Plan Sponsor Manual For Self-Funded Clients

Updated: November 2018

B2BLUE IT'S WHERE BUSINESS IS GOING

Blue Cross Blue Shield of Rhode Island

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Introduction

Thank you for choosing Blue Cross & Blue Shield of Rhode Island (BCBSRI) as your self-funded administrator.

This administrative guide is designed to help you with the implementation and ongoing administration of your self-funded health plan. Our goal is to provide you with unparalleled client support throughout this process. From your initial benefit selection through discovering the financial and reporting resources that BCBSRI provides our self-funded clients, we will be with you every step of the way.

A dedicated client implementation manager will be assigned to you as your main point of contact throughout the implementation. They will work in tandem with your dedicated account executive and account manager to support a holistic and unified process.

Detailed project plans will be provided upon implementation, and recurring meetings will be scheduled to ensure the timely execution of the plans.

We have prepared this guide as an important resource for you and your designees in regards to the implementation and administration of your self-funded health plan. The samples provided are illustrative and are meant to provide a general view of what you can expect from BCBSRI. The information you receive may differ slightly based on the specifics of your self-funded administrative services contract.

Benefit Designs and Group Structure

One of the initial steps in the implementation process is the finalization of benefit offerings. Your client implementation manager (CIM) will be provided benefit decisions by your account executive and will work to validate the benefit configuration schedule with our internal teams.

During the finalization of benefits, the CIM will address, at a minimum, the following items as they pertain to you:

- Consumer-directed health plan options
- Pharmacy offerings and optional enhancements
- Telemedicine
- Wellness
- Dental
- Vision
- Stop loss
- Essential health benefits and state mandates

Upon completion of benefit review, the CIM will provide you with detailed benefit grids requiring review and signature prior to benefit construction.

A proposed group structure will be provided to you for review and confirmation. Group structure will reflect the benefit packages offered to your employee populations and can be organized by various categories, including client locations, entities, active, COBRA, and retiree enrollment, as well as part- and full-time status. Group structure can also help to assist in organizing your monthly administrative bills by various entities (such as affiliate level, etc.). BCBSRI will work to create a structure that meets your specific needs.

Financial Information and Client Invoices

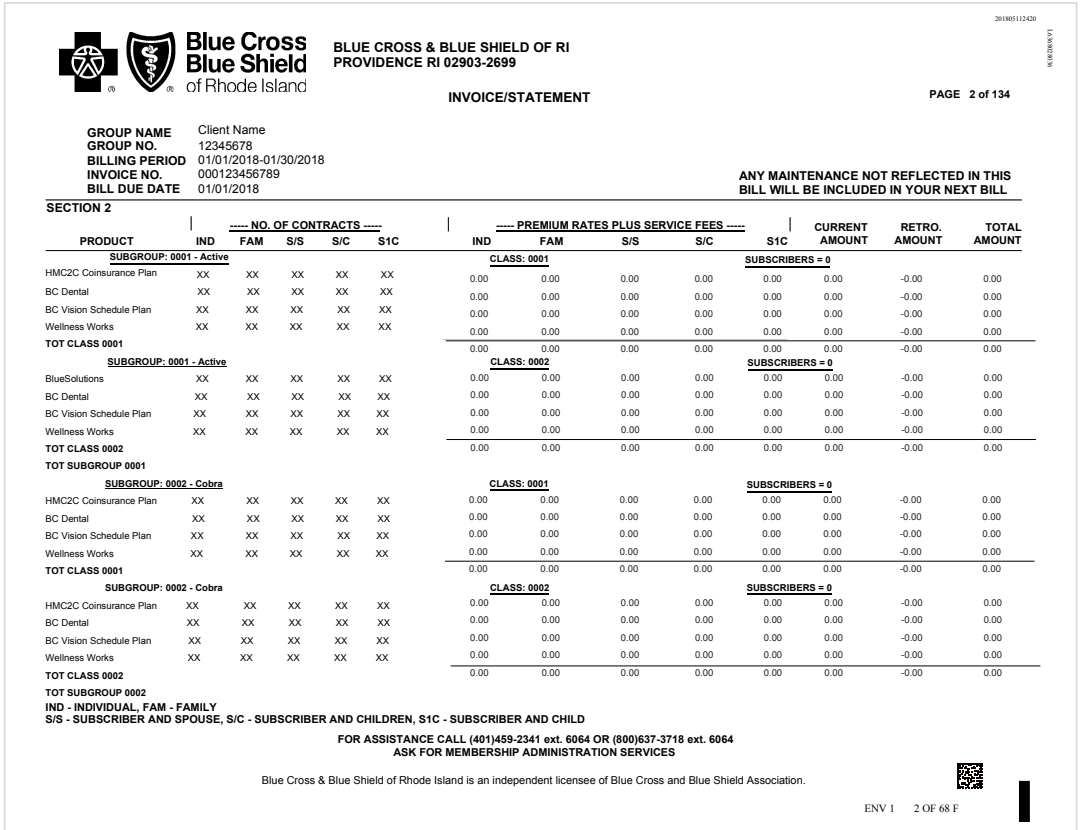
In support of self-funded benefit plans, BCBSRI clients receive a monthly invoice for fixed administrative costs, including the negotiated administrative fee and optional services and products, such as stop loss and wellness. **Monthly Administrative Invoices** are posted to bcbsri.com on the Employer Portal. The invoice can be configured in different formats of account characteristics. Payment can be remitted to BCBSRI via ACH debit or wire transfer and is due on the 1st of the following month.

