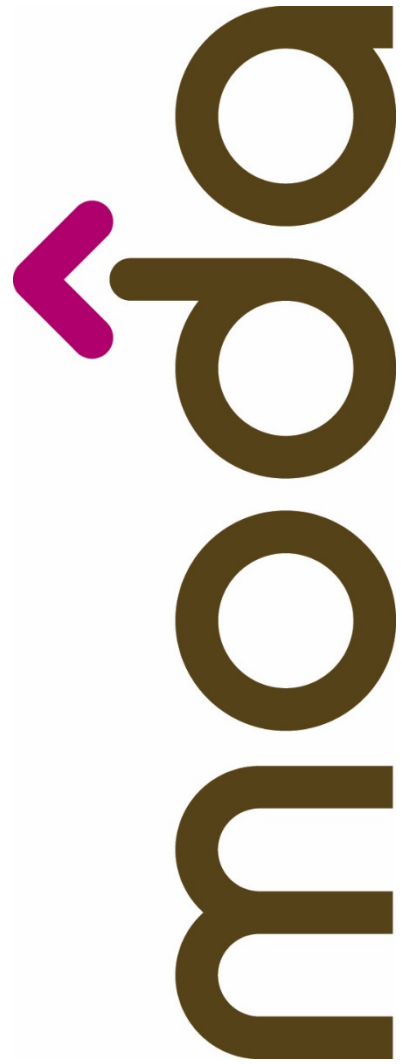


Oregon Group Admin Guide



Welcome

Moda Health and Delta Dental Plan of Oregon are dedicated to providing superior service to our members. Part of our exceptional customer service is having an easy reference tool to help group administrators manage their employees' (also referred to as subscribers) health benefits. This guide is intended to do just that.

This guide explains our administrative procedures, your billing statements and forms we commonly provide. By illustrating typical administrative functions such as enrollment and billing, as well as eligibility rules and responsibilities, we hope this guide will be a useful tool for you.

In explaining our administrative procedures, we've included some provisions from our standard contracts. If any provisions printed in this guide differ from those in your contract, the provisions in your contract or Member Handbook will apply.

All information is subject to change without notice, except when required by law. However, we will make every effort to provide advance notice, when appropriate. Our website, modahealth.com, is your best resource for the most current information.

The partnership between you, as the group administrator, and our Membership Accounting Specialist, is crucial to accurately and efficiently managing your employees' health benefits. Your Membership Accounting Specialist will be able to walk you through any part of the process and answer questions about enrolling members, billing and other payment questions.

At Moda Health and Delta Dental, our goal is to make healthcare easier. One of the best ways we can do this is to listen to our group administrators. We value your feedback, and welcome any thoughts you have about our current processes. We look forward to working with you.

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Web resources

Moda Health and Delta Dental provide a wide range of web resources for group administrators and our members. You can find any of the below online resources by accessing our website at modahealth.com/employers. Select the Resources tab.

Moda Health/Delta Dental website

You and your employees can access the following:

- > Find participating providers
- > Enrollment forms
- > Claim forms
- > Customer service telephone numbers
- > Overview of medical, dental, pharmacy and vision plans
- > Plan administration information

Employer Dashboard

Employer Dashboard gives you better control of your benefits and instantly connect you with everything you need to administer your employees' coverage in one, online location. You can access the Employer Dashboard through our website modahealth.com/employers. The Employer Dashboard connects and processes updates in real time to our core system. It is easy to use and available seven days a week, 24 hours a day, at no additional charge. By accessing the Employer Dashboard, you can:

- > Enroll members
- > Order ID cards
- > Update address and personal information
- > Update primary care physician (for applicable plans)
- > Update Medical Home selections (for applicable plans)
- > Terminate coverage
- > View current eligibility and make updates
- > View employee eligibility history
- > Access group reporting
- > View current Member Handbook, group and plan information, such as provider network information, dependent/student stop ages, probationary periods and much more
- > View administrative rules
- > Download censuses
- > View medical or dental claims (for self-insured groups)

Utilizing this valuable resource makes all of our jobs easier. To get more information on this service, please contact your membership accounting specialist or send us an email via enroll@modahealth.com.

eBill services

Through eBill services, you can save time, streamline billing tasks, and reduce paper waste by accessing your account information online.

With eBill, you can:

- > Manage your accounts
- > Pay online and schedule reoccurring payments
- > Set up email notifications when your bill is ready
- > Set up email notifications before bills are due
- > Set up payment methods
- > View your billing statements electronically, with the option to elect paperless invoices
- > Download your billing in Excel format to aid in the review of your group

To learn more about this exciting service, please visit modahealth.com/employers/ebill.shtml.

Web resources available to Moda Health and Delta Dental members

myModa

myModa is a customized member website, designed with the member in mind. It allows members to get current, accurate and easy-to-understand information about their Moda Health or Delta Dental plan. Members can access myModa through our website by selecting the “I’m a member” tab. By accessing myModa, members can:

- > View claims status and payment information
- > View current eligibility for themselves and family members
- > Add/Change PCP
- > Add/Change a Medical Home selection for members on a Medical Home plan for self and family
<https://www.modahealth.com/medicalhome/>. See more information below in PCP and Medical Home section.
- > View detailed benefit information specific to their plan
- > Download the Member Handbook
- > Order ID cards or print an eCard
- > Search for participating providers
- > Change their address
- > Print Explanation of Benefits (EOB)
- > Email customer service
- > Check prescription price information

PCP and Medical Home selection

On applicable contracts, myModa allows for an easy and intuitive experience in selecting or changing the PCP or Medical Home for the

subscriber and all family members. You can find additional information about Medical Home plans, and how to select a Medical Home provider, at modahealth.com/medicalhome.

myHealth tools

Moda myHealth tools offer personalized support to help members get well sooner and live well longer. myHealth tools are part of all Moda Health medical plans, and are available through myModa. They include:

eDoc

This service helps covered employees understand their symptoms and make informed health decisions. Email a specialized health professional at any time of day to get the answers they need. eDoc gives members access to:

- > Board-certified physicians
- > Licensed psychologists
- > Pharmacists
- > Dentists
- > Dietitians
- > Fitness experts
- > eDocVoice – Leave a message for a provider, and get a phone response within 24 hours.

