



New Hampshire Small Group Administration Manual

**Northeast Small Group Sales
Two College Park Drive, Hooksett NH 03106
Phone 800-456-6575
Fax 603-268-7973 or 603-268-7971**

WELCOME TO CIGNA*

Dear Small Group Client,

CIGNA HealthCare is pleased to be the carrier you have selected to provide your employees access to quality health care services over the coming year. Please be sure to carefully review all of the enclosed materials to become familiar with the administration of your group's benefits plan. This manual has been prepared as a guide to help you enroll/term members and report changes as they relate to your group's benefits plan.

We encourage you to become familiar with the information and procedures contained in this manual. Questions regarding the administration of your Plan should be directed to the Employer Service Center. You may also call the Customer Service Center or the Small Group Sales Office. The phone numbers of these offices are set forth on the Contact Page of this manual.

This manual explains the processes associated with the administration of your group's benefits plan. The information contained in this manual does not alter or waive the terms and conditions of the plan documents. The plan documents may be in the form of summary plan descriptions, booklets, certificates, insurance policies, or similar documents. If there is a conflict between this manual and the terms and conditions of the plan documents, the plan documents will govern. In addition, this manual does not set forth your legal obligations relating to the administration of your Plan. If you have questions about such legal obligations, please contact your attorney.

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Below is a listing of contact areas to help you with more specific questions or concerns.

GENERAL QUESTIONS, ALL EMPLOYER ISSUES

Northeast Small Group Sales
(800) 456-6575

MEDICAL COVERAGE AND CLAIM ISSUES

Customer/Member Services
1-800-CIGNA24
(1-800-244-6224)

ENROLLMENT, ELIGIBILITY AND BILLING ISSUES

Small Group Employer Services
(800) 603-0125
Fax (603) 268-7830

ENROLLMENT /CHANGE FORMS

For Enrollments, Changes and Terminations you may mail your forms directly to:
CIGNA HealthCare
Employer Services
PO Box 2010
Concord, NH 03302
Or fax to:
(603) 268-7830

MONTHLY BILLING INVOICE

Please mail your monthly premium payment to:
CIGNA HealthCare
Attn: Lockbox # CGLIC 13880
Collections Center Drive
Chicago, IL 60693

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SECTION I: ELIGIBILITY & ENROLLMENT

ELIGIBILITY EMPLOYEES

Eligibility for membership is based on the following:

- **Enrollment During Scheduled Open Enrollment Period**

Each employee must complete an Employee Enrollment/Change of Coverage Form (application) before the end of the designated open enrollment period. The Employer Service Center must receive all Employee Enrollment Forms taken during open enrollment no later than 31 days after the conclusion of the open enrollment period.

- **New Hires Enrollment**

A new employee who is enrolled during an "off open enrollment" time of the year must complete an Employee Enrollment Form no later than 31 days after his/her date of eligibility. If the Employee Enrollment Form is not completed during this period, the employee's eligibility is postponed until the next scheduled open enrollment.

Note: If there is an eligibility waiting period for new employees, the enrollment period for completing the CIGNA HealthCare Employee Enrollment/Change of Coverage Form is 31 days from the employee's date of eligibility. If your plan is subject to Internal Revenue Code Section 125, check your Section 125 Plan Document to determine if employees are allowed to enroll after the waiting period.

- **Re-enrollment During Open Enrollment**

An employee who enrolled on your group health plan during a previous open enrollment or as a new hire, who elects to remain with CIGNA HealthCare during a subsequent open enrollment, and does not have *any* changes to report, *may not be required to complete a new Employee Enrollment Form*. Your internal employment policies will govern this requirement.

- **Prospective Applicant who Rejects CIGNA HealthCare During Open Enrollment or New Hire Opportunity**

An employee who does not take the opportunity to join CIGNA HealthCare during an open enrollment or new hire situation may enroll himself/herself and all eligible family members during the next scheduled open enrollment.

ELIGIBLE DEPENDENTS

An eligible Dependent is defined as an employee's

- Legal spouse.
- Opposite gender partner to a civil union.
- Children, under nineteen (19) years of age, who are (a) unmarried and (b) dependent upon the employee for support.
- Children, nineteen (19) years of age or older, but under twenty-six (26) years of age, who are (a) unmarried **and** (b) reside in the state of New Hampshire **or** are registered as full-time students in regular attendance at an accredited school, college, or university and (c) not currently covered as a subscriber under any other group or individual health plan or entitled to be covered under certain government programs.
- Children, twenty-six (26) years of age or older who are unmarried and incapable of self-sustaining employment because of mental retardation or physical handicap.
- Children, nineteen (19) years of age or older who reside outside the state of New Hampshire and do not meet the requirements outlined above are not eligible for coverage.

The term children includes the employee's natural children, adopted children, stepchildren, children supported by the

employee according to the terms of a court order and children for whom the employee is appointed legal guardian.

A Dependent whose group coverage in the healthplan terminates because he/she becomes age nineteen (19) and does not reside in the state of New Hampshire or qualify as a full-time student, who subsequently resides in New Hampshire or becomes a full-time student and is again eligible for group coverage as an eligible Dependent, may be re-enrolled immediately.