Access to the Employer Portal will be discussed in the next section.

Additionally, self-funded clients will be invoiced weekly for claims paid by BCBSRI on behalf of members enrolled in the self-funded plan. These weekly claims invoices are summaries of paid claims and are distributed via email to the appointed client's financial contact. Payment is due to BCBSRI within 48 hours of receipt and is typically remitted via ACH debit. Please see next page for an example of a **Weekly Paid Claims Invoice** and Appendix A for additional pages.

In order to provide BCBSRI with the information necessary to ensure proper banking set-up for any desired ACH debits and invoicing preferences, please complete the **Finance Intake Form** and return to Corporate Accounting at corporate.accounting@bcbsri.org. Please see next page for a sample of the form and Appendix B for additional pages. The Finance Intake Form may also be found on the BCBSRI Employer Portal by going to Forms > Large Employers > Self-Funded Employers > Finance Intake Form.

MONTHLY ADMINISTRATIVE INVOICE



Blue Cross Blue Shield of Rhode Island

BLUE CROSS & BLUE SHIELD OF RI
PROVIDENCE RI 02903-2699

INVOICE/STATEMENT

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GROUP NAME Client Name
GROUP NO. 12345678
BILLING PERIOD 01/01/2018-01/30/2018
INVOICE NO. 000123456789
BILL DUE DATE 01/01/2018

ANY MAINTENANCE NOT REFLECTED IN THIS BILL WILL BE INCLUDED IN YOUR NEXT BILL

SECTION 2

PRODUCT	----- NO. OF CONTRACTS ----- IND	FAM	S/S	S/C	S1C	----- PREMIUM RATES PLUS SERVICE FEES ----- IND	FAM	S/S	S/C	S1C	CURRENT AMOUNT	RETRO. AMOUNT	TOTAL AMOUNT
SUBGROUP: 0001 - Active						**CLASS: 0001**				**SUBSCRIBERS = 0**			
HMC2C Coinsurance Plan	XX	XX	XX	XX	XX	0.00	0.00	0.00	0.00	0.00	0.00	-0.00	0.00
BC Dental	XX	XX	XX	XX	XX	0.00	0.00	0.00	0.00	0.00	0.00	-0.00	0.00
BC Vision Schedule Plan	XX	XX	XX	XX	XX	0.00	0.00	0.00	0.00	0.00	0.00	-0.00	0.00
Wellness Works	XX	XX	XX	XX	XX	0.00	0.00	0.00	0.00	0.00	0.00	-0.00	0.00
TOT CLASS 0001						0.00	0.00	0.00	0.00	0.00	0.00	-0.00	0.00
SUBGROUP: 0001 - Active						**CLASS: 0002**				**SUBSCRIBERS = 0**			
BlueSolutions	XX	XX	XX	XX	XX	0.00	0.00	0.00	0.00	0.00	0.00	-0.00	0.00
BC Dental	XX	XX	XX	XX	XX	0.00	0.00	0.00	0.00	0.00	0.00	-0.00	0.00
BC Vision Schedule Plan	XX	XX	XX	XX	XX	0.00	0.00	0.00	0.00	0.00	0.00	-0.00	0.00
Wellness Works	XX	XX	XX	XX	XX	0.00	0.00	0.00	0.00	0.00	0.00	-0.00	0.00
TOT CLASS 0002						0.00	0.00	0.00	0.00	0.00	0.00	-0.00	0.00
TOT SUBGROUP 0001													
SUBGROUP: 0002 - Cobra						**CLASS: 0001**				**SUBSCRIBERS = 0**			
HMC2C Coinsurance Plan	XX	XX	XX	XX	XX	0.00	0.00	0.00	0.00	0.00	0.00	-0.00	0.00
BC Dental	XX	XX	XX	XX	XX	0.00	0.00	0.00	0.00	0.00	0.00	-0.00	0.00
BC Vision Schedule Plan	XX	XX	XX	XX	XX	0.00	0.00	0.00	0.00	0.00	0.00	-0.00	0.00
Wellness Works	XX	XX	XX	XX	XX	0.00	0.00	0.00	0.00	0.00	0.00	-0.00	0.00
TOT CLASS 0001						0.00	0.00	0.00	0.00	0.00	0.00	-0.00	0.00
SUBGROUP: 0002 - Cobra						**CLASS: 0002**				**SUBSCRIBERS = 0**			
HMC2C Coinsurance Plan	XX	XX	XX	XX	XX	0.00	0.00	0.00	0.00	0.00	0.00	-0.00	0.00
BC Dental	XX	XX	XX	XX	XX	0.00	0.00	0.00	0.00	0.00	0.00	-0.00	0.00
BC Vision Schedule Plan	XX	XX	XX	XX	XX	0.00	0.00	0.00	0.00	0.00	0.00	-0.00	0.00
Wellness Works	XX	XX	XX	XX	XX	0.00	0.00	0.00	0.00	0.00	0.00	-0.00	0.00
TOT CLASS 0002						0.00	0.00	0.00	0.00	0.00	0.00	-0.00	0.00
TOT SUBGROUP 0002													

