

## CAQH Phase 2 PPO Group Administrator FAQs

### Employers/Group Administrators' Frequently Asked Questions about the Blue Cross of California or BC Life & Health Insurance Company PPO (Prudent Buyer) 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.*

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#### 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
- Dental
- Behavioral Health
- MedCall Demand Management Program
- Prescription Drug Plans
- Life and AD&D

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

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#### Pharmacy

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### 2. Does a member have to purchase prescription drugs from a network pharmacy to receive benefits?

If the member is covered by the Blue Cross Prescription Drug Plan, he/she will receive benefits for covered prescription drugs wherever they are purchased. However, the member will usually pay less out of pocket if he/she purchases prescription drugs at network pharmacies.

### 3. How can a member 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.

### 4. 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.

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

All Small Group plans include prescription drug coverage as part of the schedule of benefits. The option to decline prescription coverage is not available.

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## **Provider Network**

### 6. Describe your provider networks.

#### MEDICAL:

Blue Cross of California's PPO network includes coverage throughout the state (over 42,000 physicians and 418 hospitals). In addition, through our affiliation with the Blue Cross Blue Shield Association, we can offer members outside of California the BlueCard program, which is comprised of an extensive network locally managed by the Blue Cross and/or Blue Shield plans across the United States. All network providers are carefully screened and must meet and maintain high standards of quality. This includes coverage both at home and when our members are traveling. Location specific information is available via the [Provider Finder](#) feature on our home page or by contacting your local Blue Cross Representative.

#### PHARMACY:

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Blue Cross of California has an extensive nationwide pharmacy network that includes both chain and independent pharmacies. In California, our network includes over 4,700 pharmacies, which represents approximately 95% of all pharmacies in the state. Our nationwide network includes almost 52,000 pharmacies, which is approximately 95% of all chain and independent pharmacies throughout the country.

These networks are also used by BC Life & Health Insurance Company.

### **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.

### **8. What is the difference between in-network and out-of-network?**

When members choose to receive care from a Blue Cross PPO participating network provider, they pay less out of pocket (sometimes only a small copayment for each visit) and generally do not have to file claims.

When the provider is not contracted with the Blue Cross PPO network, benefits are usually less and the member's share of the costs will be higher, including deductible, coinsurance, and possibly the balance in excess of our allowance. In addition, many out-of-network providers may require immediate, full payment from the patient and require the patient to submit a claim to Blue Cross in order to receive benefits.

### **9. How do I know what network is affiliated with my health plan?**

While all PPO members can access any participating Blue Cross/Blue Shield participating provider, members can tell whether they belong to Blue Cross PPO or BlueCard by their ID card. For Blue Cross PPO, the Blue Cross logo appears in the upper left hand corner of the ID card. For BlueCard, the Blue Cross/Blue Shield logos appear in the upper left hand corner of the ID card.

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### **ID Cards**

### **10. How does the member use his/her Blue Cross of California or BC Life & Health Insurance Company 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 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 plan booklet.
- Report an emergency hospital admission.

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- 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.*

### **11. 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.

### **12. Whose name and member ID/certificate number should appear on the ID card?**

For PPO products, Blue Cross of California or BC Life & Health Insurance Company issues ID cards in the name and certificate number of the subscriber only. Two (2) cards will be issued with any new enrollment or request for replacement ID cards.

### **13. What if the member loses the ID card or needs to order additional cards?**

If the member loses his/her Blue Cross of California or BC Life & Health Insurance Company 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.

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## **Physicians and other Providers**

### **14. 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.

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### **15. What if a provider the 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.

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.

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

To ensure that the member receives in-network benefits, the member should always ask the provider's office staff to confirm when the member makes the first appointment that the provider is still in the Blue Cross PPO network. Members can also check the [Provider Finder](#) on this web site.

### **17. What are the advantages of using a network provider?**

When members choose to receive care from a Blue Cross PPO participating network provider, they pay less out of pocket (sometimes only a small copayment for each visit) and generally do not have to file claims.

When the provider is not contracted with the Blue Cross PPO network, benefits are usually less and the member's share of the costs will be higher, including deductible, coinsurance, and possibly balance in excess of our allowance. In addition, many out-of-network providers may require immediate, full payment from the patient and require the patient to submit a claim to Blue Cross in order to receive benefits.

