

Regence BlueShield of Idaho
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Benefits Administrator Guide

ADMINISTERING YOUR REGENCE HEALTH PLANS

*share the well*SM



Regence

Group Administrator's Manual

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Introduction

This manual is designed to help you administer your employee benefits program. Detailed information is included on benefits, eligibility, enrollment, monthly billing statements and claims submission to help you answer your employees' questions.

Because this manual will be used as a reference by different groups with varying benefits, it includes only our standard policies and procedures. *Please refer to your contract and booklet for specific policies pertinent to your group size and benefits. Any special eligibility enrollment procedures or other provisions specified in your contract or booklet supersede materials in this manual.*

The Benefit Administrator's Role

As a benefit administrator, your employees will often come to you with questions relating to their health care benefits. This guide will help you answer many of those questions and provide information you'll need to administer your group's plan.

The following information will help you become familiar with your role as benefit administrator:

1) Enroll new employees

When new employees are hired, you will provide a brief explanation of your group's benefits and the options being offered. Then, make sure that the proper forms are completed, signed and returned to us on time. Applications for enrollment and changes to enrollment are available on our [website](#).

2) Provide new employees with copies of required member notices, including:

- a) Your Special Enrollment Period Rights
- b) Notice of Pre-Existing Condition Exclusion
- c) Notice of Privacy Practices
- d) Notice of Women's Health and Cancer Rights Act
- e) General Notice of COBRA Continuation Rights, if applicable

3) Provide the appropriate creditable or non-creditable prescription coverage notice to new employees, those current employees approaching Medicare eligibility, and all employees annually.

This letter is available on our [website](#).

4) Communicate benefit changes

Occasionally, benefits will change for reasons that may include government requirements (mandated benefits or legislative changes), the development of new technologies or treatments, or contract revisions negotiated with your group. **You will be notified at the time of your renewal, or other times throughout the year as applicable, of any benefit or administrative changes.** We rely on you to inform your employees about these changes when they occur.

5) Answer employee questions

This guide will be most helpful to you when employees come to you with questions about their Regence coverage. You will find many of the answers here, along with explanations of which forms need to be completed and how and when they should be submitted.

6) Verify eligibility

It is the designated group contact or benefit administrator's responsibility to verify that all employees and dependents are eligible under the contract's Eligibility Provisions. We reserve the right to examine employee records to confirm any employee's employment status. We may also discontinue this contract or coverage for a member on any premium due date with written notice and/or re-rate and collect any additional funds from the group as follows: for fraud or intentional misrepresentation of material fact by the group; for the group's failure to provide us with quarterly state tax and wage detail reports and/or other employment records as

deemed necessary to validate eligible employees; for annual census information; for failure to respond to our written request for current status information, including group size, participation and contribution; or for failure to comply with our minimum participation or employer contribution requirements.

a) Ineligible persons

It is the designated group contact or benefit administrator's responsibility to delete terminations from the billing in a timely manner. We can retroactively terminate coverage and refund premiums up to 30 days prior to the date we received your request to terminate a member's coverage as long as no claims have been paid for expenses incurred during the period of ineligibility. If we have paid claims for the member in question, the premium is due and must be paid for that member during the period in which claims are incurred. If this contract is terminated, we shall refund any unearned premium to the group. If this contract is terminated because of material misrepresentation, we shall refund to the group any unearned premium less the amount of paid claims.

b) Eligibility audits

We have an enrollment audit process that helps keep premium for coverage as low as possible by ensuring compliance with eligibility provisions. The enrollment audit process includes periodically checking group employment records for compliance with our eligibility requirements. Most eligibility mistakes are the result of misinterpretations of our enrollment provisions. In these cases, we can provide additional information about your options.

Where to Go When You Have Questions

Membership

If you have questions regarding enrollment and/or eligibility, please contact your membership administrator at 1-800-505-6801.

Customer Service

We have knowledgeable Customer Service specialists who can quickly and accurately answer your employee's specific questions about their benefits and claims.

- **Innova[®] and EngageSM**: 1 (888) 367-2117
- **ActivateSM**: 1 (866) 219-6356
- **Regence HSA Plans**: 1 (877) 508-7359

When you have specific questions regarding benefit changes, new programs, premiums, etc., please call your Regence account executive.

