

CAQH Phase 2 HMO Group Administrator FAQs

Employers/Group Administrators' Frequently Asked Questions about the Blue Cross of California HMO (CaliforniaCare) Health Plans

The topics below contain a broad list of group administrators' Frequently Asked Questions. Please use the links below to refine your search, or simply scroll down to locate the subjects of most relevance to you. The answers are only general descriptions of coverage. Please refer to Evidence of Coverage for more complete details about the plan including benefits, limitations and exclusions.

[Products](#)

[Pharmacy](#)

[Provider Network](#)

[ID Cards](#)

[Physicians and Other Providers](#)

[Approvals and Referrals](#)

[Emergency Care](#)

[Disabled Employees](#)

[Coverage/Benefits](#)

[Enrollment and Renewals](#)

[Eligibility](#)

[Notification of Changes](#)

[COBRA](#)

[HIPAA](#)

[Premiums/Rates and Quotes](#)

[Claims](#)

[NCQA](#)

[HEDIS](#)

[Products](#)

1. What products and services do you offer?

Blue Cross of California* offers a full spectrum of managed and traditional products and services. We offer:

- HMO medical
- PPO medical
- EPO medical
- Indemnity medical
- Dental
- Behavioral Health
- MedCall Demand Management Program
- Student Insurance
- Prescription Drug Plans
- Senior Plans
- Life and AD&D

* Please note, some products are offered by our affiliate, BC Life & Health Insurance Company.

2. Describe Blue Cross of California's Disease Management Program.

Blue Cross of California and BC Life & Health Insurance Company offers a variety of educational and proactive Health Management Programs (disease management). These services reinforce

CAQH Phase 2 HMO Group Administrator FAQs

the recommendations of members' physicians and encourage members to become more actively involved in their own care. The Health Management Programs include:

- A Program for People with Asthma
- A Program for People with Congestive Heart Failure (CHF)
- A Program for People with Diabetes
- Balancing Life: A Program Supporting Body & Mind (for members with depression)

All Blue Cross Health Management Programs are designed to achieve the following goals:

- Improve the overall health of members participating in the program
- Prevent clinical exacerbation and complications
- Improve quality of life

Each of our Health Management Programs contains all of the following elements:

- Population-based identification process
- Risk stratification and matching of appropriate interventions
- Interventions designed for members and physicians including, but not limited to developing and providing evidence-based or consensus-based clinical practice guidelines; educating members about the diseases and self-management skills and providing them with relevant tools (e.g. medication diaries, peak flow meters); and outcomes and process measurement, evaluation, management, and reporting

Some health management services are delivered by well-known and respected national disease management organizations and some are delivered by internal personnel. Together with members' physicians, Blue Cross aims to improve members' overall health and prevent clinical exacerbation and complications by educating members about managing and monitoring their chronic disease and teaching self-management skills.

[\[Back to top\]](#)

Pharmacy

3. Does a group or a subscriber within a group have to take prescription drug coverage?

All Small Group plans include benefits for covered prescription drug expenses.

4. How can I find a network pharmacy?

We offer a few different ways for members to locate network pharmacies:

- Consult the [Provider Finder](#) on this web site. It allows members to search by pharmacy name, city, state or ZIP code. Most listings provide maps and driving directions to the pharmacy.
- Call the toll-free customer service telephone number on the identification card.

In addition, members can always inquire at any pharmacy of their choice to see if they accept Blue Cross of California.

CAQH Phase 2 HMO Group Administrator FAQs

5. What is a drug formulary?

The formulary, a dynamic managed care tool, is a continually revised list of therapeutically efficacious and cost-effective pharmaceuticals that assists the physicians in selecting drug products considered most beneficial to their patient populations. Our prescription drug plans include open, closed, and partially closed formulary options. Members should refer to the evidence of coverage for more complete details about their plan including benefits, limitations and exclusions. Members may also access the formulary through this website.

[\[Back to top\]](#)

Provider Network

6. Describe your provider networks.

Blue Cross HMO contracts with an extensive network of providers to make access to care convenient for our members. This convenience and a choice of community physicians plays an important part in our members' satisfaction. The HMO network contains over 28,000 physicians and professional specialists throughout California, including over 10,000 primary care physicians. Complementing the provider network, there are over 400 HMO-contracted hospitals.