### **18. What happens if a current physician is not a network provider?**

The member can call the provider or Blue Cross Customer Service to find out if the provider has joined the network since the website information was last updated or the directory was last printed. If the current provider is not in the Blue Cross PPO network, the member may choose to see the provider; however, only the limited out of network benefits will apply.

Members may nominate a physician for inclusion in the network. We are willing to recruit additional physicians provided that these physicians meet our criteria for participation and that the addition of them is consistent with overall strategies for optimum network accessibility.

New members who are in the hospital or who have ongoing care on the effective date may be eligible for transition assistance. Transition assistance is a process that allows continuity of care for new members whose treating physicians are not part of the Blue Cross network and who are:

- In the midst of treatment for an acute condition or a serious chronic condition.
- In their second or third trimester of pregnancy or are high risk regardless of trimester.
- Hospitalized or already scheduled for certain surgeries at the time their coverage becomes effective. When eligible, members complete treatment with the non-network provider at their

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higher in-network benefit level. Transition Assistance eligibility is determined on the individual member's clinical condition and not by diagnostic classifications.

Blue Cross transition assistance staff ensure that qualified members and their covered dependents receive uninterrupted care until their course of treatment is complete or until their care can be safely assumed by a participating network provider. Most members complete treatment or safely transition to a Blue Cross contracted provider within 90 days; however, because the Blue Cross network is so extensive, many members who apply for transition assistance are pleased to learn it is not necessary since their treating provider(s) are contracted.

### **19. What if a network provider isn't available to treat a condition?**

Generally, the in-network level of benefits is available only when a network provider is used. However, if a certain service is required that is not available through a participating provider, the member can request an out-of-network referral if out-of-network referrals are permitted by the plan of benefits.

Referrals to non-participating providers will be authorized only when all of the following criteria are met:

1. There is no participating provider who practices the appropriate specialty or provides the required services or has the necessary facilities within a 50-mile radius of the member's residence;
2. The member is referred to the non-participating provider by a physician who is a participating provider; and
3. The services are authorized as medically necessary before services are received.

For more information, members should call Customer Service at the number on their ID card.

### **20. Can the member go to a non-network provider?**

Yes, under a PPO, the member has out-of-network benefits. Generally, the Blue Cross PPO Plan covers the same health services whether the member receives them in-network or out-of-network. The member will, however, usually pay higher out-of-pocket costs for out-of-network care, in the form of deductibles, coinsurance and possibly balance billing.

### **21. 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 listed 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.*

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

The benefit summary in the member's evidence of coverage specifies the amounts and the types of out-of-pocket charges for covered services. Depending on the service and whether the provider is in-network or out-of-network, the member may have to pay:

- Copayment - the amount the member pays for each physician home or office visit. Network physicians agree to accept the member's copayment and Blue Cross' reimbursement as payment-in-full for covered services if the plan pays 100% of the covered charge. If the Schedule of Benefits states that the plan pays less than 100% for physician office visits, the member may have additional out-of-pocket costs.
- Deductible - the amount the member or covered family member must pay annually before Blue Cross begins to pay for covered services other than in-network physician visits. Copayments do not count towards the annual deductible. The Schedule of Benefits states the amount of the deductible and whether it exists for both in-network services and out-of-network services, or out-of-network services only.
- Coinsurance - the percentage of the covered charge the member pays out-of-pocket after any deductible or copayment. The percentage of the coinsurance amount for in-network care is usually lower than the percentage of coinsurance for out-of-network care.
- Out-of-Pocket Limit - To protect the member from high medical expenses, the plan may limit the amount the member must pay out-of-pocket each year for all covered services. Once the member reaches the out-of-pocket limit, the plan pays 100% of covered charges for the rest of the calendar year, subject to the terms and conditions of the plan. Depending on the plan, deductible and coinsurance payments for certain kinds of expenses may not apply toward the out-of-pocket limit. The member should refer to his/her evidence of coverage for out-of-pocket limit and charges to which the out-of-pocket limit does not apply.
- Reasonable and Customary Charge - the amount, determined by Blue Cross, that most providers in the member's area charge for the same service or procedure in the same setting (office or hospital). Out-of-network deductibles and coinsurance apply only to the provider's charge, or Blue Cross' reasonable and customary charge, whichever is less.
- Balance Bill - The amount a provider may bill the member if the charge for care is greater than Blue Cross' reasonable and customary charge. Blue Cross does not cover this amount, nor will it count toward any plan out-of-pocket maximums. Network providers never balance bill for covered services. They always accept as payment-in-full the total of any copayment, deductible and coinsurance that the member pays and the network reimbursement that Blue Cross pays.