Call a nurse

The nurse line allows members to get answers and health information over the phone, day or night. Nurses can help members with basic health situations, such as:

- > Understanding symptoms
- > Treatment for minor injuries and burns
- > Home cold and flu remedies
- > When it's time to make a doctor's appointment
- > Whether they should go to urgent care or the emergency room

Condition management and health coaching

Moda offers in-depth support programs for those dealing with chronic health conditions. Members have access to tools and resources that help them maintain a healthy lifestyle. Individual health coaches provide members with one-on-one support. These specialized programs include:

- > Cardiac Care
- > Depression Care
- > Diabetes Care
- > Lifestyle Coaching

- > Women's Health & Maternity Care
- > Respiratory Care
- > Spine & Joint Care
- > Dental Health

Care coordination

If members are dealing with a serious illness or recovering from an accident, they have access to case managers who can help them navigate the complexities of the healthcare system. A Moda Health case manager can help:

- > Communicate with providers
- > Explain treatment options
- > Arrange for in-home caregivers
- > Order medical equipment

Health tools

Moda Health provides secure, online health education tools and information to help members better manage their health. Keep track of their progress by using the following tools:

- > Health and symptom evaluation
- > Medical library
- > Health helpers (tools such as health trackers, calculators and more)
- > Pharmacy costs and research
- > myHealth files
- > News, forums and communication

Employee Assistance Program (EAP)

If the employees or their eligible family members are experiencing life's ups and downs that are affecting them personally and professionally, the Employee Assistance Program can help. This free and completely confidential counseling benefit can assist with a variety of concerns they may have, including:

- > Relationship problems
- > Depression or anxiety
- > Stress management
- > Alcohol or drug abuse
- > Community resources
- > Identity theft

Note: Not all plans have access to all tools and resources.

Eligibility

We recognize knowing and understanding eligibility rules is an important part of providing health benefits to our members. As the group administrator for your organization, administering eligibility means applying all of the eligibility rules required per your group's contract to enroll members on the plan. Several resources are available for your reference in applying the eligibility rules, including your medical and dental handbooks, our website, modahealth.com, and your assigned Membership Accounting Specialist.

Your Membership Accounting Specialist's role is to help assist you with managing your members' enrollment within our system. At times, it may be necessary for us to contact you to clarify dates or to obtain additional information in order to process your requests accurately. The partnership and open communication between you and your Membership Accounting Specialist is critical to effectively manage your enrollment needs.

Who is eligible?

Employees

Qualified employees are eligible for the employer sponsored insurance-based contract. Each employee must satisfy any required waiting period, look back period, orientation period, or accumulative service requirements. They must also work the minimum number of hours per week as required by your group contract. Please see your contract for waiting period and minimum hour requirements.

Employee/Subscriber-only policies do not cover spouses, domestic partners, dependent children, etc. These plans only cover the employee.

Spouse

If an employee is married, his/her legal spouse may be eligible for insurance. A valid marriage certificate must accompany the enrollment form when requesting special enrollment for a new spouse. Review your group contract to verify if this applies to your group.

Domestic partners

Oregon plans that cover spouses should also cover registered domestic partners. Your organization may also offer domestic partnership coverage through an Affidavit of Domestic Partnership. Your group can use its own Affidavit or use our form by downloading the Affidavit from our website, modahealth.com, in the "I'm an employer" or "I'm a member" tab.

Dependent children

Children may be eligible if they are under the maximum child age for your contract. Children over the maximum child age may be eligible for coverage if they are incapable of self-support due to a disability. The following are considered dependent children:

- > An employee's biological child
- > The biological or adopted child of the employee or the employee's spouse or domestic partner
- > Children placed for adoption with the employee (adoption paperwork must be provided)
- > Children related to the employee by blood or marriage for which the employee is the legal guardian (the employee will need to provide a court order showing legal guardianship)
- > A foster child (if the plan covers foster children)
- > A child for whom an employee or employee's spouse or domestic partner is required to provide coverage by a legal Qualified Medical Child Support Order (QMCSO)

Dependents with disabilities

If a subscriber has a child who has sustained a disability rendering him or her physically or mentally incapable of self-support at even a sedentary level, that child may be eligible for coverage beyond the dependent maximum age. To be eligible, the child must be unmarried and principally dependent on the employee for support, and must have had continuous medical coverage. The incapacity must have arisen, and the required substantiating information must be received, before the child attains the dependent maximum age. Social Security Disability status does not guarantee coverage under this provision. We will determine eligibility based on commonly accepted guidelines and documentation of the child's medical condition. Periodic review by Moda Health will be required on an ongoing basis, except in cases where the disability is certified to be permanent. For dental-only coverage, Delta Dental will accept the member's medical carrier's disability certification as sufficient documentation for disability.