7. How often are your paper and online directories updated?

Printed provider directories are updated three times a year and reflect all changes as of the print date. Provider information is also available online through the [Provider Finder](#) feature. We download provider information to our Internet site directly from our mainframe database once a week.

[\[Back to top\]](#)

ID Cards

8. How does the member use his/her Blue Cross of California identification card?

The identification (ID) card is the member's passport to Blue Cross of California or BC Life & Health Insurance Company health plan benefits. Presenting the ID card in a physician's office or hospital admissions office enables the provider to confirm that the member is eligible for benefits. The name of the member's Primary Care Physician (PCP) is displayed on the ID card.

The ID card lists one or more toll-free telephone numbers that will link the member or provider to Blue Cross member service staff if the member needs to:

- Pre-certify required inpatient hospital admissions and any other services specified in the member's Evidence of Coverage.
- Report an emergency hospital admission.
- Ask a question about benefits or a specific claim.
- Access Blue Cross' health information, case management or health promotion services.

This is only a brief summary of the plan. Please refer to the Evidence of Coverage for more complete details about the plan including benefits, limitations and exclusions.

CAQH Phase 2 HMO Group Administrator FAQs

9. Who may use the Blue Cross ID card?

Only the member and covered family members enrolled through the employer may use their member ID card and receive plan benefits. A member should never lend his/her ID card to anyone.

10. Whose name and member ID/certificate number should appear on the ID card?

Each individual member's name will appear on the ID card, but the subscriber's certificate number will be on all cards.

11. What if a member loses his/her ID card or needs to order additional cards?

If the member loses his/her Blue Cross of California ID card and needs a replacement, or the member would like to order additional ID cards, the member may call our toll-free customer service number or notify their company's benefits administrator immediately. The member may also go to online [Member Services](#) or call the toll free number on the back of the ID card. The card will normally be delivered within seven working days from the time the request is placed. If medical care is required before ID cards are received, the member should give the provider of care the certificate number that was used to access the member's account.

[\[Back to top\]](#)

Physicians and Other Providers

12. How can a member find the names, addresses and other important information concerning physicians, hospitals and other health care providers in the network?

There are three sources for information on network providers:

- The [Provider Finder](#) on this web site
- The Network Provider Directory
- Blue Cross of California's Customer Service, which members can reach at the toll-free number on the identification card

All of these sources can give the member the names, addresses, medical specialties, and hospital affiliations of network providers. He/she can ask for providers in certain ZIP Codes that may be convenient to where the member lives or works. In some cases, these sources can help identify physicians who speak languages other than English and give detailed directions from home or workplace to the provider's location.

13. What if a provider a member would like to use is not listed in the Provider Finder or the Network Provider Directory?

The member can call the provider or Blue Cross Customer Service to find out if the provider has joined the network since the web site information was last updated or the directory was last printed.

CAQH Phase 2 HMO Group Administrator FAQs

If the provider is not in the network, the member may telephone or write to us. We then will analyze the request and respond according to our policies for maintaining good member relations, provider qualifications and network access.

14. What if a member's provider has left the network since the Provider Finder was last updated or the directory was last printed?

Blue Cross HMO Participating Medical Groups/Independent Physician Associations (PMG/IPA) are required to notify enrolled members when an individual physician within the PMG/IPA leaves the group or is terminated from our network. The PMG/IPA must offer the services of another PCP within the group.

If a PMG/IPA contract is terminated by or with Blue Cross, members enrolled with that PMG/IPA will be notified by Blue Cross' Customer Service by mail. A minimum of 90 days' notice is required for terminating the contract by either Blue Cross or the PMG/IPA so that ample time is available for notifying members and arranging alternative assignments. At the same time, Blue Cross sends a letter to the employers of affected members.

The re-assignment letter includes an automatic reassignment to a new PMG/IPA in the member's area, plus the choice of alternative providers if the reassignment is unacceptable, and instructions to contact us immediately if the member has questions or is in the course of treatment. For members who are in a course of treatment, Blue Cross will assist with any transition needs.