If a Dependent's group coverage in the healthplan terminates under NH State Continuation Coverage / COBRA Coverage, coverage in the healthplan may be continued through the Dependent's right to become a **Continuant**. (See Section IV: Continuation Provisions, for instructions on submitting COBRA applications.)

A Dependent child's group coverage/membership in the healthplan terminates on the last date of the month in which his/her 26th birthday occurs. See the definition of Eligible Dependents in this section.

CIGNA provides the same coverage to parties of a civil union that we provide to married persons under state insurance laws. The rights of married persons under federal law may not be available to parties to a civil union.

HANDICAPPED CHILDREN

Membership in the healthplan for a Dependent child who reaches his/her 26th birthday may be continued indefinitely, if the child is mentally or physically incapable of self-sustaining support. The disability must have commenced prior to the child's 26th birthday.

A handicapped child must be:

- Unmarried.
- Emotionally and/or physically incapable of earning a living.
- Wholly Dependent upon the employee for support.
- Continuously incapacitated and Dependent upon the employee from the time the child reaches the maximum age.

Certification of Disability/Handicapped Children

Approximately two months before the Dependent reaches the maximum Dependent age under your plan, the employee will receive a letter from CIGNA HealthCare, together with a Questionnaire for Verification of Dependent Eligibility and a Physician Form, notifying the employee that the Dependent's disability must be verified in order for coverage to continue beyond the maximum age limit.

Where to Send

The employee completes Section B of the Questionnaire for Verification of Dependent Eligibility, signs and dates the form, and returns it along with the completed Physician Form to CIGNA HealthCare at the Eligibility Services address listed on the form.

What to Expect

CIGNA HealthCare will review the questionnaire, obtain additional information as needed and based upon the final findings, and notify the employee of the approval or rejection of the request to continue the Dependent's coverage beyond the maximum age limit. Depending upon the nature of the Dependent's disability, CIGNA HealthCare will request annual re-verification of disabled status. An approved handicapped Dependent will not require additional annual re-verification.

EFFECTIVE DATES OF COVERAGE

Effective Dates of Coverage will be determined according to the following:

- **Enrollment During Scheduled Open Enrollment Period**
Coverage becomes effective on the date that you establish as the effective date as indicated in your Group Contract.
- **New Hire Enrollment**
Coverage becomes effective on the date each employee completes the eligibility waiting period, if applicable. If coverage becomes effective between the 1st and 15th of the month, premium will be charged for the entire month. If coverage becomes effective between the 16th and the last day of the month, premium will not be charged for that month. Premium charges will commence on the 1st of the next month.
- **Adding a Newly Acquired Dependent**
Coverage becomes effective on the Dependent's date of eligibility. If coverage commences between the 1st and the 15th of the month, premium is payable for the entire month. If coverage begins between the 16th and the last day of the month, premium will not be charged for that month. Premium charges will commence on the first day of the next month.

The date of eligibility is the date the employee acquires the Dependent through marriage (spouse and/or stepchildren), birth, adoption, court order, or legal guardianship. An Employee Enrollment/Change of Coverage Form adding the Dependent must be completed and submitted to The Employer Service Center prior to, or within 31 days after, the Dependent's date of eligibility. (See Section II: Changes.)

- **Former Employee Returning to Work**
Unless otherwise noted on the Group Policy, former employees who are rehired and return to work either during a scheduled open enrollment or during an off open enrollment time of the year must be treated as either; (a) a new employee and must again serve your new employee waiting period or (b) a returning employee and eligible for reinstatement of coverage as of the date they return to active employment. Once you have determined which policy you wish to administer, it must be adhered to for every employee. A new Enrollment/Change Form must be completed and sent to the Employer Service Center.
- **Request to Re-enroll a Former Dependent During an Off Open Enrollment Time of the Year**
An employee who seeks to add an eligible Dependent, who was previously covered, during an off open enrollment time of the year must wait until the next scheduled open enrollment to re-enroll the Dependent. The exception is a former Dependent student, whose group coverage terminated because he/she ceased to be a full-time student and who resumes full-time student status. If he/she still qualifies according to the age definition of a full-time student, he/she may be re-enrolled without waiting until the next scheduled open enrollment. The effective date of coverage will be the first day of the semester.

ENROLLING NEW EMPLOYEES: COMPLETING THE ENROLLMENT/CHANGE FORM

Enrolling New Employees

Use the Employee Enrollment/Change of Coverage Form to enroll an employee for medical benefits. The Employee Enrollment Form can be found on the CIGNA HealthCare Small Group Website: www.cigna.com, under "Locate," select "Brokers and Consultants" from the left-hand side of the page, under "Information for Small Groups," select "CIGNA HealthCare Broker Information for Small Groups." Select "New Hampshire," select "Document Library." The Employee Enrollment / Change of Coverage Forms can be found under "New Hampshire New Group Documents. The forms include instructions on how to complete each form.