IND - INDIVIDUAL, FAM - FAMILY
S/S - SUBSCRIBER AND SPOUSE, S/C - SUBSCRIBER AND CHILDREN, S1C - SUBSCRIBER AND CHILD

FOR ASSISTANCE CALL (401)459-2341 ext. 6064 OR (800)637-3718 ext. 6064
ASK FOR MEMBERSHIP ADMINISTRATION SERVICES

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WEEKLY PAID CLAIMS INVOICE

Blue Cross Blue Shield of Rhode Island

Invoices

ABC Company
123 Main Street
Suite 123
Providence, RI 02903

Paid Claims For the Week of _____

GROUP	HOSPITAL*	SURGICAL MEDICAL*,**	DRUGS	Total
00000000-0001	0.00	0.00	0.00	0.00
00000000-0002	0.00	0.00	0.00	0.00
00000000-0003	0.00	0.00	0.00	0.00
Total Due	$0.00	$0.00	$0.00	0.00

* Hospital and Surgical Medical Claims include BlueCard Access fees, Administrative Expense Allowance (AEA) Fees, Non-Standard AEA Fees, and fees associated with Negotiated National Arrangements as described in your Administrative Service Contract.

**Includes payments made pursuant to any arrangements with service or healthcare providers, including payments for Value Based Programs, as described in your Administrative Service Contract.

If you have any questions, please contact corp.accounting@bcbsri.org

Corporate Accounting Dept. A/R/S
500 Exchange Street
Providence, RI 02903-2699

FINANCE INTAKE FORM

Blue Cross Blue Shield of Rhode Island

Invoices

Finance Intake Form
For Self-funded Clients

Parent Group Name: _____ **Parent Group Number:** _____

Remittance Methods	
Weekly Paid Claim Invoices *ACH Debit is initiated 24 hours subsequent to claim invoice notification and funds deposited to BCBSRI bank 24 hours thereafter.	✓ Please check one: ☐ **ACH Debit*** ☐ **Wire****
Monthly Administrative Fee Invoices *ACH Debit is initiated for Administrative Fees by the first business day of each month	✓ Please check one: ☐ **ACH Debit*** ☐ **Wire****
Required Deposit	✓ Please check one: ☐ **ACH Debit** ☐ **Wire**** ☐ **Check**

**BCBSRI Chief Financial Officer or Vice President of Finance will present a signed letter to Client on BCBSRI letterhead as affirmation to deposit funds to the BCBSRI bank account.

Banking Information: ACH Debit	
If electing to utilize the ACH Debit method of payment, please complete all fields to ensure proper banking set-up.	
Bank Name:	Bank Account Name:
ABA/Routing Number:	Bank Account Number:

Employer Authorized Billing Contacts
Monthly administrative invoices are provided to the individual by mail. The weekly claims invoices are provided by email.