Unless the member calls customer service to request a PMG/IPA other than the one identified, the member's enrollment record will be updated with the designated PMG/IPA, and a new identification card will be issued to the member.

15. How can a member learn what services the health plan covers?

To learn more about what services the health plan covers, the member may log in to online [Member Services](#) and access his/her Benefits Detail. In addition, the Evidence of Coverage will briefly describe the covered services in the health plan. Covered services are the medically necessary procedures and types of care for which the plan will provide benefits. The limitations and exclusions section of the Evidence of Coverage will describe types of care that the plan does not cover. Members may also call the toll-free member service line on their ID card for information regarding covered services.

This is only a brief summary of the plan. Please refer to the Evidence of Coverage for more complete details about the plan including benefits, limitations and exclusions.

16. What are the out-of-pocket costs that a member may have to pay?

The benefit summary in member's Evidence of Coverage specifies the amounts and the types of out-of-pocket charges for covered services. Depending on the service and the provider, the member may have to pay a copayment. The copayment is the amount a member pays for each independently contracted in-network physician home or office visit. Physician copayments are for in-network care only. Network physicians agree to accept the copayment and Blue Cross of California's reimbursement as payment-in-full for covered services.

Because this is an HMO, only service provided by the member's Primary Care Physician (PCP) or authorized by the member's PMG/IPA are covered except in an emergency.

CAQH Phase 2 HMO Group Administrator FAQs

This is only a brief summary of the plan. Please refer to the Evidence of Coverage for more complete details about the plan including benefits, limitations and exclusions.

17. How do you recommend that a member choose a new physician?

In choosing a new primary care physician (PCP), the member may want to consider:

- Is the physician's office location convenient to his/her home or workplace? Blue Cross of California's [Provider Finder](#) supplies maps and driving directions for most network provider locations.
- Does the physician have admitting privileges at a (network) hospital that the member prefers?
- Does the physician have office hours that work with the member's schedule?
- If English is not the member's primary language, does the physician speak the language the member prefers?
- Is the physician board-certified?
- Does the member have friends or colleagues who recommend the physician from first-hand experience?

18. What if a member cannot keep his/her appointment?

Blue Cross of California does not cover charges for broken appointments. The member should always try to keep an appointment or notify the provider in plenty of time if he/she must cancel.

[\[Back to top\]](#)

Approvals and Referrals

19. Does Blue Cross cover visits for specialty care?

Yes, however, services must be authorized by the member's own primary care physician (PCP) or Participating Medical Groups/Independent Physician Associations (PMG/IPA) in order for benefits to be payable. The referral authorization process varies by medical group. Many PMG/IPAs have internal policies that allow their physicians to refer directly to specialists without going through a formal referral approval process. Other medical groups allow their members to self-refer to specialists within the group.

Referrals are made when services of a specialist are deemed medically appropriate by the primary care physician and the medical group. The PCP arranges for the referral and gives the member a completed referral form, which authorizes specific treatment or services.

Members that require specialized care over a prolonged period for life threatening, degenerative or disabling conditions may be eligible for a standing referral to a specialist who has expertise in treating the condition or disease; this is for the purpose of having the specialist coordinate the member's treatment.

This is only a brief summary of the plan. Please refer to the Evidence of Coverage for more complete details about the plan including benefits, limitations and exclusions.

20. Does Blue Cross require that a member obtain a referral for OB/GYN services?

CAQH Phase 2 HMO Group Administrator FAQs

Blue Cross HMO allows women to self-refer to an OB/GYN designated by the PMG/IPA for annual well-woman care.

21. What if the member needs Specialists, Lab Tests or X-rays?

If a member requires care that cannot be provided by the PCP at the medical group, the PCP will request authorization from the PMG/IPA utilization review committee to refer the member to a specialist or a facility outside the member's medical group. Referrals are made when services of a specialist are deemed medically appropriate by the PCP and the medical group. The PCP arranges for the referral and gives the member a completed referral form, which authorizes specific treatment or services. The referral authorization process varies by medical group. Many PMG/IPAs have internal policies that allow their physicians to refer directly to specialists without going through a formal referral approval process. Other PMGs allow their members to self-refer to specialists within the group. The member's medical group is also responsible for arranging second opinions and specialty care with providers within or affiliated with that medical group.