Permanent Identification Cards will be sent to the employee for each covered family member approximately two weeks after the Employer Service Center receives and processes the completed Employee Enrollment Form.

EMPLOYEE ENROLLMENT AND MAINTENANCE TOOL PROCESSING (available only if you have requested CIGNAaccess.com)

The Employee Enrollment and Maintenance Tool is available through CIGNAaccess.com. The tool allows you, the Employer, the ability to enroll and maintain eligibility information in "real time" for employees who have chosen CIGNA HealthCare benefits. Once eligibility is populated, standard processing will occur and normal update times to downstream systems will apply, for example, an average of 24-hours from CIGNA Eligibility Department (CED) load to pharmacy update.

The system will accommodate the most common eligibility maintenance activities such as adding an employee and Dependents for coverage with CIGNA HealthCare, terminating coverage, adding and canceling covered Dependents, and making changes to benefit elections and demographic information.

The tool was created with ease of use in mind. In addition, on-line resources are available through Help and FAQ links. These links can be found in the lower left corner of the screen on the Enroll, Search and Summary pages. Each page within the tool offers a 'Help' link in the upper right corner of the screen.

If you experience technical difficulties, please contact our CSC Help Desk at 1.800.272.5713, or if you need assistance with eligibility data or have business questions, please contact the Small Group Employer Services number listed in the Contact Pages of this manual.

If you currently do not have CIGNAaccess.com and would like to establish this access, please contact the Small Group Employer Services number listed in the Contact Pages of this manual.

Note: Employee Enrollment and Maintenance Tool Processing does not apply to COBRA, FSA, MERPS or DERPS. Manual eligibility processing will still be required for these products. Refer to Manual Eligibility Processing section of these instructions for further details.

IDENTIFICATION CARDS

Each covered employee and Dependent will receive a personalized Identification Card, which must be presented to his/her provider whenever health care services are requested. The Identification Card is not a guarantee of benefits. Its primary function is to give providers the information needed to verify eligibility at the time services are rendered. The Identification Card discloses the Member's Name, ID Number, Group Number (employer's account number), and Effective Date of Coverage.

Identification Cards for all family members are mailed directly to the employee's home address.

Incorrect Identification Cards

If an employee or Dependent receives an Identification Card with incorrect information, it should be reported to the Member Services Department at the local CIGNA HealthCare Office immediately. The employee may contact Member Services at the phone number shown on the Contact Pages at the beginning of this manual. Member Services will request a corrected Identification Card, which the employee/Dependent should receive usually within two weeks. The incorrect card should be destroyed as soon as the corrected card is received.

SECTION II: CHANGES

ADDITION OF DEPENDENT COVERAGE

If an employee is not eligible for Dependent coverage when he/she initially enrolls in the healthplan, Dependent coverage may be added on the date the employee acquires his/her first eligible Dependent. Refer to "Section I: Eligibility & Enrollment" for the definition of Eligible Dependents.

Each Dependent must be added prior to or within 31 days following his/her date of eligibility. A Dependent addition reported to the Employer Service Center more than 31 days following his/her date of eligibility will be considered a late enrollment and will be rejected. The Dependent will have to wait until the next scheduled open enrollment to be added.

An Employee Enrollment/Change of Coverage Form must be completed and sent to the Employer Service Center when an employee adds Dependent coverage or adds new Dependents to his/her current family coverage. If Dependents are added on separate effective dates, the employee must submit a separate Employee Enrollment/Change of Coverage Form and for the Dependent(s) added on each effective date.

ENROLLMENT AFTER AN OPEN ENROLLMENT PERIOD

Employees may experience specific circumstances that allow them to enroll in this Plan during an "Off Open Enrollment" time of the year.

1. If, after the Open Enrollment Period, an employee becomes eligible for coverage as an Employee or a Dependent, he/she may enroll within thirty-one (31) days of the day on which he/she met the eligibility criteria. To enroll, the employee must submit an Employee Enrollment/Change of Coverage Form. If so enrolled, the effective date of coverage will be the day on which the employee met the eligibility criteria.

If the employee does not enroll within the thirty-one (31) days, the next opportunity to enroll will be during the next Open Enrollment Period.

2. If an employee is enrolled for coverage, he/she may enroll a newborn child within thirty-one (31) days after the child's birth. To enroll a newborn child, the employee must submit an Employee Enrollment/Change of Coverage Form. If so enrolled, the effective date of coverage for the newborn child will be the date of his/her birth.

If the employee does not enroll a newborn child within the thirty-one (31) days, the next opportunity to enroll the child will be during the next Open Enrollment Period.

3. If an employee is enrolled for coverage, he/she may enroll an adopted child or child for whom he/she has been granted legal guardianship within thirty-one (31) days of the date the child is legally placed with the employee for adoption or within thirty-one (31) days of the date he/she is granted legal guardianship. To enroll an adopted child or a child for whom the employee is the legal guardian, the employee must submit an Employee Enrollment/Change of Coverage Form. If so enrolled, the effective date of coverage for the child will be the date of legal placement of the child for adoption or the date of court ordered legal guardianship.
4. If the employee does not enroll an adopted child for whom he/she is legal guardian within the thirty-one (31) days, the next opportunity to enroll the child will be during the next Open Enrollment Period.