Declining coverage

If at the time of initial eligibility an employee declines to enroll in coverage and/or coverage for any eligible dependent, enrollment will not be accepted until the next open enrollment (unless the employee has special enrollment rights as outlined below). In most cases, open enrollment occurs once a year at your group's renewal. It is required that all employees and their eligible dependents complete their enrollment forms within 31 days of eligibility.

Employees and their dependents may be eligible for a **special enrollment**. This allows them to enroll in the plan outside of the open enrollment period. Refer to the Member Handbook for specific rules. The following are considered special enrollment events:

- > Marriage (a valid marriage certificate is required upon enrollment)
- > Entering into a domestic partnership (a valid Domestic Partnership Affidavit or a Certificate of Registered Domestic Partnership is required upon enrollment)
- > Birth
- > Adoption (adoption paperwork is required upon enrollment) or placement for adoption
- > Loss of other coverage or becoming eligible for a premium assistance subsidy
- > Qualified Medical Child Support Order (QMCSO)
- > A person's coverage under Medicaid, Medicare, Tricare, Indian Health Service, eligibility for premium subsidy or a publicly sponsored or subsidized health plan has been involuntarily terminated within 63 days prior to applying for coverage in a group health benefit plan.

Employees wishing to enroll due to a special enrollment right must enroll within 31 days of the event. An employee who does not enroll within the 31 days will not be eligible to enroll until the next open enrollment period. *Note: Those covered under Medicaid or CHIP who lose coverage or become eligible for a premium assistance subsidy have up to 60 days to enroll.*

Enrollment

We make the submission of enrollment data for each specific group as convenient as possible. You can either submit paper enrollment forms or use Employer Dashboard, a web-based enrollment application that's easy to use and secure. We can also receive eligibility electronically. Our method of receiving electronic eligibility is the HIPAA 834 format. Please contact your Sales and Account Services representative if you wish to submit eligibility electronically.

Application process

We will provide you with the necessary enrollment forms for your employees. Completion of all fields on the enrollment form is critical to properly enrolling your employees in a timely fashion.

We must receive a signed, dated and fully completed enrollment form within the 31-day window for a qualifying employee to be covered. For assistance with eligibility requirements, please see the Eligibility section of this guide.

In order to administer the contractual agreement between Moda Health or Delta Dental and your group, it is important that we receive complete and accurate enrollment information on all members.

Checklist

- Have employee complete a Moda Health or Delta Dental enrollment form.
- Mail, email or fax the completed enrollment form and any required documentation to us.

Note: Enrollment forms must be signed and dated within 31 days (depending on your group contract) of becoming eligible.

We are unable to enroll a member if any of the following **required information is missing**:

- > First and last name of employee and all dependents enrolling in coverage
- > Social Security number of all enrollees
- > Birth dates of all enrollees
- > Dependent's relationship, such as child, spouse, ward, etc.
- > Gender of all enrollees
- > Address
- > Type of coverage
- > Plan selection
- > Group name, group ID, subgroup and class
- > Qualifying event, accompanied by required supporting documents
- > Dated signature of the employee
- > Date of hire

Failure to complete enrollment forms correctly or submitting forms past their due dates may cause a delay in enrolling a new employee or dependent until the next open enrollment period. Enrollment forms are available online at modahealth.com. You may request a supply by contacting your Membership Accounting Specialist.

Your Membership Accounting Specialist may contact you about incomplete information or clarification of the information you've provided. Enrollment will not be completed until all requested information has been received.

Using Employer Dashboard

Group administrators can request direct access to our eligibility system. Enrollments such as new member additions, terminations and changes can be made 24 hours a day, seven days a week by group administrators. You can request access to the Employer Dashboard by

notifying your Sales and Account Services representative. Once your account has been activated, you can access the Employer Dashboard by going to our website at modahealth.com/employers.

When using Employer Dashboard for enrollment functions you are required to retain all enrollment materials, such as enrollment forms and special enrollment rights documentation, for a seven-year period and to provide us with reasonable access to such material. If you do not wish to retain the enrollment material, you may submit it to us for retention.

Checklist

- Receive a completed Moda Health or Delta Dental enrollment form.
- Log on to Employer Dashboard.
- Update Employer Dashboard with the enrollment information.
- Retain the documentation of the enrollment for seven years, or mail or fax the completed enrollment forms and any required documentation to Moda Health/Delta Dental.

Note: Enrollment form must be signed and dated within the 31 days of eligibility event.

Enrollment for newly acquired dependents

Employees must enroll their eligible dependents for coverage within 31 days of their eligibility. The employee's premium may increase with this enrollment change.

Newly acquired dependents who are eligible for the plan are as follows:

New spouse

The employee must complete an enrollment form within 31 days of the date of marriage when adding a spouse. A copy of the valid marriage certificate or license is required upon enrollment. Coverage becomes effective on the date specified in the Member Handbook.

Domestic partner

The employee must complete an enrollment form and submit the state registration of domestic partnership within 31 days of the registration. Coverage becomes effective on the date specified in the Member Handbook.

If your plan offers domestic partnership coverage through an affidavit, the employee must complete an enrollment form and submit an Affidavit of Domestic Partnership within 31 days of when the employee and the domestic partner have signed the affidavit. Coverage becomes

effective on the date specified in the Member Handbook. *Note: Refer to your Member Handbook to determine if your plan covers domestic partners through an affidavit.*

Spouse's or domestic partner's children

The employee must complete an enrollment form within 31 days of marriage or filing of the Affidavit of Domestic Partnership when adding children of a new spouse or domestic partner. Coverage becomes effective on the date specified in the Member Handbook.