Primary Billing Contact	
Name:	Title:
Email Address:	Phone Number:
Please list the Group and Subgroups numbers for user to be granted access to:	
✓ **Please check applicable invoices to be received :**	☐ Weekly Claims Invoice ☐ Monthly Administrative Invoice

Employer Portal and Security Access

As part of your self-funded implementation process, your account manager (AM) will work with you to identify the individual designated as your administrator. The administrator will be provided access to your member-specific data on the BCBSRI Employer Portal.

Once identified, the administrator will receive a welcome notice as well as separate credentials allowing them to sign into the portal. On the portal the administrator will be able to:

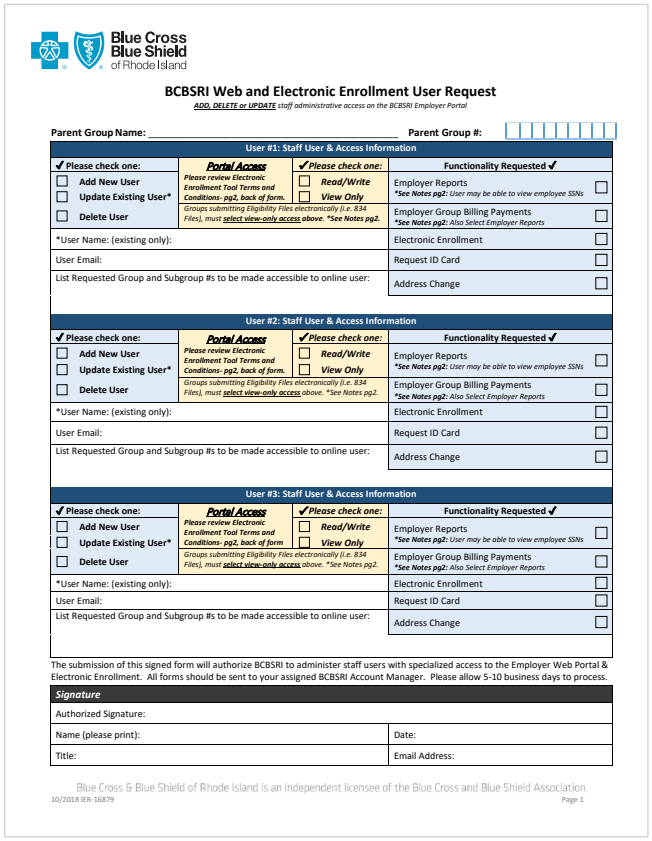
1. Access our Online Electronic Enrollment Tool to manage eligibility
2. View Employer Reporting
3. View Group Billing including monthly premium invoices (administrative fees) and payment status
4. Request employee ID cards
5. Update employee addresses
6. Download forms pertaining to enrollment and eligibility
7. View Benefit Booklets and Summary of Benefits and Coverage (SBC) documents

For clients with multiple entities and/or locations, having a single administrator with sole access to the entire account's information may not be desirable. In these cases, BCBSRI may retain this function and serve as the client's Employer Portal administrator. To initiate this process, you simply need to complete the **BCBSRI Web and Enrollment User Request** (see next page). This form may be requested from your AM.

In addition to designating BCBSRI as the administrator for your account, this form may also be used to request that BCBSRI create "staff" user accounts for other members of your team. Users can be granted varying levels of access. Once established, your AM will provide each staff user with individual log-in credentials. This form can also be utilized to change user access, if necessary.

Since certain reports provided by this access contain individually identifiable member information or protected health information (PHI), it is important that the client manages access to the portal diligently. You are responsible for ensuring that your designated users are aware of the terms and conditions that accompany access. Clients designating BCBSRI as their administrator are also responsible for notifying BCBSRI when any changes need to be made in relation to user access designations, including additions, terminations, and functionality changes.