SPECIAL ENROLLMENT AFTER OPEN ENROLLMENT PERIOD

There are also special circumstances (qualifying events) under which an individual who was eligible to enroll for coverage, but did not do so, may be eligible to enroll himself/herself and any eligible Dependents outside of the Open Enrollment Period.

After the Open Enrollment Period, the employee may submit an Employee Enrollment/Change of Coverage Form for himself/herself and any eligible Dependent(s) within thirty-one (31) days of the date of the following events:

1. Marriage;
2. Birth of a Dependent newborn child; or
3. Adoption of a Dependent child or legal placement of a child for adoption.
4. Loss of eligibility for other coverage.
5. Termination of another employer's contributions to other coverage (e.g. spouse's employer ceases to contribute to spouse's coverage)
6. Exhaustion of COBRA continuation coverage.

If so enrolled, the effective date of coverage will be the day of the event creating eligibility.

If the employee does not enroll within the thirty-one (31) days of one of these events, the next opportunity for the employee and any eligible Dependents to enroll will be during the next Open Enrollment Period.

ENROLLMENT DUE TO LOSS OF PRIOR CREDITABLE COVERAGE

If an employee and/or his/her Dependent(s) did not enroll during the Open Enrollment Period because the employee and/or the Dependent(s) had other creditable health care coverage, they may be eligible to enroll for coverage under this plan if they later lose that coverage. The employee must submit to the Group an Employee Enrollment/Change of Coverage Form within thirty-one (31) days of the day that the employee or their Dependent(s):

1. are no longer eligible for the other coverage for any reason (including separation, divorce or death of the employee);
2. lost the other coverage because an employer or plan sponsor failed to pay required premium or fees; or
3. completed continuation of other coverage as provided under federal or state law.

If so enrolled, the effective date of coverage will be the first day of the month following the day on which the healthplan received the Employee Enrollment/Change of Coverage Form.

If these conditions are not met, or if the employee does not submit a Employee Enrollment/Change of Coverage Form within thirty-one (31) days of one of these events, the next opportunity for the employee and any eligible Dependent(s) to enroll will be during the next Open Enrollment Period.

ENROLLMENT DUE TO SECTION 125 LIFE STATUS EVENTS

If you provide your plan under the rules of IRS Code Section 125, you may choose to permit mid-year enrollment of an employee and/or his/her Dependents if they experience a life status event. You are not required to permit the mid-year change. Examples of allowable life status events are: Spouse's plan has a different open enrollment period; there is a significant cost or coverage increase or decrease; the employee moves into or out of your plan's service area. Other situations may be allowable. Please consult your legal counsel or tax advisor for assistance.

ADDITION OF DEPENDENT COVERAGE

Employee should complete the New Hampshire Employee Enrollment/Change of Coverage Form, adding Dependent information, and forward to employer.

Employer must:

- Complete the Employer section of the Enrollment/Change Form.
- Check the employee/Dependent information for accuracy and completeness.
- Sign and date the form.
- Photocopy the completed Enrollment/Change Form.
- Send the original to the CIGNA Employer Service Center.
- Give the copy to the employee for his/her records.

REQUESTING NEW IDENTIFICATION CARDS

Employee may request this change by phoning Member Services

An employee may request new ID cards for himself/herself and/or a covered Dependent by phoning the Member Services Department at the local CIGNA HealthCare office. The Contact Pages at the beginning of this manual disclose the telephone number of Member Services.

MEDICAL PLAN ELECTION (TEFRA/DEFRA/COBRA/OBRA) MEDICARE PRIMARY

Synopsis of Federal Legislation: The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA); Amending the Age Discrimination in Employment Act (ADEA).

Medicare and Small Group Coverage

Eligibility rules for your employees who are Medicare eligible can be confusing. The responsibility for compliance generally rests with the employer, and there are penalties for failure to comply. CIGNA can provide some assistance but we encourage you to direct questions to your own legal counsel to ensure proper administration of these requirements. Generally if a group employs 19 or fewer employees, Medicare is considered primary and if a group employs 20 or more employees, the group health plan is considered primary.

When Group Size Changes

When group size changes please complete the "Medicare Certification Form" (Attachment A) and forward along with required payroll records to the Northeast Small Group Sales Unit.

Working Aged

This legislation requires employers with 20 or more employees to provide active employees age 65 and over and their spouses ages 65 and over the same coverage under any group health plan that is offered to younger workers. For these Medicare eligible individuals the group health plan is the primary payor and Medicare is the secondary payor. This provision is referred to as "Medicare Secondary Payor Rule" and applies to employers with 20 or more employees.

When a small group with 20 or more employees meets federal requirements, CIGNA HealthCare or Group Medical Plan will provide primary coverage to all active employees and their Dependents who are Medicare entitled. Medicare will provide secondary coverage for Medicare Part A (Hospitalization) Benefits that may not be fully covered by the Group Medical Plan. Medicare will provide secondary coverage for Medicare Part B (Doctors' Visits) only if the employee enrolls in Medicare Part B and pays the applicable premium.