Web Address

www.id.regence.com

Eligibility and Enrollment Guidelines

This section outlines our administrative policies about eligibility and enrollment. Complete eligibility information is included in your contract and benefit booklets. In the contract this information is found in the “Member Eligibility” section; in the benefit booklet it is in the “Who Is Eligible” section.

1) New Hires

All new members enrolled will become effective the first of the month following satisfaction of any employee new-hire probationary period requirements (except newborns and adopted children). Changes to your group’s probationary period can be made only during the annual enrollment period, to be effective on the date of renewal.

Any member living in or moving to Hawaii will not be eligible for coverage.

Eligible employees must be actively employed at the time of enrollment.

Once members are enrolled, we will send member cards to the address provided in the member’s record.

Newly hired employees and their eligible dependents have 30 days **from the date they first become eligible** to submit an Application for Enrollment/Change. Employees and dependents who do not submit their applications within the specified time period will be classified as late enrollees and will not be eligible to submit applications until the group’s next annual open enrollment period (or the occurrence of an event that triggers a special enrollment opportunity; see “Special Enrollment Period” on page 8).

Employees who decline medical/dental coverage for themselves or their dependents when they are initially eligible will be required to complete a Waiver Form. (Groups with more than 100 eligible employees are not required to submit Waiver Forms.) If an employee declines due to having other coverage, we require that the name of the other carrier and the employee’s policy number be provided on the form. Waiver Forms are available on our [website](#) or in the *Forms* section of Employer Center. Employees who involuntarily lose other coverage may be eligible to enroll in the plan before your next open enrollment period provided we receive an Application for Enrollment/Change within the required timeframe.

2) Grandchildren/Guardianship

A grandchild or child placed in an employee’s home due to guardianship can be added to a contract if the Application for Enrollment/Change is received within 60 days of the custody date based on the court papers. The court papers must be submitted within 90 days of the custody date.

3) Adoption

An adopted child may be added to a contract if the Application for Enrollment/Change is received within 60 days of date of placement. The effective date of coverage must be the date of placement. Appropriate adoption paperwork

must be received within 90 days of the date of placement to verify eligibility before the child is added to the coverage.

4) Domestic Partner

If this coverage is elected on the Group Master Application, a domestic partner's Affidavit of Qualifying Domestic Partnership form must be received within 30 days of the date the Application for Enrollment/Change is received if it is not submitted with the application. This form is available on our [website](#) or in the *Forms* section of Employer Center.

5) Dependent Maximum Age

The dependent maximum age is 26 for Idaho-based groups. Once a dependent reaches maximum age, eligibility will be terminated on the last day of the birth month. Regence will send the member a cancellation letter, along with a Certificate of Coverage.

6) Incapacitated Dependents

If a dependent child needs coverage beyond the dependent maximum age and is incapable of self-support due to a developmental disability or physical handicap or is disabled due to physical impairment that began prior to reaching the maximum age, the dependent must be unmarried, meet the other dependent eligibility requirements of the contract/booklet and be approved by Regence.

For requests for dependent enrollment with a new-group sale, the dependent must have been continuously covered as a dependent on the group's coverage since reaching the maximum age, or the dependent must be active on the employee's coverage with Regence immediately prior to reaching the maximum age.

An Affidavit of Qualifying Incapacitated Dependent Eligibility form is available on our [website](#) or in the *Forms* section of Employer Center. Section One of the form, "Statement of Dependent's Eligibility," must be completed by the employee; Section Two, "Statement of Incapacitation," must be completed by the dependent's attending physician. Regence must receive the completed form within 31 days of the dependent reaching the maximum age or when initially eligible as part of a new group, as stated above. Regence will make a determination based on the information provided. If Regence denies the request, a letter will be sent to the employee informing them of the determination. All incapacitated dependents will require recertification not more frequently than once a year.

7) Newborns (including children adopted and placed for adoption)

The request must be received within 60 days from the date of birth or adoption or placement for adoption. The dependent will be enrolled from the date of birth or the date of placement if the Application for Enrollment/Change is received as specified above. All newborns must be effective on the newborn's date of birth.