Newborn children

A member's newborn child is eligible from birth. To enroll a new child, an enrollment form must be submitted. When a premium increase is required, the enrollment form and payment must be submitted within 31 days. If payment is required but not received, the child will not be covered.

Adopted children

A subscriber's adopted child, or a child placed for adoption, will be eligible on the date of placement. To enroll a new child, an enrollment form must be submitted and adoption paperwork must be provided. The application and payment must be submitted within 31 days. If payment is required but not received, the child will not be covered.

Checklist

Once you become aware of a newly acquired dependent, you must:

- Provide an enrollment form to the employee and explain the information in the packet.
- Ask the employee to complete an enrollment form and return it to you for review.
- Ask the employee to provide any required documentation supporting the qualifying event such as Marriage Certificate.
- Forward a completed enrollment form and all required documentation to your Membership Accounting Specialist.

Special enrollment

If coverage is declined for an eligible employee or any dependent(s) when initially eligible or at an open enrollment period because of other health coverage, they may enroll in the plan outside of the open

enrollment period if the other coverage is terminated as a result of a loss of eligibility. Refer to the Member Handbook for specific criteria that must be met in order to be eligible.

Identification cards (ID cards)

Member ID cards automatically generate for new employees enrolling in coverage or those making any coverage changes that effect their ID card. Each ID card request will yield two identical ID cards for the subscriber.

Members may also download ID cards onto their iPhone or Android Smartphone. In addition, a PDF eCard version can be obtained through myModa.

If additional ID cards are needed, you may request them using Employer Dashboard or call your Membership Accounting Specialist. Members may access their myModa account or call our customer service department to request additional ID cards. ID cards will be mailed within three business days.

ID cards are not a guarantee of coverage and benefits. ID cards should be used for informational purposes only.

Exclusion period

For plans that include it, the dental exclusion period is the period (beginning on the member's enrollment date with Delta Dental) during which the plan does not cover certain expenses. The length of the exclusion period can be reduced or eliminated if proof of prior creditable coverage is provided to Delta Dental. An exclusion period may not apply to all dental plans.

Proof of creditable coverage

For plans that include it, the exclusion period will be reduced for members who show proof of creditable coverage. For new or reinstating members, documentation from the previous dental plan should be sent along with the enrollment form to Delta Dental. Documentation may be a letter from the prior dental insurance company that verifies a member was covered for a specific period of time. New groups, as well as groups adding dental coverage, are asked to submit the final bill from their prior dental carrier as proof of prior coverage.

Making changes

As employees' lives and work situations change, their eligibility for coverage under your company's Moda Health or Delta Dental plan may change. This section takes you through the process of maintaining proper records. It also serves as a reference tool enabling you to guide

your employees when completing necessary forms. Your assistance ensures that the benefit coverage made available by your company remains in force and accurate throughout an employee's relationship with your company and ours.

It is important that you keep us apprised of such changes and keep employees informed of the effect the changes may have on their coverage. We request notification if one of the following relevant changes occurs in an employee's status:

- > Name change
- > Family status change (new enrollment or termination of dependents). This may be due to events such as a birth, death, divorce or adoption
- > Address change

Such events may require a change such as:

- > Enrolling a new member
- > Terminating coverage
- > Changing a home address and contact information
- > Issuing a new ID card

You may make the following changes by accessing Employer Dashboard, having the employee complete, sign and date a new enrollment form or by sending your Membership Accounting Specialist the appropriate paperwork:

- > Name changes
- > Address changes
- > Employee and/or member additions
- > Termination of coverage for an employee and/or member

You may terminate coverage through Employer Dashboard or by listing the employee and dependent's name on the group billing change form included with your monthly bill. Refer to the Billing section for a sample of the form.

If the change is processed using Employer Dashboard, please ensure that the exact date of termination is used for members whose employment has ended. This will ensure the correct termination is reflected in our system.

Your employees may make the following changes by accessing myModa or by calling our Customer Service Department:

- > Medical Home changes

Retroactive eligibility

Retroactive eligibility refers to an eligibility event (which may include a new enrollment, reinstatement or termination) with a retrospective

effective date. We monitor retroactivity on all groups, regardless of contract type or eligibility administration responsibility.

Retroactive time limitations are typically 90 days. Time limitations refer to the amount of time you have to submit eligibility changes to us. All eligibility requirements such as signature dates, qualifying events and documentation apply. See your Member Handbook for eligibility guidelines. We encourage submitting terminations to us as soon as possible in order to ensure correct claims processing. However, we will typically allow retroactivity up to 90 days from the eligibility change date.

The Affordable Health Care Act (ACA), also known as Health Care Reform, prohibits retroactive termination of medical, vision, and pharmacy plans in certain circumstances.

To keep consistent administration of eligibility, we will apply the medical termination rules to all lines of coverage for any member with medical (including dental services that may be reimbursed under the medical), vision, pharmacy and dental coverage. *Note: If a member has dental-only coverage with Delta Dental, these rules will not apply.*

Under the ACA standards for rescission (which means cancellation or discontinuation that is retroactive), plans and issuers cannot rescind coverage retroactively except in the following situations:

- > Premium or Administrated Services Only (ASO) payments not paid timely
- > Employee contribution not paid timely
- > Fraud or intentional misrepresentation of material fact

A termination requested by an employee that is processed retroactively is still permissible under the law since the employee originated the request.

A retroactive termination is not allowed if it does not meet the above criteria.