When An Employee Becomes Eligible for Medicare

An employee becomes eligible for Medicare for the following reasons:

- They turn 65
- They have end-state renal disease at any age
- They qualify as permanently disabled at any age

Determining When the Employer Health Plan is Primary

When individuals, age 65 or older, are covered by an employer group health plan through their own employment or that of their spouse, the TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), and subsequent amendments, require that the employer plan pay as primary, before Medicare, providing the employer has 20 or more employees (full and part time).

The total number of employees is the essential factor in determining whether Medicare or the group plan is primary. Full and part time employees working 20 or more calendar weeks in the current or preceding year are included in the total employee count.

An employer is considered to have 20 or more employees for each working day of a particular week if the employer has at least 20 (full and part time) employees on its payroll each working day of that week.

The Group Health Plan will pay before Medicare for the following covered persons providing the above requirements are met:

- Employees who actively continue to work after age 65
- A Dependent spouse age 65 and over of an active employee

Determining When Medicare is Primary

Federal law also requires that Medicare benefits be applied before group health plan benefits when individuals, age 65 or older, are covered by an employer group health plan through their own employment or that of their spouse, providing the employer has 19 or fewer employees (both full and part time).

Again the total number of employees is the essential factor in determining whether Medicare or the group plan is primary. A group must have 19 or fewer employees for each working day during the past full calendar year (January thru December) in order for the Group Health Plan to be considered secondary.

Medicare will pay before the Group Health Plan for the following covered persons providing the above requirements are met:

- Employees who actively continue to work after age 65
- A Dependent spouse age 65 and over of an active employee

Coverage for End-State Renal Disease (ESRD)

Special Federal rules apply to all group health plans when an individual is entitled to Medicare benefits on the basis of end-state renal disease (ESRD). Medicare benefits are secondary to benefits payable under an employer plan for services provided to an ESRD member.

Waiver of Medicare Part B Late Enrollment Penalty

Individuals who delay enrollment in Medicare Part B upon attainment of age 65 are subject to a late enrollment penalty. However, delayed enrollments in Medicare Part B are permitted without penalty if the individual elected group coverage/membership in the healthplan or Group Medical Plan. The waiver ends when group coverage/membership in the healthplan or Group Medical Plan ceases. These individuals must follow specific Medicare enrollment procedures for Medicare Part B in order to avoid the late enrollment penalty. Forms for delayed enrollment can be obtained from your local Social Security Office.

Furthermore, if an employee plans to leave active employment and is a member of the healthplan or Group Medical Plan, Medicare will extend a special seven month Medicare Part B enrollment period. This period begins three months prior to the date membership in the healthplan or Group Medical Plan ceases.

The Omnibus Budget Reconciliation Act of 1993 (OBRA)

Disabled Individuals

This legislation applies to group health plans offered by employers with 100 or more employees, this Medicare Secondary Payor Rule deals with plan participants under age 65 who are entitled to Medicare on the basis of disability; that is, they meet the Social Security Act disability criteria. It requires that the group plan provide primary benefits for covered individuals who are under 65 years of age and who have collected Social Security disability benefits for 24 months.

The group plan must provide primary benefits for those disabled individuals based upon the individual's or a family member's current employment status. For the group health plan to be the secondary payor, the employer must provide the Medicare carrier with the name, date of birth, gender, social security number and Health Insurance Claim (HIC) number of each Medicare disabled individual covered by the employer's group plan who does not have coverage on the basis of his or her own or a family member's current employment status. The employer certifies this by signing a letter and sending it to the Medicare carrier who must act upon it before any services provided can be paid primary by Medicare.

When the Medicare carrier responds to an employer's request for a review of payment status for a group of disabled Medicare individuals, the carrier will send a letter back to the employer with the decision that includes the effective date, the disabled individuals' names or HIC numbers. The employer should provide each affected disabled individual with a copy of the letter (deleting any other individuals' names) and advise the affected disabled individual that he/she was identified by Medicare as one for whom Medicare will be the primary payor for covered services.

The disabled individual should be advised by the employer to take both the employer letter and the Medicare letter to the Social Security Administration when enrolling in Part B of Medicare. Disabled employees who have not enrolled in Part B of Medicare will be granted a special enrollment period during which the enrollment may occur. The individuals may enroll in any of the seven months immediately following the month of notice from the employer that the group plan is no longer primary payor or in any of the seven months immediately following the last month the group plan is primary payor. The entitlement to Part B of Medicare may be established as of the first day of the month of filing.

The employer must notify the disabled individual in writing of the date the group plan will begin to pay secondary to Medicare and advise the disabled individual to enroll in Part B of Medicare as soon as possible.

End-stage Renal Disease

As of August 1, 1997, the Social Security Act makes all group health plans primary to Medicare for the first 30 months of treatment for employees and their Dependents who are entitled to Medicare due to end-stage renal disease.