This is only a brief summary of the plan. Please refer to the Evidence of Coverage for more complete details about the plan including benefits, limitations and exclusions.

22. What if the member needs inpatient hospital care?

If the member needs to be hospitalized, the Primary Care Physician (PCP) will arrange for admission to a network hospital that works with the member's PMG/IPA. The PCP will also continue to be responsible for overseeing the member's care.

This is only a brief summary of the plan. Please refer to the Evidence of Coverage for more complete details about the plan including benefits, limitations and exclusions.

23. Do any other services require pre-certification?

The Evidence of Coverage will describe if the Blue Cross HMO health plan requires pre-certification for certain care. Generally, pre-certification for HMO benefits is the responsibility of the PMG/IPA. There is also an authorization program providing for prior approval for medical care or service by a non-Blue Cross HMO provider. In order for the benefits of the Blue Cross HMO plan to be provided, members must get approval before they get services from non-Blue Cross HMO providers. When they get proper approvals, these services are called authorized referral services. The member or the member's physician must get this authorization before scheduling an admission to, or before the members get the services of, a non-Blue Cross HMO provider. Referrals to non-Blue Cross HMO providers will be approved only when all of the following conditions are met:

- ~ There is no Blue Cross HMO provider who practices the specialty the member needs, provides the required services or has the necessary facilities within 50-miles of the member's home; AND
- ~ The member is referred to the non-Blue Cross HMO provider by a doctor who is a Blue Cross HMO provider; AND
- ~ The services are authorized as medically necessary before the member gets the services.

This is only a brief summary of the plan. Please refer to the Evidence of Coverage for more complete details about the plan including benefits, limitations and exclusions.

CAQH Phase 2 HMO Group Administrator FAQs

[\[Back to top\]](#)

Emergency Care

24. What qualifies as an Emergency?

In the Evidence of Coverage, an emergency is defined as “A sudden, serious, and unexpected acute illness, injury, including active labor, or sudden and unexpected severe pain which could permanently endanger health if medical or psychiatric treatment is not received immediately.”

This is only a brief summary of the plan. Please refer to the Evidence of Coverage for more complete details about the plan including benefits, limitations and exclusions.

25. What does a member do in case of an emergency?

If a sickness or injury is an emergency and immediate medical attention is a must, the member should go directly to the nearest emergency facility or call 911. Once the member is stabilized, the Primary Care Physician (PCP) must approve any additional care needed. The member should request that the hospital or emergency room doctor call the PCP, who will approve any other medically necessary care or will take over the member's care.

This is only a brief summary of the plan. Please refer to the Evidence of Coverage for more complete details about the plan including benefits, limitations and exclusions.

26. Do you cover emergency care?

Members and their families have coverage for medical emergencies both in and outside of the Blue Cross HMO service area.

In emergencies, the member should always go directly to the nearest emergency facility or call 911. Members may also want to call their PCP and follow his or her instructions. The PCP or medical group may:

- Ask the member to come into their office;
- Give the member the name of a *hospital* or emergency room and tell him or her to go there;
- Order an ambulance for the member;
- Give the member the name of another doctor or medical group and tell him or her to go there;
or
- Tell the member to call the 9-1-1 emergency response system.

Members may need to pay a copay for emergency room services, but this may be waived if the member is admitted from the emergency room to the hospital for inpatient care. Members must call Blue Cross of California or BC Life & Health Insurance Company within 48 hours if they are admitted to a hospital.

This is only a brief summary of the plan. Please refer to the Evidence of Coverage for more complete details about the plan including benefits, limitations and exclusions.

[\[Back to top\]](#)

Disabled Employees

CAQH Phase 2 HMO Group Administrator FAQs

27. I have an employee out on disability. How long am I required to keep them on the group health insurance policy?

You, as the employer, select the period for continued eligibility of a disabled employee. They typically range from 3 months to 6 months. Please notify Blue Cross of the time period that you are selecting.