BCBSRI WEB AND ELECTRONIC ENROLLMENT USER REQUEST



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BCBSRI Web and Electronic Enrollment User Request

ADD, DELETE or UPDATE *staff administrative access on the BCBSRI Employer Portal*

Parent Group Name: _____ **Parent Group #:**

User #1: Staff User & Access Information			
✓ Please check one:	***Portal Access***	**✓*Please check one:***	**Functionality Requested ✓**
☐ **Add New User**	***Please review Electronic Enrollment Tool Terms and Conditions- pg2, back of form.***	☐ ***Read/Write***	Employer Reports ☐
☐ **Update Existing User***		☐ ***View Only***	***See Notes pg2:** User may be able to view employee SSNs*
☐ **Delete User**	*Groups submitting Eligibility Files electronically (i.e. 834 Files), must **select view-only access** above. **See Notes pg2.***		Employer Group Billing Payments ☐ ***See Notes pg2:** Also Select Employer Reports*
*User Name: (existing only):			Electronic Enrollment ☐
User Email:			Request ID Card ☐
List Requested Group and Subgroup #s to be made accessible to online user:			Address Change ☐

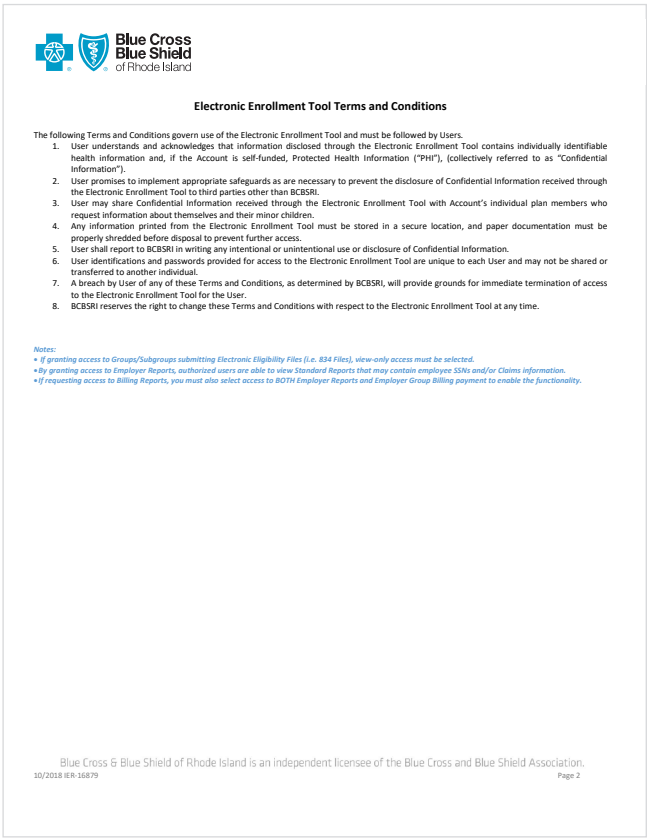
User #2: Staff User & Access Information			
✓ Please check one:	***Portal Access***	**✓*Please check one:***	**Functionality Requested ✓**
☐ **Add New User**	***Please review Electronic Enrollment Tool Terms and Conditions- pg2, back of form.***	☐ ***Read/Write***	Employer Reports ☐
☐ **Update Existing User***		☐ ***View Only***	***See Notes pg2:** User may be able to view employee SSNs*
☐ **Delete User**	*Groups submitting Eligibility Files electronically (i.e. 834 Files), must **select view-only access** above. **See Notes pg2.***		Employer Group Billing Payments ☐ ***See Notes pg2:** Also Select Employer Reports*
*User Name: (existing only):			Electronic Enrollment ☐
User Email:			Request ID Card ☐
List Requested Group and Subgroup #s to be made accessible to online user:			Address Change ☐

User #3: Staff User & Access Information			
✓ Please check one:	***Portal Access***	**✓*Please check one:***	**Functionality Requested ✓**
☐ **Add New User**	***Please review Electronic Enrollment Tool Terms and Conditions- pg2, back of form***	☐ ***Read/Write***	Employer Reports ☐
☐ **Update Existing User***		☐ ***View Only***	***See Notes pg2:** User may be able to view employee SSNs*
☐ **Delete User**	*Groups submitting Eligibility Files electronically (i.e. 834 Files), must **select view-only access** above. **See Notes pg2.***		Employer Group Billing Payments ☐ ***See Notes pg2:** Also Select Employer Reports*
*User Name: (existing only):			Electronic Enrollment ☐
User Email:			Request ID Card ☐
List Requested Group and Subgroup #s to be made accessible to online user:			Address Change ☐

The submission of this signed form will authorize BCBSRI to administer staff users with specialized access to the Employer Web Portal & Electronic Enrollment. All forms should be sent to your assigned BCBSRI Account Manager. Please allow 5-10 business days to process.

Signature	
Authorized Signature:	
Name (please print):	Date:
Title:	Email Address:

FRONT



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Electronic Enrollment Tool Terms and Conditions

The following Terms and Conditions govern use of the Electronic Enrollment Tool and must be followed by Users.