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

In choosing a new physician (whether in-network or out-of-network), 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?

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- Does the member have friends or colleagues who recommend the physician from first-hand experience?

### **24. 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.

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### **Approvals and Referrals**

### **25. What if a member needs Specialists, Lab Tests or X-rays?**

If a member or a covered dependent needs any of these services, he/she will not need a referral. If the member goes to a network provider, he/she will keep out-of-pocket expenses to a minimum. If requested, network physicians can usually help refer the member to another provider in the network.

### **26. What if the member needs inpatient hospital care?**

All inpatient admissions (except urgent/emergent admissions) are precertified by telephone for medical necessity and length of stay according to the guidelines in the member's Evidence of Coverage. Emergency admissions are reviewed by telephone for medical necessity within twenty-four hours or the next working day after admission. If medical necessity criteria are met, the admission is then certified for level of care and length of stay. If medical necessity criteria are not met, the case is referred to a physician advisor for determination.

The prospective review process evaluates medical necessity, appropriate level of care and assigns expected length of stay. It also identifies catastrophic diagnoses for potential case management referral and redirects or channels care to appropriate network providers when indicated.

PPO providers are contractually bound to initiate utilization reviews for the member, or the member can call a toll-free number to initiate the process. A registered nurse review coordinator then contacts the provider's office by telephone to obtain the necessary clinical information regarding the patient's condition and the proposed treatment (i.e., proposed procedure, procedure date, admission date and preoperative preparation). The review nurse determines medical necessity of the proposed procedure, appropriate setting and length of stay using established medical criteria, which includes, but is not limited to, severity of illness/intensity of service.

### **27. Do any other services require pre-certification?**

The Evidence of Coverage will describe if the Blue Cross PPO plan requires pre-certification for certain outpatient diagnostic tests and surgical procedures or for services like home health care or skilled nursing facility admissions. Procedures for obtaining pre-certification for these services, if required, are the same as for inpatient admissions.

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### Emergency Care

#### **28. What qualifies as an Emergency?**

In the Evidence of Coverage, an emergency is defined as “a sudden, serious, and unexpected acute illness, injury, or condition (including without limitation sudden and unexpected severe pain) which the member reasonably perceives, could permanently endanger health if medical treatment is not received immediately. Final determination as to whether services were rendered in connection with an emergency will rest solely with us.”

*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.*

#### **29. What does a member do in case of an emergency?**

Members are instructed to go to the nearest participating hospital or call 911 for assistance, as appropriate, to obtain emergency care. Out-of-network inpatient care continues to be classified as emergency service, as long as a transfer to network facilities would pose a health risk, or would be unreasonable, given the distance involved and the nature of the member's medical condition.

For an emergency admission or procedure, we must be notified within 48 hours of the admission or procedure, unless extraordinary circumstances prevent such notification within that time period.

*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.*

#### **30. Do you cover emergency care?**

Blue Cross covers emergency care wherever and whenever our members need it - 24 hours a day, seven days a week. If faced with an emergency, a member should always seek immediate care by going directly to the nearest emergency room or calling 911. Benefits for covered emergency services will be the same whether or not the hospital is in-network or out-of-network. Many plans require a special copayment for emergency room care. The member makes the same copayment whether the emergency room is an in-network or out-of-network facility.

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### Disabled Employees

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

The period for continued eligibility is determined by the employer at the time of application. The length of time will vary based on that selection (Typically 3 or 6 months). An employee in the position should contact their employer or Blue Cross of California for verification.

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### Coverage/Benefits

#### **32. Will Blue Cross of California or BC Life & Health Insurance Company 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.

#### **33. What are pre-existing conditions and how do they impact coverage?**

Pre-existing condition means an illness, injury or condition which existed during the six-month period immediately prior to either (a) the member's effective date or (b) the first day of any waiting period required by the group, whichever is earlier. A condition is considered to have existed when the member: (1) sought or received medical advice for that condition; (2) received medical care or treatment for that condition; or (3) received medical supplies, drugs or medicines for that condition.