SECTION III: TERMINATIONS

TERMINATION EFFECTIVE DATE

Employee Termination

An employee's group coverage in CIGNA HealthCare will terminate, in accordance with the Group Contract, when the first of the following events occurs:

- The employee terminates employment.
- The employee cancels required payroll deductions.
- The employee otherwise loses eligibility for coverage.

In accordance with the Group Contract, coverage ceases at midnight on the day on which the termination event occurs or at the end of the month in which the termination event takes place. This is the *Termination Effective Date*.

Dependent Termination

A Dependent's group coverage in CIGNA HealthCare will terminate when the first of the following events occurs:

- The Dependent reaches the maximum age for Dependent children.
- The Dependent marries.
- The Dependent graduates or otherwise ceases regular attendance at an accredited school, college, or university.
- The Dependent's eligibility ceases because he/she is no longer an emotionally or physically handicapped child.

In accordance with the Group Contract, coverage ceases at midnight on the day on which the termination event occurs or at the end of the month in which the termination event takes place. This is the *Termination Effective Date*.

Group coverage/membership in CIGNA HealthCare for **all** of an employee's Dependents will terminate when the first of the following events occurs:

- The employee's group coverage terminates.
- The employee discontinues required payroll deductions for Dependent coverage.
- The employer discontinues Dependent coverage.

In accordance with the Group Contract, coverage ceases at midnight on the day on which the termination event occurs or at the end of the month in which the termination event takes place. This is the *Termination Effective Date*.

REPORTING TERMINATIONS

Employer Obligation

- **Notify the Employer Service Center of Employee and Dependent Termination on an Employee Enrollment/Change of Coverage Form** Terminations of group coverage on employees and Dependents must be reported to the Employer Service Center on an Employee Enrollment/Change of Coverage Form. Each termination should be reported within 31 days following the Termination Effective Date. Otherwise, you (the employer) could become financially responsible for claims paid and health care services rendered after the Termination Effective Date through the date the Employer Service Center receives notification of termination.
- **Retroactive Terminations**
CIGNA HealthCare's Billing Retroactivity Policy allows a maximum of 31 days on retroactive employee and Dependent terminations. The 31 days is counted back from the date on which the eligibility change is received by the Employer Service Center.

SECTION IV: CONTINUATION PROVISIONS

CONTINUATION OF COVERAGE

New Hampshire Small Group Continuation of Coverage Benefits (For Small Businesses with 1-19 Employees)

The New Hampshire Small Group Continuation of Coverage Law requires small group carriers to provide for the continuation of health benefits to employees of small businesses with 1-19 employees.

New Hampshire Small Group Continuation benefits must be provided to qualified beneficiaries upon the occurrence of a qualifying event. Qualified beneficiaries are generally individuals who are covered under a small group health benefit plan on the day before the qualifying event. Qualified beneficiaries can be:

- An employee
- The spouse of an employee
- The Dependent child of an employee

Qualifying events are events which would cause a qualified beneficiary to lose health coverage if New Hampshire Small Group Continuation benefits were not available. Employees, spouses and Dependents have the option to continue this coverage under the following qualifying events:

- 18 months following:
 - Termination of employee's employment (other than by reason of employee's gross misconduct).
 - Reduction in hours worked by the employee.
- 36 months following:
 - Employee's death. The surviving spouse and Dependent children may continue under New Hampshire Small Group Continuation coverage.
 - Divorce or legal separation. The spouse and Dependent children may continue under New Hampshire Small Group Continuation coverage.
 - Employee becomes entitled to Medicare. The spouse and Dependent children may continue under New Hampshire Small Group Continuation coverage.
 - Dependent child is no longer considered to be Dependent under the Small Group Health Benefit Plan. Dependent child may continue New Hampshire Small Group Continuation coverage.

The election period is the period of time during which a qualified beneficiary may decide to continue New Hampshire Continuation coverage. Qualified beneficiaries have 60 days in which to elect to continue coverage.

The premium for this coverage cannot exceed 102% of the cost of the Small Group Health Benefit Plan for similarly situated individuals who have not had a qualifying event. The first premium payment must be made within 45 days after New Hampshire Small Group Continuation Coverage is elected.

COBRA CONTINUATION

COBRA Provisions

In general, COBRA provides for a continuation period of up to 18 to 36 months, depending on the qualifying event, if the employer employs 20 or more employees (full and part time) on more than 50% of the previous calendar year. Qualifying events are limited to those circumstances provided in the law and corresponding regulations such as: termination of employment, divorce or legal separation, death of the employee, the employee's entitlement to Medicare, and loss of Dependent child status under the plan. If specific requirements are met, an 18 month COBRA continuation period can be extended by an additional 11 months (for a total of 29 months) if an individual is determined by the Social Security Administration to be disabled.

Employer Obligations Under COBRA

Under COBRA and its corresponding regulations, employers have specific obligations and timeframes for compliance, such as:

- Provide covered employees and spouses with advance General Notice of the COBRA requirements;
- Notify the plan administrator or COBRA administrator of qualifying events;
- Provide individuals with a notice of COBRA election rights following a qualifying event; and
- Develop and communicate policies and procedures for individuals to notify the employer of qualifying events.