1. User understands and acknowledges that information disclosed through the Electronic Enrollment Tool contains individually identifiable health information and, if the Account is self-funded, Protected Health Information ("PHI"), (collectively referred to as "Confidential Information").
2. User promises to implement appropriate safeguards as are necessary to prevent the disclosure of Confidential Information received through the Electronic Enrollment Tool to third parties other than BCBSRI.
3. User may share Confidential Information received through the Electronic Enrollment Tool with Account's individual plan members who request information about themselves and their minor children.
4. Any information printed from the Electronic Enrollment Tool must be stored in a secure location, and paper documentation must be properly shredded before disposal to prevent further access.
5. User shall report to BCBSRI in writing any intentional or unintentional use or disclosure of Confidential Information.
6. User identifications and passwords provided for access to the Electronic Enrollment Tool are unique to each User and may not be shared or transferred to another individual.
7. A breach by User of any of these Terms and Conditions, as determined by BCBSRI, will provide grounds for immediate termination of access to the Electronic Enrollment Tool for the User.
8. BCBSRI reserves the right to change these Terms and Conditions with respect to the Electronic Enrollment Tool at any time.

Notes:
- *If granting access to Groups/Subgroups submitting Electronic Eligibility Files (i.e. 834 Files), view-only access must be selected.*
- *By granting access to Employer Reports, authorized users are able to view Standard Reports that may contain employee SSNs and/or Claims information.*
- *If requesting access to Billing Reports, you must also select access to BOTH Employer Reports and Employer Group Billing payment to enable the functionality.*

BACK

Reporting

Blue Insights

BCBSRI is proud to introduce our proprietary Blue Insights employer reporting tool to clients with 100 or more contract holders and designated partners. Blue Insights provides users access to over 40 readily available reports, as well as the ability to create and modify data for reporting purposes.

This powerful tool provides the flexibility to convert data into a variety of charts and analytic aids to help large group employers make evidence-based cost-control decisions. The tool is fully customizable, from scheduling monthly reports to creating a home dashboard that monitors critical data. It is available 24/7 and delivers data employers need.

BCBSRI's Employer Reporting solution aggregates health plan enrollment, claims, and other data sources to enable reporting and analytics of employer group populations, including utilization, expense, and performance measures. It is a secure, web-based environment in which healthcare decision-makers can monitor performance metrics and drill down into detailed member-level and claims data.

The Employer Reporting solution includes the following core features:

- Dashboards, graphs, and key performance indicators (KPI)
- Over 40 standard reports
- On-demand report personalization and ad-hoc analysis
- Drill down to claim, provider, or member-level detail
- Variance and trending analysis
- Multi-dimension summary analysis
- Custom-defined dimensions
- Custom-defined metrics
- Chart builder
- Add personal reports to "Favorites"
- Point-and-click user interface
- Print-ready and exportable reports

Standard Cost and Utilization Reports

BCBSRI also provides self-funded clients with 100 or more contract holders a myriad of **standard cost and utilization reports** available on the Employer Portal at bcbsri.com. Aggregated for ease of reference, reporting suites provide valuable analytic information. On the next page is a summary of the available reports. Your account executive is available to review the reports in detail.

SUMMARY OF AVAILABLE REPORTS

	Description
Core Reporting Suite	Monthly report of account enrollment, claims, and excess claims by group and subgroup.
Product Reporting Suite	Monthly report of account enrollment and claims by product and coinsurance/deductible.
Analytic Account Profile	Quarterly report that provides actionable information and identifies areas of opportunity with an Executive Summary, Population and Financial overview, Utilization Analysis, and HEDIS results. Where appropriate, comparisons are made to benchmark and industry standards.
Pharmacy Reporting Suite (if applicable)	Monthly report of client Rx utilization by generic, brand, and specialty prescriptions.
Monthly Deductible Report	Monthly report of Deductible dollars. Report displays deductible accumulation by product and quartile for active subscribers.

CLAIMS DETAIL REPORTS

In addition to this standard reporting, all self-funded clients receive weekly and monthly **Claims Detail Reports** which provide the member-level detail supporting the paid claims invoices. These reports are posted to the Employer Portal at bcbsri.com. Given the sensitive nature of these reports, which include PHI, you have the ability to suppress certain identifying fields (fields 14-19) and/or restrict access to these reports. Your intentions regarding field suppression and distribution should be indicated in the **Finance Intake Form** (Appendix B).