8) Loss of Coverage

For a spouse or dependent added due to involuntary loss of eligibility from other coverage, coverage will be effective the first of the month following the loss of coverage. The request for coverage must be received within 30 days from the notification of loss of coverage. Information about the involuntary loss of coverage

needs to be listed on the Application for Enrollment/Change. If this information is not listed, a Certificate of Coverage will be required from the previous carrier.

9) Reinstatements

The request for reinstatement without a break in coverage must be received within the same month or within 30 days of the date the termination was processed. If you have questions or need assistance, please contact your Regence membership administrator.

Employee/Dependent Termination

If an employee or dependent no longer meets the contract's eligibility requirements, they must be terminated from coverage effective the last day of the month in which their eligibility ends.

In the case of death, employees will be terminated as of their date of death; any dependents will be cancelled effective the last day of the month of the employee's death.

For all termination requests, please contact your membership administrator in writing or by phone within 30 days. If it has been more than 30 days and your policy renewed after Sept. 23, 2010, a new requirement under federal health care reform requires certain criteria must be met to allow a retroactive cancellation due to an administrative delay in record-keeping.

When that happens, retroactive cancellations may be acceptable as long as:

- The plan covers only active employees (or those on COBRA)
- The member did not contribute to any premium beyond the requested effective date of cancellation
- The member did not have any expectation of coverage beyond the requested effective date of cancellation

If your policy renewed after Sept. 23, 2010, and you would like to request member cancellation(s) effective more than 30 days retroactive, please complete and submit a [Request for Retroactive Cancellation form](#) to confirm that the member(s) do not (or did not) have an expectation of coverage after the cancellation effective date and paid no premium(s) after the cancellation effective date.

If an employee or dependent(s) is no longer eligible for coverage, it may be possible for them to continue their coverage. If COBRA/Non-COBRA continuation is selected, the remaining active members will be enrolled on their own coverage. Please refer to page 10 for more information.

When an Employee Is Rehired

An employee will not be required to re-serve a new-hire probationary period if he or she is rehired within three months by a small group (2-50) or nine months by a mid-size or large group (51+). Mid-size and large groups may customize the provision of their rehire policy with underwriting management approval.

Annual Enrollment Period (Open Enrollment)

Group plans have an annual enrollment period at the group's renewal, which is often called "Open Enrollment." Open Enrollment (OE) is the window of time from the first of the month prior to the group's renewal through the last day of the renewal month. Employees and dependents who did not enroll when initially eligible may enroll during this period. Coverage begins the first day of the group's renewal month. **Please note: Employees residing in Hawaii are not eligible.**

Member Cards

Once enrollment is complete, we will send member cards to employees using addresses we have on record. If a duplicate card is needed, the employee can call Customer Service or log onto myRegence.com. By logging on, the employee will be able to change the level (see below for explanation) and background(s) of the card.

Card Level

Members can choose between a family-level or member-level card. A family-level card will list all family members on the same card. Two identical family-level cards will be generated and mailed to the employee's home, regardless of how many family members there are. A member-level card will display one member per card. Each member will receive one card. If a member doesn't make a card-level selection, a family-level card will be provided.

Card Background

Members can choose among seven different card backgrounds when ordering a card on myRegence.com. These backgrounds include:

- Diamonds
- Circles
- Snowboarder
- Boise Landscape
- Salt Lake City Landscape
- Seattle Landscape
- Portland Landscape

If a card background isn't selected, the member will receive the Diamonds background.

Special Enrollment Period

Employees may be eligible for a special enrollment period for themselves or their dependents if they did not enroll when initially eligible.

- 1) If an employee or dependent involuntarily loses coverage under another group health plan or other health insurance due to loss of eligibility under the Health Insurance Portability & Accountability Act (HIPAA) special enrollment rights, including exhaustion of COBRA coverage, they may be eligible to enroll on this group plan.

Coverage will commence on the first day of the month following the date of loss, provided the Application for Enrollment/Change is received within 30 days.

- 2) A member can be added at any time due to a family status change (marriage, birth or adoption).
 - a) In the case of marriage, coverage will commence for the employee (if not already enrolled), spouse and all other eligible dependents on the first day of the month following the date of marriage and after Regence has accepted the Application for Enrollment/Change, provided application is made within 60 days of the date of marriage.
 - b) In the case of a natural born child, coverage for the newborn (and employee, spouse and other dependents if not already enrolled) will commence retroactive to the date of birth, provided the Application for Enrollment/Change is received within 60 days of the date of birth.
 - c) An adopted child may be added to a contract effective the date of placement if we receive the application within 60 days of date of placement. Since adoption paperwork often takes longer than 60 days for completion, however, we give the member 90 days from the date of placement to provide the appropriate adoption paperwork that verifies eligibility. .

