needed.

Q: What is a rescission?

A: A rescission occurs when a health plan or issuer initiates:

- A cancellation or discontinuance of coverage that has a retroactive effect; or
- A cancellation that voids a policy as of the enrollment date for the subscriber or member

The ACA regulations provide an example where an employee's hours dropped below the threshold to qualify for health insurance, except that the employer did not find the change until later. The employee continued to contribute towards the health insurance plan, so the employer is not entitled to cancel the coverage retroactively. The regulations and guidance also reference retroactive terminations when an employee or member has paid any portion of the premium or has a "reasonable expectation of coverage."

Q: What is not a rescission?

A: A cancellation or discontinuance of coverage is not a rescission if it relates to a:

- Cancellation or discontinuance of coverage that is prospective (e.g., for a current or future date)
- Failure to pay premiums or required contributions to the cost of coverage on time, in which case the cancellation or discontinuance of coverage may be effective retroactive to the date of default

Q: When is a rescission permissible?

A: A rescission is permissible when the person completing the application has:

- Performed an act, practice, or omission that constitutes fraud, or
- Makes an intentional misrepresentation of material fact, as prohibited by the plan or coverage

NOTE: In New York state, cancellations for fraud must be prospective, with 30-calendar days advance notice.

Retroactivity – COBRA, NY State Continuation of Coverage & Young Adult Option (YAO)

COBRA:

The COBRA law provides for an extensive notice and election period. We will honor a request to reinstate a member to coverage as a COBRA continuant for a period of up to 179 days for an employee-related event and 239 days for a dependent-related event.

We encourage you to wait until the continuant pays his or her first premium before you reinstate the coverage or you may be liable for the premium.

Please note that you must still submit the original transaction to terminate the individual within the standard 30 days. The reinstatement to coverage as a COBRA continuant is the only portion that is an exception.

NY State Continuation of Coverage:

The notice and election period for NYS continuation is much shorter than COBRA. We will honor a request to reinstate a member to this coverage for a period of up to 95 days for a subscriber event and 125 days for a dependent event.

The subscriber/dependent must pay the premium at the time he or she elects NYS continuation.

Young Adult Option (YAO)

The election period for initial enrollment allows for retroactive enrollment. We will honor a request to enroll a young adult if we receive the request within 60 days of termination date.

The subscriber/dependent must pay the premium at the time he or she elects this option.

Tips regarding the termination of an employee

There are actions your group can take to protect itself from the likelihood that an employee can claim that his/her termination of coverage is a rescission and therefore prohibited. Here are a few suggestions:

- Remind employees frequently that coverage ends when employment ends, unless the employee elects COBRA or NYS continuation, as appropriate
- When an employee is terminated or otherwise leaves employment, provide the employee with the COBRA or NYS Continuation notice immediately
- Be certain to stop withholding employee contributions immediately at the point the employee loses eligibility for coverage

Tips regarding the termination of a dependent

Though agencies of the federal government have issued some guidance about the ACA, rescissions and the applicability to dependents who lose eligibility, much remains uncertain. It is prudent for your group to educate itself regarding the ACA. Consult with your own legal advisors and consultants in situations where the right to terminate a dependent is not clear. There are still actions your group can take to protect itself from a prohibited rescission, as follows:

- Remind employees frequently that it is their responsibility to report a change to a dependent's eligibility within 30 days
- Provide the dependent with a COBRA or NYS Continuation notice immediately
- Submit cancellation transactions through our website to ensure timeliness
- Immediately adjust the employee's withholding for any change in rate tier

Retroactivity exceptions – When retro request is not required

Death: We will terminate coverage for a deceased member who is not an active employee up to 90 days without a death certificate, and up to one year after the date of death with a death certificate. We expect you to submit terminations due to the death of an active employee within 30 days of the date of death.

Divorce: We will terminate the coverage for a divorced spouse retroactively up to 90 days from the current date of divorce. A request that exceeds 90 days from the date of divorce must be submitted for retroactive review. We may require a copy of the divorce decree or a divorce certificate as part of our review.

Self-funded group requests

If your group is self-funded, and you have questions regarding retroactive activity, please contact your Account Manager or Account Service Consultant.

Information on reporting requirements under the Affordable Care Act (ACA)

Information reporting by health coverage providers

(Section 6055 of the Internal Revenue Code)

For more information go to:

irs.gov/Affordable-Care-Act/Employers/Information-Reporting-by-Providers-of-Minimum-Essential-Coverage

www.irs.gov/affordable-care-act/questions-and-answers-on-information-reporting-by-health-coverage-providers-section-6055

Section 6055 – reporting to IRS		
Form #:	**Filed by:**	**Filing due date:**
Form 1094-B Transmittal of Health Coverage Information Returns irs.gov/pub/irs-pdf/f1094b.pdf **Instructions:** irs.gov/pub/irs-pdf/i109495b.pdf **Form 1095-B** Health Coverage irs.gov/pub/irs-pdf/f1095b.pdf **Instructions:** irs.gov/pub/irs-pdf/i109495b.pdf	**Univera Healthcare** will submit **Form 1094-B** and data from **Form 1095-B** to the IRS. **NOTE:** SSNs reported to the IRS cannot be masked for privacy.	If filing electronically*: **March 31st** of the year following the coverage year If filing by paper: **February 28th** of the year following the coverage year *Providers that file more than 250 forms must file electronically.
Section 6055 – statements to individuals (These are provided to the member on the web, however no longer required for tax filing.)		
Form #:	**Filed by:**	**Filing due date:**
Form 1095-B Health Coverage irs.gov/pub/irs-pdf/f1095b.pdf **Instructions:** irs.gov/pub/irs-pdf/i109495b.pdf	**Univera Healthcare** will send **Form 1095-B** statements to individuals that had minimum essential coverage. **NOTE:** SSNs on Statements to Individuals can be masked for privacy. **Univera Healthcare** will partially mask the SSN in the following format (example: XXX-XX-1234).	The **Form 1095-B** statements are made available to individuals by **January 31st.**