DATA FIELDS AND DESCRIPTIONS

#	Data Element Name	Data Type	Field Length	Description of Data Element
1	Account No	Character(9)	10	The Main Group identifier for the entire account.
2	Group-No	Character(8)	10	A unique identification assigned to an employer, association, organization, or other entity, for which a body of subscribers is enrolled.
3	Sub-Group-Number	Character(4)	4	A unique identification assigned to break out a group further.
4	Account Name	Character(50)	50	Name associated with the account.
5	Affiliated Group-No	Character(8)	10	A unique identification assigned to an employer, association, organization, or other entity, for which a body of subscribers is enrolled.
6	Affiliated Sub-Group-Number	Character(4)	4	A unique identification assigned to break out a group further.
7	Group Name	Character(50)	50	Name associated with the client.
8	Product Description	Character(50)	50	Product family name associated with the Product ID.

DATA FIELDS AND DESCRIPTIONS

#	Data Element Name	Data Type	Field Length	Description of Data Element
9	Plan	Character(30)	3	Identifies the subscriber contract type, e.g., single, 2-person, family, etc.
10	LOB (Claim Type)	Character(16)	16	Indicates a benefit grouping for the claim. e.g., major med, inpatient, outpatient, surgical medical.
11	Category	Character(2)	1	High-level categorization of Products. Allowed Values in this field are H, W, S. H would be for Health W would be for Workers Comp S would be for Supplemental workers comp
12	Package/Class Number	Character(4)	4	A number of benefits are grouped together and assigned a value, which is called the package/class.
13	Department Number	Character(4)	14	Identifies the department within the group that the member is associated with.
14	LID-Number	Character(45)	45	An ID from the source system that represents a member with Blue Cross & Blue Shield of Rhode Island coverage.
15	First-Name	Character(30)	30	This is the first name of the member.
16	Last-Name	Character(30)	30	This is the last name of the member.
17	Dependent No.	Character(3)	3	This is the number of dependents of the primary policyholder.
18	Relationship	Character (3)	3	Relationship between member and subscriber.
19	Claim-Number	Character(93)	23	This is the plan-specific identifier for a claim. Within the plan, this identifier may vary by source.
20	No. of Inpatient Days	Character(5)	3	This is the number of days the patient is admitted in a facility.
21	Date-of-Service	Character(8)	10	Date on which services began. Located on HCFA 1500 (Form Locator 24A) and UB92 (Form Locator 45).
22	Paid-Date	Character(8)	10	The date the claim was paid. “MM-DD-YYYY” format will be used for date.
23	Claim-Status-Code	Character(8)	10	This indicates if the claim is an “Original” claim or is a result of an adjustment.” Allowed values in this field are original or adjustment.
24	Diagnosis-Code	Character(7)	7	The member's principal condition treated during this service.
25	Diagnosis-Description	Character(80)	80	Complete description of the diagnosis code.

#	Data Element Name	Data Type	Field Length	Description of Data Element
26	Procedure-Code	Character(8)	6	Principal medical procedure a patient received during inpatient stay. The field from the source system is captured.
27	Provider ID	Character(10)	10	Rendering provider ID.
28	Provider First Name	Character(30)	30	The first name of the provider that provided service. In case of pharmacy claims this is the Pharmacy name where the services were taken for the claim.
29	Provider Last Name	Character(50)	50	The last name of the provider that provided service. In case of pharmacy claims this populates as "spaces."
30	Payee-Code	Character(4)	2	Code used to identify if a payment was to a provider or a member. PV = Provider; PM = Provider Pay Manual; MB = Member; OT = Other
31	Copay Amount	Decimal(11,2)	11	Amount an insured individual pays directly to a provider at the time the services or supplies are rendered.
32	Other Carrier Liability Amount	Decimal(11,2)	11	Amount paid by the secondary carrier that was submitted with the claim. All dollar values are right justified with a preceding negative sign. Ex: 1.11, -1.11, -11.11 etc.
33	Claims Payments	Decimal(11,2)	11	The amount sent to the payee from the health plan. This amount is to include withhold amounts and any member cost sharing.
34	Deductible Amount	Decimal(11,2)	11	This amount is the portion of this service that the member must pay that is applied to the total period deductible. Deductibles are usually applied over a specific time period, such as per calendar year.
35	Coinsurance Amount	Decimal(11,2)	11	The amount the insured individual pays, as a set percentage of the cost of covered medical services, as an out-of-pocket payment to the provider.
36	Value Based Program Code	Character(4)	4	The specific value based program by provider arrangement.