No payment will be made for services or supplies for the treatment of a pre-existing condition during a period of six months following either the member's effective date or the first day of any waiting period required by the group, whichever is earlier. However, this limitation does not apply to a child born to or newly adopted by an enrolled subscriber or spouse, or to conditions of pregnancy. Also, if the member was covered under creditable coverage, the time spent under the creditable coverage will be used to satisfy, or partially satisfy, the six-month period.

*Please reference the Evidence of Coverage for further information.*

#### **34. 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.

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

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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.

### **35. When traveling, can my employees receive coverage out-of-area?**

Blue Cross PPO members may elect to self-refer to non-contracting providers out of their service area and be eligible for the out-of-network level of benefits for covered services. However, PPO members also have access to BlueCard PPO providers nationwide, which allows members to take advantage of the providers' negotiated rates. The BlueCard PPO is comprised of an extensive network developed and managed at the local level by independent Blue Cross and/or Blue Shield plans across the United States. In addition, emergency services are covered at in-network levels.

### **36. Does Blue Cross of California or BC Life & Health Insurance Company 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.

### **37. When does coverage begin?**

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

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### **Enrollment and Renewals**

#### **38. What documentation is necessary for enrolling a group?**

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

#### **39. 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.

#### **40. 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.

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

A group can apply for a change in benefits during one (1) of two (2) options-- Either once in a 12-month period or during their anniversary month, but not both.

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

A group can apply for a change in benefits during one (1) of two (2) options -- Either once in a 12-month period or during their anniversary month, but not both.

#### **43. 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

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Oxnard, CA 93031-9062

Fax: (805) 499-0842

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

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

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**Eligibility**

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

Fully completed applications are reviewed and processed by membership services within 3-7 business days of receipt. Any application that is missing necessary information may be delayed. This delay could include a delay in the effective date of coverage.

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**Notification of Changes**

**46. 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

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

A group can apply for a change in their waiting period under the same conditions as a benefit change. This can be submitted by completing an Employer Application or by outlining the requested changes on company letterhead and signed by the appropriate authorized

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representative. The new waiting period will apply only to those employees hired on or after the effective date of the updated waiting period.

### **48. 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.*

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## **COBRA**

### **49. 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.

### **50. 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.

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## **HIPAA**

### **51. 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.

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

### **52. 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.

The following does not apply to Blue Cross of California or BC Life & Health Insurance Company:

A plan or issuer may elect the "alternative method" for crediting coverage for all employees. The plan or issuer determines the amount of an individual's creditable coverage for any of the five specified categories of benefits, which are mental health, substance abuse treatment, prescription drugs, dental care and vision care. The standard method is used to determine an individual's creditable coverage for benefits other than the five categories that a plan or issuer may use. (The plan or issuer may use some or all of these categories.)

With the alternative method, the plan or issuer looks to see if an individual has coverage within a category of benefits (regardless of the specific level of benefits provided within that category).

If your employer's plan requests information from your prior plan regarding any of the categories of benefits under the alternative method, your former plan must provide such information.

### **53. 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 and BC Life & Health Insurance Company do business. Our practices and procedures will all be in compliance with HIPAA requirements.

### **54. 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 coverage is insured and the break in coverage is related to employer-sponsored coverage.

## **CAQH Phase 2 PPO Group Administrator FAQs**

### **55. 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 related to employer sponsored coverage under a Blue Cross insured plan) 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.

### **56. 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.

### **57. How will newly hired employees prove that they had prior creditable coverage?**

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."

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.

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### **Premiums/Rates and Quotes**

### **58. 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.

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

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

## **CAQH Phase 2 PPO Group Administrator FAQs**

### **60. 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.

### **61. 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.

### **62. 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.

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## **Claims**

### **63. 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.

## CAQH Phase 2 PPO Group Administrator FAQs

### **64. 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.

### **65. When will my employees need to file a claim?**

PPO providers and hospitals participating under our standard business contracts will submit claims on the member's behalf. Other providers may require members to submit their own claims. Members may call the customer service number on the ID card or [contact us](#) through online [Member Services](#) if you need additional information.

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