Here is an example of a situation that cannot be processed retroactively: If an employee loses eligibility due to a reduction in hours, but the employer continues to collect any employee contribution, the termination can be processed only prospectively.

Because only employers know the specifics about the termination (e.g., if payment of an employee contribution was made or if the termination was requested by the employee), we will accept retroactive termination requests from groups, with the mutual understanding that the group is only submitting requests that are consistent with the state and federal regulations (e.g., ACA). If you need help determining if a retroactive termination complies with the regulations, please contact your Membership Accounting Specialist.

It is important to make your employees notify you of life events in a timely fashion. As the employer, it is necessary to regularly review the Moda Health/Delta Dental bill and/or membership lists to make sure our records match yours.

New enrollments/reinstatements

Employees must sign, date and submit enrollment forms to you within the timeframe in your group's contract. This is generally 31 days from the eligibility date. Upon receipt, we recommend that you forward that information to us via an enrollment form because the retroactive time limitations will apply. We must receive the enrollment form within 90 days to accommodate delays or errors involving a qualifying event when all other eligibility rules are met. Otherwise, a late enrollee must wait for a new qualifying event or open enrollment.

Premium impact

If the retroactive addition(s) or reinstatement(s) increase the premium/administration fee, you will owe an additional amount for month(s) that were not previously billed. Retroactive premiums will appear on the first bill to print following the date the eligibility event was entered in our system.

If retroactive terminations decrease premium/administration fees, the billing will be adjusted to reflect a credit for the extra premium/administration fee paid. Retroactive credits will appear on the first bill to print following the date the eligibility event was entered in our system. Any claims paid during this time will be reprocessed.

PCP or Medical Home changes

On applicable contracts, PCP or Medical Home changes are effective the first of the month following notification to Moda Health. A Medical Home selection is required on all Summit and Synergy plans.

When coverage ends

When an employee or dependent loses coverage, you must notify us no later than 31 days after the date of loss of coverage. Coverage for enrolled dependents ends at the same time the employee's coverage ends.

Coverage ends when one or more of the following occurs:

- > Group plan termination
- > Death
- > Loss of eligibility
- > Termination, layoff or reduction in hours of employment (including strike or lockout)
- > Divorce or termination of domestic partnership

> Nonpayment of premium by the employee

Checklist

- Advise employee of cancellation effective date.
- Advise employee of options to continue benefits.
- Notify us of a termination and the reason of termination.
- Delete employee and/or dependents from billing statement.

Group plan termination

If the group contract is terminated, insurance ends for the employees and any insured dependents on the date the plan contract ends.

Death

When an employee dies, coverage for their insured dependents ends on the last day of the month in which the employee's death occurs.

However, surviving dependents may extend their insurance for up to 36 months if they meet the requirements listed in the Continuation of Coverage section of this guide. Remember to notify the surviving dependents of their rights to continue coverage. If they choose to continue coverage, a completed enrollment will need to be submitted and you will need to notify your Membership Accounting Specialist.

Loss of eligibility

If employment ends, it is your responsibility to notify the terminated employee of the right to continue coverage.

Insurance will normally end for the employee and all insured dependents on the last day of the month in which termination occurs.

Layoff or reduction in hours

In the case of a loss of coverage due to layoff or reduction in hours of employment, coverage ends for the employee and their insured dependents on the last day of the month in which the layoff or reduction of hours occurs. However, if an employee is laid off and returns to active work within nine (9) months, the employee and any previously enrolled dependents may re-enroll in the group plan on the date the employee is rehired. Coverage will begin on the date of rehire. If an employee experiences a reduction in hours and within nine (9) months the employee's hours increase and they qualify for benefits, the employee and any previously enrolled dependents may re-enroll in the

group plan on the date the employee qualifies. Coverage will begin on the date the employee qualifies. You must notify us that an employee has been rehired following a layoff or that the employee's hours have increased, and the necessary premiums for the coverage must be paid.

Divorce or dissolution of domestic partnership

Insurance ends for an insured spouse and any applicable dependents on the last day of the month in which a decree of divorce or annulment is final or date of legal separation. Insurance ends for an insured domestic partner on the last day of the month in which a judgment of dissolution or annulment of the domestic partnership is entered or a partnership no longer meets the requirements of the Affidavit of Domestic Partnership filed with the employer. Please remember to notify the spouse or domestic partner of any rights to continue coverage.

When dependent children lose eligibility

Coverage ends for a dependent child on the last day of the month in which the child is no longer eligible due to the following reasons:

- > The child has reached the dependent maximum child age as specified in your policy.
- > The employee is no longer legally required to provide health insurance for the child.

Note: Remember to terminate any covered dependent children from the plan when they lose eligibility. Be sure to also notify terminated dependents of any rights to continue coverage through state continuation of Coverage or COBRA plans.

Notification guidelines

It is your employee's responsibility to notify you of any change in their dependent's eligibility status. To avoid retroactive adjustments on your billing statement, you will need to notify your Membership Accounting Specialist of the termination by email, fax, enrollment form or billing change form. You may also access Employer Dashboard to terminate coverage. Any claims processed before the eligibility changes will be adjusted, if necessary.