[\[Back to top\]](#)

Coverage/Benefits

28. Will Blue Cross of California send out detailed benefit information to employees?

Generally, we provide standard plan documents to the employer for distribution to the employees. We provide separate standard evidence of coverage (EOC) booklets for each type of medical coverage. Booklets routinely include allied benefits (e.g., pharmacy). Combined booklets of all offered products are not feasible since individuals may not enroll in all available coverages.

29. What are pre-existing conditions and how do they impact coverage?

Blue Cross HMO plans do not contain pre-existing condition clauses.

30. Do you issue policies to minors?

Blue Cross of California's Small Group policies are issued to the employer, not to individuals. If for any reason an employee ceases to be eligible for the plan, the employee and its covered dependents (including minors) may be eligible to continue their coverage under COBRA or Cal-COBRA options.

31. When does coverage begin?

Coverage begins once the member has satisfied the eligibility requirements and employer waiting period, if applicable, assuming timely application.

32. What type of wellness or health promotion programs do you offer to your members?

Blue Cross offers a variety of health and wellness programs. Our goal is to improve the health status of Californians through comprehensive medical benefits and health promotion/education activities.

The health and wellness programs available include chronic disease seminars, fitness seminars, smoking cessation, sessions targeting heart health, men's and women's health issues, nutrition seminars, prenatal seminars, stress management, Weight Management Behavior Modification Program, health education literature and newsletters

We are continually reviewing and adding modules to our programs which incorporate emerging research and technology in the health and wellness field. Our professionally trained staff can also work with employer groups to identify programs specific to the group's needs.

In addition, our contracting PMGs and IPAs offer health education and wellness programs. The costs for these programs vary, but are generally minimal.

CAQH Phase 2 HMO Group Administrator FAQs

We also offer an innovative program designed to expand options through non-traditional health care services. HealthyExtensions gives members information about significant discounts offered by alternative health care practitioners on a variety of alternative health care and wellness products and services, at no additional premium cost.

Members have access to discounted services from a variety of alternative service providers, including hypnotherapists, massage therapists, and yoga instructors. These providers must pass a screening process. Providers and vendors who participate are responsible for the services and products they provide.

HealthyExtensions also provides information on discounts offered by independent vendors on a wide array of products and services, including consultations with a registered dietitian, fitness club memberships, nutrition programs, vitamin supplements and books, tapes and videos covering health, fitness, nutrition, and stress management. A variety of well-known companies have offered to give members special rates for the services and products that they offer. These companies include: drugstore.com, Lindora Lean for Life, Therapyzone.com, 24-Hour Fitness, Gold's Gym, GlobalFit, Healthyroads, House of Healing, HealthyDrugstore.com, The Chopra Center for Well Being, Beltone Hearing Centers, Newport Audiology, Vision One from Cole Vision, TruVision, Baby Genius, Complexions Rx, and Things Remembered. More information may be accessed through the [HealthyExtensions](#) area of the Blue Cross of California website.

Blue Cross of California does not necessarily endorse the goods and services offered through HealthyExtensions. Such goods and services are not benefits of Blue Cross of California coverage. Discount offers may be changed or withdrawn at any time without notice.

Employers may also choose to offer MedCall, our demand management program, which puts the power of information at our member's fingertips whenever and wherever they need it so they can become better-informed health care consumers. MedCall is automatically included for all fully-insured groups. This telephone information service puts the member in touch with nurse counselors who can answer any health care questions any time, day or night. This service includes an audio library with over 200 audio-tapes covering a wide range of health topics as well as the Healthwise Knowledgebase. Healthwise is a comprehensive resource of decision-making information created for medical consumers.

33. When traveling, can my employees receive coverage out-of-area?

Members traveling within California but outside the service area of their PMG/IPA are covered for emergency or urgent care.

Dependent children attending school away from home or living outside the employee's service area, but within the state, may select their own Primary Care Physician at a conveniently located PMG/IPA. In such cases, regular procedures for obtaining care apply.

Members traveling out-of-state are eligible for urgent or emergency care through the BlueCard provider network, an extensive network developed and locally managed by the Blue Cross Blue Shield plans across the United States. Members may need to pay a copay for emergency room services, but this may be waived if the member is admitted from the emergency room to the hospital for inpatient care. Members must call Blue Cross of California within 48 hours if they are admitted to a hospital.