** Self-funded plan sponsors can use a combined form (Form 1095-C, including Part III) to file reporting information for both Sections 6055 and 6056. Self-funded groups are responsible for their own reporting*

** Upon request, Univera Healthcare will provide available data for Part III of form 1095-C to self-funded employers*

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security rules

The HIPAA privacy regulations protect the security and privacy of an individual's PHI. PHI is individually identifiable health information transmitted or maintained in any form or medium. Some examples of protected health information are name, address, birth date, Social Security number, unique subscriber ID number, claim payment and diagnosis. Unless the member expressly authorizes release, or as otherwise permitted by the regulations, the disclosure of PHI is restricted to the member or his/her health care provider.

How HIPAA affects you as the group administrator

In accordance with privacy regulations, we must use due diligence in verifying the identity of our caller. We obtain the information in order to authenticate calls to our Enrollment Processing department:

1. The group leader's name
2. The name of the company (group)
3. The group number associated with the group

We need the above information to protect the privacy of your group and eligible employees. Please advise your members that they will have to authenticate themselves when calling our Customer Care department by providing their Social Security number, unique subscriber ID number, name and address.

PHI disclosure

We cannot disclose Protected Health Information (PHI) to anyone other than a member without a completed Authorization to Share Protected Health Information form on file. The form authorizes us to disclose information to the person whom the member has designated. Members can complete this form online or they may download it from our website and return it to our mailing address.

Please advise your eligible employees that our Customer Care Advocates are unable to assist a spouse without an authorization form on file. We recommend that you include an authorization form when submitting the initial enrollment request for married or domestic partnered couples. If a member has a dependent child 18 years or older, an authorization must be on file for Customer Care to discuss the child's PHI with the child's parent or stepparent.

Family members

When a member calls customer care regarding family members, please note the below information:

- If family member is age 18 or older, we need an authorization on file
- If a person is calling regarding a family member under age 18, we can release the information, unless a protected health diagnosis is involved

The necessary forms can be completed online – or we can fax or mail copies to you.

To complete online the member must have an online account.

- Once the member is logged in, they would select **"Manage Privacy"** from the **"My Account"** dropdown menu
- They will click on the button **"Enter or Update Authorizations"**. It will then show the member's active and inactive authorizations
- The member can also click on **"learn more"** to read about our privacy policy and look at frequent questions and answers
- They can then enter the required information to grant authorization
- Member's can stop an authorized person's access at any time

Protected health diagnosis

If the call is regarding one of the protected diagnoses below, other laws apply that prevent the release of information without the member's authorization.

The following diagnoses require specific authorization to release the information, even when the patient is under the age of 18. Extenuating circumstances, particularly with infants and very young children, will be addressed on a case by case basis.

- Sexually transmitted diseases – New York Public Health Law
- Substance abuse – Federal law
- Abortion – New York Public Health Law (this does NOT include pregnancy)

The following diagnoses have a protected age of 18, so information can be released to the personal representative (most commonly, the parent) without an authorization on file. Once the minor turns 18, a specific authorization will be needed for these two conditions, along with the release of any other protected health information.

- Genetic testing – New York Civil Rights Law
- Mental health – New York Mental Hygiene Law

HIV has a protected age limit of 13. Information can be released to the personal representative (most commonly, the parent) without an authorization on file. Once the minor turns 13, a specific authorization will be needed.

- HIV – New York Public Health Law

This information does not intend to dispense legal advice. If you are uncertain how the various state and federal privacy rules apply to your organization's group health plan, please seek legal counsel as necessary. If you would like more information about the HIPAA Privacy Rule, you can obtain information at **hhs.gov/ocr/privacy/index.html.**

Frequently asked questions

Should I wait to submit a termination request for an employee until after the employee responds to the COBRA offering?

No. Please submit termination requests as they occur. If an employee later opts for COBRA within the guidelines, we will reactivate his or her coverage.

Is the addition of a newborn child a qualifying event to add a spouse to coverage?

Yes, the addition of a newborn is a change in family status that is a qualifying event to add a spouse.

If a member wants to change his or her last name, what is required?

Please submit the change in writing or as a Web request. You should maintain documentation to establish the basis for the name change.

If a group receives a court order to add a dependent, what is required to add the dependent?

When you submit an application to add an eligible dependent pursuant to a court order such as a Qualified Medical Child Support Order (QMCSO), the court order is required, along with a completed application and QMCSO Enrollment Form.

Can I send activity requests with my bill?

No, please submit activity via our website, secure email process or a group enrollment form.

If I feel my bill is incorrect, what do I do?

Check the activity changes listed on the invoice and if you find a discrepancy, please contact your Account Service Consultant immediately. Remember, most activity is subject to the 30-day retroactivity period.

Should I adjust my payment based on activity requests that are not reflected on the bill?

No, please pay as billed. This activity will appear on the next bill.

How do I obtain a benefit summary?

Please contact your Account Service Consultant to obtain a benefit summary.

Can members of my group change their addresses?

Yes, if they sign up for online member access, they can do this themselves. Please note, the group representative will be notified of this request.

Notes

Notes

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