Continuation of coverage

Members may be eligible for other coverage either through COBRA or state continuation. The circumstance that causes members to lose coverage is called a "qualifying event." Such events might include the following:

- > Covered employee's termination of employment (including retirement) unless due to gross misconduct
- > Covered employee's reduction of hours (including a layoff, strike, etc.)
- > Death of the covered employee
- > Divorce from the covered employee
- > Dissolution of domestic partnership from the covered employee
- > The covered employee becomes eligible for Medicare
- > A dependent child ceases to be a dependent child under the terms of the plan
- > Employer bankruptcy (this only relates to retiree plans)

COBRA

Under COBRA, employers with 20 or more employees on 50 percent of the typical business days in the prior calendar year (some church plans are exempt) must provide continuation coverage to members who have experienced loss of coverage due to a qualifying event. Length of coverage depends on the qualifying event.

Qualifying events, maximum of 18 months of COBRA coverage:

Applies to employee, covered spouse and children

- > Covered employee's termination of employment
- > Covered employee's reduction in hours

Qualifying events, maximum of 36 months of COBRA coverage:

Applies to spouse and covered children

- > Death of the covered employee
- > Divorce or legal separation from the covered employee
- > The covered employee becomes eligible for Medicare
- > A dependent child ceases to be a dependent child under the terms of the plan

Retirees whose former employer files Chapter 11 bankruptcy may be eligible for benefits for life.

COBRA laws are specific about the notices, process of applying for benefits and payment of the premiums. Please check with your legal counsel for details. As to some key points, you are responsible for providing COBRA initial notice and election notice to your employees:

- Within 14 days of the date you receive a qualifying event notice from an employee
- Within 44 days of the employee's termination of employment, reduction in hours, death or becoming entitled to Medicare, or the employer filing for Chapter 11 reorganization

- You are also responsible for notifying us within 30 days of the qualifying event and collecting the initial premium from your employee within 45 days after the qualified beneficiary elects COBRA

Eligible employees and their dependents who elect COBRA will pay their monthly premiums directly to you, their employer. Members must pay their monthly premiums within 45 days of the date they elect COBRA and within 30 days thereafter or coverage will terminate without the option to reinstate.

Your Membership Accounting Specialist will work with you to enroll your qualified employees and their dependents in COBRA coverage.

COBRA premiums are based on the premiums charged to plan participants who are not on COBRA. However, you may require the COBRA beneficiary to pay the full cost of the premium (no employer contributions) plus an administrative fee of two percent.

Checklist

- Notify members of COBRA eligibility.
- Notify Moda Health/Delta Dental of triggering qualifying event.
- Collect premium from your COBRA members.
- Notify Moda Health/Delta Dental if payment is not received.
- Notify Moda Health/Delta Dental when members terminate coverage.

Premiums may also increase due to a disability extension. COBRA beneficiaries who are receiving 29 months of coverage due to a disability extension may be charged 150 percent of the premium after 18 months of coverage. You are responsible to notify us of a disability extension notice within 60 days of receipt of such notice from the member. The information shall include name and Social Security number of the qualified beneficiary, date of initial qualifying event and date the disability began as indicated in the Social Security Administration's disability determination. We will have no obligation to provide extended coverage if this information is not timely and complete.

State continuation of coverage

State continuation applies to employers who are not required to provide COBRA coverage, including employers with fewer than 20 employees on 50 percent of the typical business days, and certain government and church plans. Members have up to nine (9) months of continuation coverage after group coverage is lost due to a qualifying

event. No later than 10 days after Moda Health/Delta Dental is notified of a qualifying event, we will send a continuation notification including enrollment forms to the member. The member has 10 days from the issue date of the letter to request continuation coverage. Premium cost is to be paid by the member without any employer contribution. The member will continue to appear on the group billing invoice monthly. The member's failure to pay the premium timely will result in termination due to nonpayment.

Billing

We strive to make the billing and premium payment process as convenient and easy as possible. Your billing will be set up on our electronic billing (eBill) service. This allows you to access paperless billing, as well as premium payment online. You will receive an email confirmation with your sign on and password information during your group setup. eBill services save time, streamline billing tasks and reduces paper waste through online access to your account information. Examples of your billing documents can be found on the following pages of this guide.

For more information on eBill, please see the eBill section of this guide. You may also visit modahealth.com/employers/ebill.shtml.

What you will receive

Billing statement

Paperless billing statements are viewable in eBill and will list all active employees and COBRA participants covered under the plan. If a third-party administrator (TPA) is handling the COBRA premiums, the COBRA participants will not be included on the billing statements remitted to the employer. Any new enrollment and terminations that we received prior to your bill generating will also be reflected. You will see each covered employee listed for the current month's coverage, as well as any other retroactive months of coverage that apply.

Billing summary

The billing summary provides the premium breakdown by subgroup and line of business. The amount due to us is listed in the column labeled "Total Due." This is your total premium payment. You will receive two copies of the summary. One copy is to be sent in with the premium payment; the other is for your records. We encourage you to pay as billed. Changes received after your bill generates (i.e., terminations, additions, plan changes) will be reflected in your subsequent month's billing statement.

Billing change form

The Billing Change Form is a method for you to report to us any employee changes such as new enrollment, terminations, changes in subgroups, etc. This allows your Membership Accounting Specialist to process the requested changes. The changes received after your bill generates will be reflected on the next month's billing statement. While you can complete a Billing Change Form and return it to us with your payment, we prefer changes are sent to us as you receive them. This enables us to generate an accurate monthly bill. Each new enrollment does require an enrollment form to be submitted.

Checklist

- Review the billing statement.
- Complete billing change form for new enrollments, terminations and changes.
- Pay total due shown on billing summary.



601 SW Second Ave.
 Portland, OR 97204
 (503) 228-6554, toll-free 877-337-0647

Billing Statement Totals

Group/Subgroup: 1000####/ 000#
 XYZ Company, Inc.