[\[Back to top\]](#)

CAQH Phase 2 HMO Group Administrator FAQs

Enrollment and Renewals

34. What documentation is necessary for enrolling a group?

The following documentation is necessary for enrolling a group: application, binder check, mandatory benefit forms, new case installation paperwork and enrollment forms.

35. Does the renewal paperwork require signatures from the broker and/or the group, if there are no changes other than the renewal rates?

No, the renewal paperwork does not require signatures from the broker and/or group if there are no changes other than renewal rates.

36. What are the enrollment deadlines for a new group?

A new Employee Application must be fully completed and received by Blue Cross after the date of hire, and before the last day of the month following the end of the waiting period selected by the group. Applications must also be received no later than the last day of the month prior to the requested effective date.

37. Can a group upgrade medical and/or dental off renewal if the group has grown?

Small Group employers can apply for changes in coverage during one (1) of two (2) periods. Either once in a 12-month period or at the groups anniversary date, but not both.

38. Can a group downgrade to a less-expensive product off its normal renewal date?

Small Group employers can apply for changes in coverage during one (1) of two (2) periods. Either once in a 12-month period or at the groups anniversary date, but not both.

39. How do I submit enrollment files to the plan?

All Small Group Employee Applications requesting or declining coverage should be mailed or faxed to:

Mail: Small Group Services
 Blue Cross of California
 P.O. Box 9062
 Oxnard, CA 93031-9062

Fax: (805) 499-0842

40. Can I e-mail enrollment files to the plan?

No, Blue Cross does not accept electronic files from Small Groups.

CAQH Phase 2 HMO Group Administrator FAQs

[\[Back to top\]](#)

Eligibility

41. What is the average turnaround time required to determine a group or a subscriber's eligibility or underwriting status?

Small Group applications are reviewed for completeness and eligibility within 3-7 business days. An application can be delayed for timely processing if necessary information is not included with the submission. This may include a delay in the coverage effective date.

[\[Back to top\]](#)

Notification of Changes

42. Who must be notified of a change of address or other administrative change?

It is recommended that an address change for your firm or employees be made in writing. Only the authorized representative of the group or the employee respectively can initiate an address change. Notification of employee address changes can be submitted via a Change of Coverage Application, a Small Group Information Change Form, or by letter from the employee. Notification of an employer address change must be submitted on an Employer Application or on company letterhead and signed by an office of the company. Please note that address changes may impact the available plan selection and current rates. It is therefore important that Blue Cross be notified of address changes in a timely fashion.

Mail: Small Group Services
Blue Cross of California
P.O. Box 9062
Oxnard, CA 93031-9062

Fax: (805) 499-0842

43. How do I change the waiting/elimination/probationary period on a group's policy?

The employer can request a change only once in a 12-month period or at the groups anniversary date, however not both. The request must be submitted in writing, either by completing an updated Employer Application or simply outlining the request on company letterhead and signed by the appropriate party of authority. The request must be submitted and approved prior to the requested effective date of the change. The new waiting period would only affect those employees with a date of hire following the effective date of the change.

44. What is the maximum waiting/elimination/probationary period a group can impose?

HIPAA defines "waiting period" as "the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan". For Blue Cross Small Group's, the employer can choose a one, two, three, four, five or six month waiting period or no waiting period.

Important Note: *The waiting period is applied to all employees within the group. No exceptions can be made to this requirement. Blue Cross does not waive the waiting period for any eligible employee.*

CAQH Phase 2 HMO Group Administrator FAQs

[\[Back to top\]](#)

COBRA

45. Does COBRA coverage count as creditable coverage?

Yes, COBRA counts as creditable coverage as long as there was no break in coverage longer than 63 days under federal law. However, insured California contracts extend the break in coverage to 180 days if the prior coverage was employer sponsored and the new coverage is also employer-sponsored.

46. Do I have to offer COBRA to terminating employees or their dependents?

Yes, as mandated by Consolidated Omnibus Budget Reconciliation Act of 1985, the federal law that requires employers with more than 20 employees to extend group health insurance coverage, you must offer COBRA to terminating employees. You should also advise such persons that if they fail to take available COBRA or Cal-COBRA, they may lose rights under federal law to future guaranteed individual coverage.