The U.S. Department of Labor has developed a model General Notice which, when appropriately modified and supplemented, may be used to satisfy the initial notice requirement. Upon request, CIGNA will provide an electronic copy of the model General Notice to employers for reference. A copy may be requested from your CIGNA sales representative.

CIGNA does not offer COBRA administration services.

COBRA Elections

As the policyholder, you must report all terminations and changes to CIGNA to assure proper payment of claims. Complete an Enrollment/Change form, checking COBRA or State Continuation in the Reason for Application box, Event Date, Reason and the appropriate Length of Continuation (e.g., 18, 29 or 36 months). Keep a copy for your records. Mail the completed form to the Employer Service Center at the address listed on the Contact Pages of this manual. Any coverage other than medical, dental, vision and/or prescription drug provided by the plan should be canceled as usual on the actual date of termination.

COBRA Premiums

COBRA permits employers to charge up to 102% of the applicable premium for COBRA coverage. During the 11-month disability extension, employers may charge up to 150% of the applicable premium. Monthly premium payments are reported and paid by you (the policyholder) to CIGNA in the usual manner. Do not send individual continuant checks to CIGNA. Continuant should be included with active participants in applicable coverage on your monthly payment report.

End of COBRA Coverage Period

Continuation of COBRA coverage for employees and Dependents will cease on the earliest of the following dates:

- When all group health plans with CIGNA sponsored by the employer terminate.
- When all employee/Dependent enrolls in another group plan, without a pre-existing condition that affects him/her.
- When the employee/Dependent becomes entitled to Medicare.
- Upon the employee/Dependent's failure to pay monies due.
- Upon the expiration of the maximum continuation period allowed by law.
- At the end of the month that begins more than 30 days after the date of final determination that the individual is no longer disabled under the Social Security Act. (Only applies under the 11 month disability extension).

SECTION V: MONTHLY BILLING STATEMENT

MONTHLY BILLING INVOICE

CIGNA HealthCare provides a monthly billing statement that discloses the total charges due for the billed month. Each statement reflects enrollment activity submitted to the Employer Service Center in time to be included on the current invoice, as well as other charges that may not be billed based on eligibility. Enrollment activity that will impact the monthly invoice consists of new enrollments, Dependent additions, terminations and COBRA enrollments. Additional changes to the invoice may be due to actions such as adding/changing/discontinuing benefits or an increase or decrease in rates.

Eligibility Based Billing Policy

All membership driven charges shown on the bill will be calculated using the eligibility data submitted to CIGNA HealthCare.

Billing census is calculated using the Fifteenth of the Month Wash Method. Therefore, premium is billed on a full month basis rather than pro-rated. The wash method is applied as follows:

New Enrollment Wash Method

If a member's *Coverage Effective Date* is on or before the fifteenth day of the *Month of Coverage*, then premium or other amounts are due for that member for that month.

Example: If March 5 is the member's *Coverage Effective Date*, then premium or other amounts are due for that member for the entire month of March.

If a member's *Coverage Effective Date* is after the fifteenth day of the *Month of Coverage*, then **no** premium or other amounts are due for that member for that month.

Example: If March 18 is the member's *Coverage Effective Date*, then premium or other amounts are NOT due for that member until the month of April. Coverage for March 18 to March 30 is free.

Termination Wash Method

If a member's *Deemed Termination Effective Date* is on or before the fifteenth day of the *Month of Coverage*, then **no** premium or other amounts are due for that member for that month.

Example: If March 5 is the member's *Deemed Termination Effective Date*, then NO premium or other amounts are due for that member for the month of March. (Coverage for March 1 to March 4 is free.)

If a member's *Deemed Termination Effective Date* is after the fifteenth day of the *Month of Coverage*, then premium or other amounts are due for that member for that month.

Example: If March 18 is the member's *Deemed Termination Effective Date*, then premium or other amounts are due for that member for the month of March.

Premium Due Date Policy

The Premium Due Date is the first day of the Month for which coverage is provided. The normal Bill Day is the day on which CIGNA HealthCare produces and mails each monthly bill.

For example, a bill for the month of March 2009 could be sent to you during the month of February OR during the month of March. In either case, the End of Grace Period remains March 31, 2009.

Payments

Each invoice is due and payable on the first of the month of service. A cancellation letter is mailed if payment is not received by the end of the grace period.

Remittance should always equal the Total Amount Due on the billing invoice, which means the invoice is “paid-as-billed”. In the rare instance that the remittance amount does not match the Total Amount Due, a detailed explanation must be included. In order to continue group coverage on employees and their covered Dependents, it is important to remit premium payments on time and for the full amount due.

Each payment should be sent with the Payment Voucher to the CIGNA HealthCare Lockbox shown on the voucher. If the voucher is not received or becomes misplaced, payment should be sent to the Lockbox address shown on the Contact Pages at the beginning of this manual.

Employee Enrollment/Change of Coverage Forms should not be included with remittances. Completed Enrollment/Change Forms should be sent directly to your contact at the Employer Service Center as reflected in the Contact Pages at the beginning of this manual.