Notice of New Special Enrollment Period

As of April 1, 2009, our group health plan is subject to a new special enrollment period. A special enrollment period is an opportunity for certain individuals, who otherwise are eligible for, but have not enrolled in a group health plan, to enroll outside the group health plan's annual open enrollment period.

This new special enrollment period is available to an employee or eligible dependent if either:

- The employee or the dependent loses coverage under either a Medicaid plan under title XIX or under a state child health plan (CHIP) under title XXI of the Social Security Act due to a loss of eligibility for that program's coverage; or
- The employee or the dependent becomes eligible for premium assistance with respect to the cost of coverage under our group health plan through either a Medicaid plan under title XIX or under a state child health plan (CHIP) under title XXI of the Social Security Act.

In either of the above situations, the employee or the dependent has 60 days from the date of the triggering event described above to exercise the special enrollment right.

Federal Rules Applying to Employees and Dependents Age 65 or Older

- 1) You must give the employee the appropriate creditable/non-creditable drug coverage letter regarding enrollment in Medicare Part D.
- 2) In groups with fewer than 20 employees, an employee who qualifies for Medicare on the basis of age may, if actively employed, continue in the group with the same benefits, but Medicare will pay as primary. (However, the group coverage will not duplicate benefits provided by Medicare.)

- 3) Groups with 20 or more employees are required to offer active employees age 65 or over and dependents age 65 or over of active employees of any age the same group health care benefits offered to other employees and dependents under age 65. If such employees and dependents qualify for Medicare on the basis of age, this group health care coverage will be primary to Medicare.

Please contact your legal counsel if you have questions regarding your responsibilities.

COBRA

COBRA applies to employer groups that have employed 20 or more employees for 50% or more of the typical business days in the preceding calendar year, with the exception of federal government plans and church plans.

The group is responsible for determining eligibility for their employees and dependents. It is the group's responsibility to provide notification of available continuation options to eligible members. Electing COBRA does not guarantee eligibility, and your membership administrator will validate the information on the Application for Enrollment/Change.

Please contact your legal counsel if you have questions regarding your responsibilities.

Visit the **COBRA administration [website](#)**.

Non-COBRA Continuation of Coverage

A group that is not required to offer COBRA Continuation of Coverage must offer a continuation of group coverage benefits upon loss of eligibility of coverage. If your group is not eligible for COBRA there are other options for continuation of group coverage. Please refer to your contract for details. You must notify your employees and their enrolled dependents of their continuation rights. The maximum continuation of benefits period is six months; however, there are circumstances that can result in an earlier termination of the continuation of benefits.

Conversion

When eligibility under the contract terminates at the end of any available continuation coverage (COBRA or Non-COBRA continuation) period, members will be allowed to convert to a conversion program through us provided that they meet the following conditions:

- They have been continuously enrolled and eligible under the contract or its predecessor for a least the six months immediately prior to termination;
- They do not acquire other group coverage covering all pre-existing conditions that are covered under the contract; and
- Their loss of eligibility is not the result of failure to pay any required contribution to the cost of coverage.

The conversion program will be the comprehensive major medical conversion coverage in effect at the date of conversion offered by us to members upon termination of coverage. The conversion coverage will not include dental benefits, and maternity benefits will be available only under a family contract continued through the termination of a covered pregnancy. All members who are covered as part of the same family under the contract and who lose eligibility at the same time must choose to convert coverage as a family. This conversion option will be available only after the member has exhausted all rights to continuation of coverage under any applicable federal or state law. The conversion option must be exercised within 60 days following loss of eligibility, including COBRA continuation rights. When such continuous coverage is maintained, no medical underwriting is required and pre-existing condition limitations will not be imposed.

Note: COBRA continuation coverage is not the same as conversion coverage. Conversion coverage provides an Individual policy of health coverage handled directly between the member and the health plan, provided the member applies for conversion coverage within the applicable time limits. Unlike COBRA continuation coverage, conversion coverage does not guarantee coverage identical to that described in the benefit booklet, and the premium will be paid directly to us at Individual rates.