For groups of less than 20 employees, Cal-COBRA is offered by the carrier to those employees who qualify. The employer must notify the carrier of the qualifying event and date.

[\[Back to top\]](#)

HIPAA

47. Who is eligible for HIPAA?

Terminated employees and/or their dependents and employees and/or their dependents who have exhausted or are not eligible for COBRA or Cal-COBRA coverage may be able to continue coverage through Health Insurance Portability and Accountability Act (HIPAA) or the Blue Cross Conversion Plan. They may also apply for Individual Blue Cross coverage.

When advising an employee or dependent of their rights to continue coverage under COBRA or Cal-COBRA, the employer must be sure that the employee or dependent understands if they do not elect COBRA or Cal-COBRA continuation, they will NOT be entitled to the HIPAA guaranteed option.

The employer is responsible for informing eligible employees and their dependents of the conversion option.

48. How does crediting for preexisting condition waiting periods work under HIPAA?

Blue Cross uses the "standard method" to credit coverage. The individual receives credit for previous coverage that occurred without a break in coverage of 63 days or more as allowed by the federal law, however, under California law, a 180-day break in coverage is allowed if both the prior and new coverage are employer sponsored. Coverage prior to the allowed break in coverage is not credited against a preexisting condition exclusion period. Blue Cross' HMO plans do not include preexisting condition exclusions.

CAQH Phase 2 HMO Group Administrator FAQs

49. How will the latest HIPAA requirements regarding security, privacy, etc. affect the products your plan offers?

The requirements do not affect the products offered, however, they do affect the way Blue Cross of California does business. Our practices and procedures will all be in compliance with HIPAA requirements.

50. What qualifies as creditable coverage?

Most health coverage is creditable coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO, individual health insurance policy, Medicaid or Medicare.

Coverage consisting solely of "excepted benefits," such as coverage solely for limited-scope dental or vision benefits is not included as creditable coverage.

Days in a waiting period during which members have no other coverage are not creditable coverage under the plan, nor are these days taken into account when determining a significant break in coverage (generally a break of 63 days or more). This 63-day break period is extended under California law to 180 days if the price and new plans are employer-sponsored. Blue Cross' HMO plans do not include preexisting condition exclusions.

51. How does an employer-imposed waiting period affect a break in coverage?

A period of creditable coverage shall not be counted if it is before a significant break in coverage if, after such period and before the enrollment date, there was a 63 day period (or 180 day period if the price and new plans are employer-sponsored) during all of which the individual was not covered under any creditable coverage. A waiting period is not treated as a break in coverage. Any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period shall not be taken into account in determining the continuous period. Blue Cross' HMO plans do not include preexisting condition exclusions.

52. How does a new employer or insurance carrier know that an employee had prior group coverage?

Group health plans and health insurance issuers are required to provide a certificate of coverage to an individual for documentation of prior creditable coverage. A certificate of creditable coverage shall be provided automatically by the plan or issuer when an individual either loses coverage under the plan or becomes entitled to elect COBRA continuation coverage and when an individual's COBRA continuation coverage ceases and shall also be provided, if requested, before the individual loses coverage or within 24 months of losing coverage. Blue Cross' HMO plans do not include preexisting condition exclusions.

53. How will newly hired employees prove that they had prior creditable coverage?

CAQH Phase 2 HMO Group Administrator FAQs

Under HIPAA, an employee's former group health plan and any insurance company or HMO providing such coverage is required to provide the employee with a statement of prior health coverage, commonly referred to as a "certificate of creditable coverage." Blue Cross' HMO plans do not include preexisting condition exclusions.

This certificate must be provided automatically to the individual when the individual loses coverage under the plan or otherwise becomes entitled to elect COBRA continuation coverage as well as when COBRA continuation coverage ceases.

An individual may also request a certificate, free of charge, until 24 months after the time their coverage ended. For example, an individual may request a certificate even before their coverage ends.