Terminations

To ensure timely processing of reported terminations, terminations should be sent to your Employer Services Center instead of sending with payment. If you choose to **also** report terminations by crossing out the names of the terminated subscribers on the billing invoice, the date of the termination should be entered next to each name.

SECTION VI: CLAIMS ADMINISTRATION

Claim Forms

For benefits provided by a participating provider (in-network), there are no claim forms for the employee to complete because the provider submits bills on behalf of the insured.

If your plan allows for coverage to out-of-network providers, the employee must submit all claims to the appropriate claim office. For ease in administration, the claim office address is included on the claim form.

What to Do

The Employee should call Member Services to obtain a Medical Claim Form to complete. The Medical Claim Form can also be found on the CIGNA HealthCare Website at www.cigna.com.

What the Employee Does

The employee completes all pertinent sections and signs and dates the form. A separate claim form must be used for each family member for whom a claim is filed. The employee can submit an itemized bill instead of having the physician complete the provider section by following the instructions on the back of the claim form. An itemized bill must include:

- employee name
- patient name
- type of service
- date of service
- diagnosis (ICD-9CM codes)
- charge for each service
- provider's Tax Identification Number
- provider's billing address

Employees should make copies of itemized bills – the originals cannot be returned. Canceled checks and "balance due" bills are not acceptable substitutes for itemized bills.

Pharmacy Reimbursement

Requests for pharmacy reimbursement **must** contain the following information:

- patient name
- provider name
- prescription number (NDC#)
- prescription date
- name of drug
- charge for drug

If the employee wants benefits to be paid directly to the physician or provider of service, he/she must sign the authorization. Benefits will be paid directly to the facility for hospitalization. All claims for which CIGNA HealthCare is the secondary payor should be filed along with a copy of the Explanation of Benefits (EOB) from the primary carrier.

Where To Send

Send the completed claim forms and itemized bills to the Claim Office shown on the claim form.

Explanation of Benefits

Although there is direct assignment of benefits to all Participating Providers, CIGNA HealthCare's claim processing system sends an Explanation of Benefits (EOB) to the employee each time a claim is processed. The EOB gives clear details about how benefits were determined. An EOB is sent to the employee for each benefit determination made. Copies of EOBs are not available.

- If benefits are not assigned to the provider of service, the employee receives an EOB with a check attached.
- If benefits are assigned to the provider of service, the employee receives an EOB without a check attached and the provider of service receives a benefit check.

When no payment is due, the employee receives an EOB but a check is not issued. In such a case, a note will appear on the EOB.

Form Letters

In addition to communicating with the employee via the Explanation of Benefits (EOB), CIGNA HealthCare uses form letters for the following purposes:

- to request additional information from a provider of service;
- to request information from an employee;
- to explain why an expense was not covered under the plan; and
- to request information from another insurance carrier.

CIGNA HealthCare's form letters are generated through our claim processing system following a review of a claim submitted for payment.

Payment of Claims

Most claims are processed within 10 working days of their receipt by the Claim Office. Delays in processing are most often the result of incomplete claim forms or if additional information is required by CIGNA HealthCare from the provider.

Checking on a Claim

The employee may call the Claim Office during normal business hours at the telephone number shown on their claim form. The employee should have their Member Identification Number, which can be found on their Member Identification Card, as well as their account number available when making the call.

SECTION VII: PHARMACY CLAIM ADMINISTRATION

When to file a Pharmacy Claim:

A direct claim should be made to Pharmacy Services to request reimbursement of covered prescription expenses in the following instances:

- In-network prescription purchases for which the employee paid full price

What to Do

The Employee should call Member Services to obtain a Pharmacy Claim Form to complete. The Pharmacy Claim Form can also be found on the CIGNA HealthCare Website at www.cigna.com.

What the Employee Does

The employee completes all pertinent sections and signs and dates the form. A separate claim form must be used for each family member for whom a claim is filed.

Attach the prescription receipts to the claim form. Each receipt should detail:

- patient name
- physician name
- prescription number (NDC#)
- prescription date
- name of drug
- charge for drug

Where to Send

The employee should send the completed claim form and itemized bills to the address shown on the claim form within 180 days of the prescription fill date.

Checking on a Claim

The employee may call the Claim Office during normal business hours at the telephone number shown on their claim form. The employee should have their Member Identification Number, which can be found on their Member Identification Card, as well as their account number available when making the call.

Attachment A – To be completed by employer

Group Name: _____

Small Group Policy Number: _____

For the purposes of Medicare Coordination of Benefits I hereby certify (check one):

_____ I employ 19 or fewer full and part time employees

And I have enclosed payroll records in the form of Quarterly Wage and Tax Statements for the past “full” calendar year (January through December).

_____ I employ 20 or more full and part time employees

And I have enclosed payroll records showing I have 20 or more active employees for at least 20 calendar weeks in either the current or preceding year

I fully understand that the requirements of the Law are based on the number of people I employ and not the number of individuals covered under my health plan or the number of eligible employees I may have.

Signature

Date