Notice of Pre-Existing Condition Exclusion

This plan imposes a pre-existing condition exclusion. This means that members who are age 19 or older and have a medical condition before coming to our plan may have to wait a certain period of time before the plan will provide coverage for that condition.

HIPAA mandates that all carriers credit time previously served under a creditable coverage (or chain of creditable coverages) toward a new carrier's pre-existing condition waiting period as long as there is no lapse in coverage of 63 days or more between one creditable coverage and the immediately preceding creditable coverage. If state laws are less restrictive than federal laws (beneficial to the member), then state laws will be followed.

Information regarding creditable coverage can be submitted on the Application for Enrollment/Change, online enrollment or certificate of creditable coverage. Members will receive a letter describing how much, if any, time they have left to meet on their pre-existing condition waiting period.

Dental contracts with an orthodontia benefit include an orthodontic waiting period, which will be waived with proof of any prior dental coverage (if there hasn't been a lapse in coverage). Prior dental coverage is not required to have included prior orthodontic coverage.

Understanding Your Group Bill

Premium Payments

All premium payments are due on the first day of each month. We request you pay the total amount billed; any adjustments will appear on the next billing. If paying by check, please include the stub located on the bottom of your invoice.

You can have your premium deducted directly from your group's bank account by filling out a Surepay agreement form. Draft dates can be on the fifth of each month for the current month's bill or the 25th for the next month's bill.

For groups that haven't selected Surepay, we will generate an invoice 25 days prior to the due date or once payment is received and reconciled, whichever is later. Surepay invoices are created four days prior to the draft date.

Members' Social Security numbers will not be included on the bill. Instead, members will be listed by name and date of birth. The invoice will include type of coverage, covered members and subtotal amounts (medical, dental, etc.), followed by total premium due per member. Please review your invoice each month for accuracy and contact your membership administrator with any discrepancies.

- 1) **The Billing Summary** – Description of all activity since your last billing
- 2) **Current Month Billing** – Amount billed for this billing period
- 3) **Adjustment** – Any adjustment debit or credit not reflected on the last bill
- 4) **Variance** – Difference between original amount billed and adjusted amount billed based on updated eligibility, and how those two amounts compare to the amount paid
- 5) **Outstanding Balance** – Any balance due from a previously reconciled billing period based on premium adjustments
- 6) **Unapplied Premium** – Premium that has been received but not applied to a billing invoice
- 7) **Total Amount Due** – Amount to be paid by the first of the month

Delinquency or Nonpayment of Premium

Payment **must** be paid in full or within 90% or more of the total amount due (tolerance level) to avoid delinquency.

Reminder notices are sent on accounts that are past due.

Any account that is not paid within tolerance by the 30th day after billing will be terminated for non-payment. Cancellation letters will be sent to the group. Members will receive a cancellation letter and their Certificate of Coverage letter.

Groups that have been cancelled for non-payment must request reinstatement in order to be considered for continuation of coverage. The request must be in writing and should include an explanation for the delinquency. Any request for reinstatement received after four weeks from the date of cancellation will be considered an exception and would be

granted only by written agreement from Regence. A group will not be considered for more than **one reinstatement within a 12-month period**.

Bankruptcy

In the event of a bankruptcy filing, please notify the appropriate Regence membership administrator of the file number and date of filing.

Note: Please include specific information on Chapter 7 and Chapter 11 processes.

Termination of Group Coverage

If your group wants to terminate coverage, we ask that you send the request in writing to your agent or Regence account executive indicating the reason for termination. We will generate a final billing after termination. We will issue a refund if there is a credit on the account following its termination.

Filing a Claim

A member must present his or her member card when obtaining covered services from a network provider. Any additional information that is requested must also be provided. The provider will furnish us with the forms and information we need to process your claim.

If the member obtains covered services from a non-network provider, the member must submit a claim to Regence. For information on how to submit a claim, please refer to the benefit booklet.

Within 30 days of receipt of a claim, we will notify the member of the action we have taken. This 30-day period may be extended by 15 days under certain circumstances (as outlined in the benefit booklet).