[\[Back to top\]](#)

Premiums/Rates and Quotes

54. Is payment required at the time of application?

No, you do not need to send premiums for new employees being added to the group or that do not appear on the bill. The premiums will be included on the subsequent bill, after the applications have been processed and approved by Blue Cross of California.

55. How do I obtain a small group (2-50 employees) quote?

For a small group quote, please call 1-877-275-3700.

56. How do I obtain a large group (51+ employees) quote?

To obtain a large group quote, you would submit an RFP or RFI and census information to the assigned Sales Representative or one of our nine regional large group sales offices. For assistance, please call 1-714-429-2712.

57. What percentage of premium does the employer have to contribute?

Employer must contribute at least 50% of the total premium. 100% of eligible employees and dependents must participate if the plan is noncontributory; 75% must participate if the plan is contributory. A minimum of 75% of employee premium must be contributed by the employer if no contribution is made for dependents.

58. Can a small group get lower rates if they do not use a broker?

No. For more information on a small group quote, please call 1-877-275-3700.

[\[Back to top\]](#)

Claims

CAQH Phase 2 HMO Group Administrator FAQs

59. How are claims handled for employees with more than one health insurance plan?

Blue Cross' claims processing system is programmed to check information submitted on a claim and review the member's membership profile to verify if other coverage exists, and identify a COB situation. Once a year, members are sent a questionnaire inquiring if other coverage exists. This information is loaded into the system in order to process claims correctly. Additionally, if a claim is received and there is indication of other coverage unknown to us, we pend the claim and send another questionnaire to the member asking for the COB information.

When a plan member is covered by more than one group health plan, the benefits under the member's medical and/or dental benefit plans will be coordinated as described below:

- If our plan is the primary plan, then our plan's benefits are determined first without taking into account the benefits or services of any other plan.
- If our plan is not the primary plan, then our plan's benefits may be reduced so that the benefits and services of all the plans do not exceed allowable expense.
- The benefits of our plan will never be greater than the sum of the benefits that would have been paid if the plan member were covered under our plan only.

Guidelines for investigating possible other group coverage include indications that the dependent is employed, receipt of a photocopy of a claim, or a request that the member be reimbursed directly on a high dollar claim.

We require a copy of the primary plan explanation of benefits in order to process claims for secondary benefits. All possible COB claims, regardless of claim amount, are investigated.

60. What should my employee do if a claim is denied?

Any question about the disposition of a claim can be directed to Customer Service at the phone number listed on the employee's identification card. The member's Evidence of Coverage also outlines the steps that need to be taken to follow up on a denied claim.

61. When will my employees need to file a claim?

HMO members are normally not required to file a claim form in most instances. HMO providers' capitation covers the services they provide and the services of specialists they authorize the member to use, thus eliminating the need for claim submission; however, claims need to be submitted for authorized inpatient care, emergency services and for outpatient prescription drugs purchased from a non-participating pharmacy under the Prescription Drug Program.

This is only a brief summary of the plan. Please refer to the Evidence of Coverage for more complete details about the plan including benefits, limitations and exclusions.

[\[Back to top\]](#)

NCQA

62. Is Blue Cross of California NCQA accredited?

CAQH Phase 2 HMO Group Administrator FAQs

The National Committee for Quality Assurance has awarded an accreditation status of Commendable to the Blue Cross HMO (CaliforniaCare) for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement. This accreditation is effective from 2/8/2000 through 2/8/2003.

[\[Back to top\]](#)

HEDIS

63. Does Blue Cross of California participate in HEDIS data collection?

Blue Cross of California has participated in HEDIS data collection and reporting for its HMO plan for a number of years. We recognize HEDIS as an important tool for the managed care industry as it addresses a full spectrum of health care issues from prevention and early detection to acute and chronic care. HEDIS also serves as a helpful tool for employers and members when accessing the competency level of a managed care plan. The HEDIS program is sponsored and maintained by NCQA, an independent non-profit organization that measures and evaluates the effectiveness of managed care. HEDIS was developed by a committee of health care consumers, providers, public health officials and others. HEDIS measures a plan's performance in several key areas, including effectiveness of care, stability of the health plan, accessibility/availability of care, membership and satisfaction, and use of services.

[\[Back to top\]](#)