Bill Print Date	For Coverage Beginning
MM/DD/20CC	MM/DD/20CC

Due Date : MM/DD/20CC

Benefit Type	Subscriber Count	Subscriber Premium	Dependent Count	Dependent Premium		
Dental Medical	###	\$\$\$.\$	##	\$\$\$.\$	Total this bill	\$\$\$.\$
					Outstanding Balance	\$\$\$.\$
					Please Pay This Amount	\$\$\$.\$

SAMPLE

BLPR
0000010206G000





Billing Statement

Group/Subgroup: 1000####/000#

XYZ Company, Inc.

601 SW Second Ave.
Portland, OR 97204
(503) 228-6554, toll-free 877-337-0647

Bill Print Date	For Coverage Beginning
MM/DD/20CC	MM/DD/20CC

Due Date : MM/DD/20CC

Description: Active

Subscriber ID #	Subscriber SSN	Employee Name	Coverage Date	Dental				Total



Group ID: 1000#### Group Name: XYZ Company, Inc Subgroup ID: 000# Subgroup Name: Active						
Billing Change Form for Month of _____						
Adds (New enrollments, dependent adds, and adding coverage) - Applications Required for Adds						
Subgroup	Effective Date	Subscriber Name	Subscriber ID / SSN	Description of Change	Adjustment Amount	Comment
Total for Adds					\$	
Terms (Termination of subscribers, dependents or coverage)						
Subgroup	Termination Date	Subscriber Name	Subscriber ID / SSN	Description of Change	Adjustment Amount	Comment
Total for Terminations					\$	
Changes (Changes in eligibility, benefits, or subgroup)						
Subgroup	Change Effective Date	Subscriber Name	Subscriber ID / SSN	Description of Change	Adjustment Amount	Comment
Total for Changes					\$	

Instructions: Please total changes by subgroup and transfer the amounts to the Moda Health Billing Summary form. Return Billing Change Forms and the Moda Health Billing Summary form with your payment. If you have more changes than this form can accommodate, please copy this form.

Billing and Eligibility Contact: Contact Name Here, 503-###-#### Ext: ####



Premium payment information

Payment due dates

Invoices are generated on the 7th of the prior month for all accounts that are paid current. Your payment is due to us by the first of each month. If payment is not received by the first of the month, next month's billing statement will not generate and delinquency will take effect.

Please remit the total amount billed. Any adjustments will be reflected on your next monthly billing.

Example: Payment for June eligibility is due by June 1. If payment is not received within the 15-day grace period, the contract is subject to termination. Please see the Delinquency section below for more details.

Delinquency

The premium is due on the first day of each month. If the premium is not received by the first day of the month, the employer group is considered delinquent. The group will receive a delinquency letter and coverage may be terminated back to the last day of the month in which premiums were received. Standard contracts have a 15-day grace period.

- If the premium is not received by us by the end of the grace period, we may terminate coverage.
- When a group is delinquent in premium payment, any claims that are submitted for reimbursement may not be processed. Once premiums are received and the account is current, claims on hold will be processed subject to plan provisions.

Final bills

Upon termination of coverage, we will provide a final bill indicating the ending balance due. If there are outstanding premiums owed, you will have 30 days to remit payment. If a refund is necessary, a refund check will be mailed within 30 days of the termination.

Payment options

eBill services

Through eBill you can pay online and schedule reoccurring payments if you want. To learn more about this exciting service, please visit modahealth.com/employers/ebill.shtml.

Automated Clearing House (ACH)

We provide ACH services to you, and it is simple to set up. ACH enables us to debit your organization's bank account and receive the payment for services and/or claims automatically on the first working day of each month. Please contact your Sales and Account Services representative for more information.

Check

Please remit your premium payment to the following address:

Attn: Accounting
Moda Health
601 S.W. Second Ave.
Portland, Oregon 97204-3199

Note: At this time, we do not take credit or debit card payments or payments over the phone for group monthly bills.

Reports

We provide several reports to ensure your eligibility records are consistent with our records.

Overage Dependent Report

The Overage Dependent Report is generated monthly. This report identifies all dependents who will reach the maximum child age within the next 60 days. This report also provides the anticipated termination date of the dependents who will reach the maximum age or if the appropriate dependent certification is not received. For more information, please see the Dependents with Disabilities section of this guide.

Coverage for dependents will end on the date specified in your contract, typically the end of the month after reaching age 26. Overage disabled dependents with coverage extension approved by Moda Health will not be included in the Overage Dependent Report.

Checklist

- Review overage dependent list for accuracy of terminating overage dependents before they are terminated.



**Overage Report
As of 03/31/2017**

**MESB_021
Date: 04/01/2017
Time: 8:13 pm
Page 3 of 1215**

Group: 00000001 ABC Company
Subgroup: 0003 ABC Company Retiree
Class: 0001 All Others

Subscriber ID	Subscriber SSN	Relation	Member Name	Date of Birth	Student	Termination Date	D
*****	111223333	C	Smith, Nadine M Mendez	05/02/1991		05/31/2017	Y
*****	444556666	C	Baggins, Julian D	04/18/1998		04/30/2017	Y
*****	777889999	C	Took, Joshua R	03/06/1991		03/31/2017	Y

D=Dental

Billing and Eligibility Specialist: Name

Subscriber member report

The Subscriber Member Report lists current eligible members in our system for your group. This report is helpful for auditing purposes to ensure your eligibility records and our eligibility records match. You can request this report from your Membership Accounting Specialist.