Family and Medical Leave Act of 1993 (FMLA)

The federal Family and Medical Leave Act (FMLA) guarantees up to 12 weeks of unpaid leave each year to workers who:

- Need time off for birth or placement of a child for adoption or foster care
- Need to care for a spouse or immediate family member with a serious illness
- Are unable to work because of a serious physical or mental health condition

The FMLA is an employer law—it covers employers with 50 or more employees and affects many job-related rights of employees. Among other things, this law also affects the health benefit plans maintained by employers that are required to comply.

Employers are required by FMLA to continue to provide group health benefits at the same level and under the same conditions as if the employee had continued to be

actively at work. An employee entitled to COBRA continuation as a result of not returning to active employment following FMLA leave will be entitled to COBRA continuation coverage, the duration of which shall be calculated from the date the employee fails to return from the FMLA leave.

For specific questions, call your Regence account executive or contact the Department of Labor for a complete copy of the FMLA law and Department of Labor interim final rules. Please contact your legal counsel if you have questions regarding your responsibilities.

When a Member Moves to Hawaii

The State of Hawaii requires that benefits for active employees living in Hawaii (regardless of where the group is located) be administered according to Hawaii law. This applies to all types of groups, including self-insured plans (ERISA has a specific exception for Hawaii). It applies to active employees only and does not apply to retirees or COBRA enrollees.

If an active employee moves to Hawaii, he or she is no longer eligible for Regence coverage.

Member Appeals Process

If Regence has notified a member in writing that a claim or request for services or supplies has been denied in whole or in part, the member or the member's authorized representative may request a review of the complaint or denial by calling or writing to Regence within 180 days after receiving notice of the denial or the action that led to the complaint.

Regence will send an acknowledgement letter and notification of the appeals process to the member or the member's appeal representative. If the member's treating provider determines that the member's health could be jeopardized by waiting for a decision under the standard process, the provider can request an expedited appeal. Regence will respond to the expedited appeal within 72 hours of receipt of the appeal request.

Electronic Enrollment Options

Employer Center (online enrollment and eBilling)

Online enrollment is available for groups of 51+. Employer Center, a secure site for employer groups, is available for you for this purpose. The online enrollment and e-billing features allow you to perform all of the functions that are otherwise performed using paper applications and forms. If you are comfortable with online processing and have regular access to a computer, Employer Center could be a great tool for you.

If you choose, your employees can complete their own online enrollment and coverage maintenance. The online enrollment system allows members to:

- Apply for new enrollment
- Complete the open enrollment process each year at renewal
- Perform regular maintenance such as:
 - Changing an address
 - Adding/removing a dependent
 - Ordering a member card
 - Terminating coverage
 - Changing personal information
- Receive email alerts updating them on the progress of a transaction

You also have the option of performing these tasks on behalf of your employees.

Additional benefits exist for the benefit administrator. Some of these benefits include:

- The ability to perform many billing transactions online
- The opportunity to track and view the status of transactions
- Email alerts notifying you when a new bill has been generated
- The ability to complete all online enrollment transactions on behalf of a member if desired

You can perform online enrollment through any Internet access. The system is available 24 hours a day, seven days a week. The system provides an online Help document.

If you're interested in using online enrollment, please contact your Regence account executive.

Electronic Enrollment using ANSI 834

An American National Standards Institute (ANSI) 834 transaction allows employer groups and other data trading partners to submit enrollment data for Regence members. Enrollment data can consist of full audit files showing all members, or change files that indicate newly added members, terminated members or members with changes in their demographics or benefits.

If you are interested in utilizing this type of tool for your enrollment files, please contact your Regence account executive.

HIPAA

To be eligible for one of the portability plans, an employee must:

- Have terminated coverage or been terminated from coverage due to loss of eligibility
- Not be eligible for Medicare coverage or coverage under the group contract (except under COBRA or continuation coverage) or any other health plan benefit
- Have been continuously covered up to the time of termination of coverage under the group contract (see your contract for details)

See your contract for details on how to exercise the right to one of the portability plans.

Forms

Forms can be found at www.id.regence.com or in the *Forms* section of Employer Center.

Questions?

Call Regence toll free: 1 (800) 632-2022

Forms are available at www.id.regence.com

PLEASE NOTE: This online version of this manual is the official document. If working with a printed copy please validate you are working with the most current information by verifying the last updated date on the cover compared to the official version online.