Subscriber ID numbers

In an effort to protect the privacy of our members, we will assign a non-Social Security number (SSN) ID to each subscriber. The new subscriber ID will be alphanumeric. Example: A12345678.

We will continue to require and retain the SSN for all new and existing subscribers and dependents. The SSN will be suppressed on all external communications with the exception of your billing statement. Your billing statement now includes the option of listing Social Security numbers and/or non-Social Security numbers. Please tell your Membership Accounting Specialist which option you prefer. By maintaining both numbers, we can ensure the timely processing of claims in case a provider inadvertently bills under the SSN number. Since we assign the new ID, our system supports the ability to go back and forth between the two numbers to ensure members receive the same level of service.

Turnaround times

At Moda Health/Delta Dental, we strive for excellence in all that we do. It is our intention to always provide you with the best customer service. To help us achieve our goal, we have outlined below the standard turnaround times for forms and materials submitted to us.

Enrollment forms

Enrollment information will be entered into our system within an average of two (2) business days from the date we receive the information.

Member ID cards

Member ID cards automatically generate for new employees enrolling in coverage or for those making any coverage changes that affect their ID card. ID cards will be mailed to the subscriber within an average of three (3) business days from the date we receive a request.

Members may download ID cards onto their iPhone or Android Smartphone. In addition, a PDF eCard version can be obtained through myModa.

Members may access myModa or call our customer service department to request additional ID cards, as well.

Email response time

If you have requested a response to your email, you can expect a return email within one (1) business day.

Phone response time

You should receive a call within one business day at the latest. If the person you are calling is out of the office, that team member's voicemail will direct you to a team member who has been cross-trained as a backup and is familiar with your account. There will always be someone at Moda Health/Delta Dental who can assist you with your questions.

BenefitHelp Solutions (BHS)

We offer a variety of services to our qualifying customers. BenefitHelp Solutions, a Moda subsidiary, provides third-party administration services, such as Flexible Spending Account (FSA) and COBRA administration. Since BenefitHelp Solutions is a Moda subsidiary, your Membership Accounting Specialist and your BenefitHelp Solutions Member Specialist will work in tandem to ensure a smooth transition for employees converting to COBRA coverage. For more information, please contact your Sales and Account Services representative or refer to *benefithelpsolutions.com*.

Terminology

Administrated Services Only (ASO): An arrangement between an employer and Moda Health or Delta Dental where we provide administrative services (such as the processing of claims or communication of benefits to subscribers) to the employees of the employer. The employer is responsible for paying the cost of the healthcare service provided.

Automated Clearing House (ACH): Electronic transfer of funds used for monthly premium payments.

Billing change form: Form used by employers to report eligibility changes.

Billing summary: Document sent to employers listing a grand total by subgroups and due date for the month billed.

Carrier: An insurance company.

COBRA: COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1985. This is a federal law that requires employers (some church groups are exempt) with 20 or more employees on 50 percent of the typical business days in the prior calendar year to allow people whose coverage would ordinarily end under their group plan to continue coverage under the plan for certain qualifying events.

Dependent: Any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a subscriber (an enrolled employee).

Eligibility: The determination of whether an individual has insurance coverage at a given point in time.

Eligibility waiting period (also called a probationary period): The period that must pass before the individual is eligible to enroll for benefits under the terms of the plan.

Enrollment: Information confirming that an individual is enrolled in a health insurance plan. Also, the total number of persons covered by the plan.

Late enrollee: An individual who enrolls subsequent to the initial enrollment period during which the individual was eligible for coverage but declined to enroll. If an individual declines coverage for himself for herself and/or dependents when initially eligible, he or she will not be allowed to enroll themselves and/or their dependents until the next open enrollment period unless he or she has a qualifying event.

Maximum child age: The ages at which dependents lose their eligibility on the subscriber's plan. Typically, our plans allow dependent coverage

through age 26. Sometimes the age allowed is different if the dependent is a full-time student at an accredited college.

Medical Home: A Medical Home is where a member goes for all of their healthcare needs. Medical Home offers patient-centered care with a team-based approach. A doctor or primary care provider (PCP) is connected with the rest of a member's care team (other providers, specialist, etc.) to bring them the best treatments and more affordable quality care.

Member: A member is defined as the person who is covered under the policy. This term includes the subscriber and covered dependents.

Member Handbook: A handbook made specific to each group that outlines their particular contract guidelines.

Open enrollment: A specified time period when employees have the opportunity to enroll or make changes to their health coverage.

Premium: The monthly cost that a group or individual pays for health insurance coverage.

Primary care physician (PCP): The participating physician or women's healthcare provider chosen by the subscriber to be responsible for the subscriber's continuing medical care.

Provider: Any entity or professional that provides patient care, including a hospital, physician or rehabilitation center.

Qualifying event: An event that causes an employee to gain or lose insurance coverage. For COBRA, also known as a triggering event.

Retroactivity: A change to employee/subscriber benefits that has an effective date that is backwards. Changes include additions, reinstatements and terminations. We monitor retroactivity on all groups, regardless of contract type or who administers eligibility. The retroactive time limits vary by contract type (insured or self-insured).

Special enrollment right: A qualifying event, outside of open enrollment, that makes an employee or dependent eligible for enrollment in the plan.

Subscriber: Usually the term to describe the employee on group policies.

Third-party administrator (TPA): An administrative organization, other than the employee benefit plan or healthcare provider, that collects premiums, process claims, and/or provides administrative services to providers, provider networks, employers or other groups of insured patients.