Enrollment and Eligibility

Electronic and File Enrollment Options

There are multiple ways in which you may submit eligibility to BCBSRI. Many self-funded clients utilize standard electronic enrollment files (834 files), while others utilize our online electronic enrollment tool. The individual identified as the administrator of the Employer Portal can grant access to our online enrollment tool for additional staff. A BCBSRI standard CSV layout can also be utilized, especially for initial enrollment intake. Your client implementation manager and account manager will work with you to determine the most efficient method.

How to Complete Enrollment Forms (Group Activity Report and Large Group Member Application)

A **Group Activity Report (GAR)** must be submitted with all additions, non-demographic changes (including retroactive changes), and cancellations. An example of the front and back can be found in **Appendix C**.

GROUP ACTIVITY REPORT (GAR)

Group Activity Report (GAR)
for Additions, Cancellations & Changes

Blue Cross Blue Shield of Rhode Island

The Group Activity Report (GAR) form is used to enroll new subscribers, cancel coverage for subscribers, process changes in family status, (such as the birth of a child or marriage), or to change plan coverage. This form should also be used to transfer subscribers from one group within an account to another group within the same account. Upon completion of the form, please make and retain a copy for your records.

See the back page for instructions on completing this Group Activity Report Form. If you have questions, please contact your broker or BCBSRI account representative.

1
Group Name: ABC Company
Group Number: 12345678 Subgroup Number: 0001
Date: 12 / 15 / 18
Prepared By: Thomas Jones Title: Benefits Admin
Phone Number: 401-123-4567
Email Address: thomas.jones@abccompany.com

2

BCBSRI Membership Number	Name of Employee (First Name, Last Name, Middle Initial)	Effective/ Termination Date	Process Code*	Explanation of Request**	Application Attached (check)	PCP Selection Form Attached (check)
	Samuel Sample, Q.	01/01/19	1	Add Medical and Dental	✓	
ABC123454321	Frank Fake, L.	12/31/18	2	Left employment		
ABC987654321	Elizabeth Example, T.	01/01/19	3	Change to Enrollee and spouse	✓	

Instructions
1. Complete all entries on this form
2. Include the corresponding application(s) and PCP Selection form(s) (if applicable)
3. Return completed form, application(s), and PCP Selection form(s) (if applicable) or mail to:
   BCBSRI Membership Department
   500 Exchange Street
   Providence, RI 02903-2699
email: bcbsri-enrollmentintake@bcbsri.org or fax 401-459-2385

For Member Services Use Only
Date Received: 12 / 15 / 18

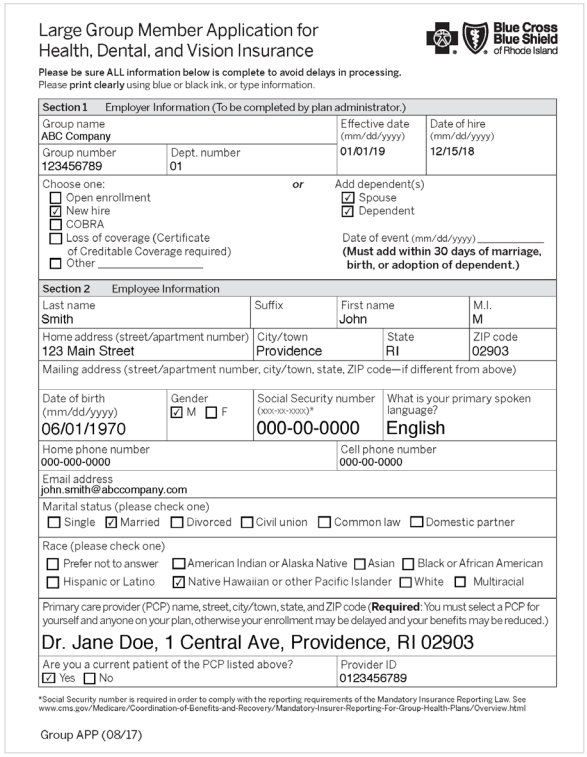
*Please use these process codes:
1-Benefit change 2-Termination 3-New addition 4-COBRA addition

**Please use these explanations:

1-Benefit Change	2-Termination	3-New Addition**
- Add: • Medical • Dental • Vision - Drop: • Medical • Dental • Vision - Change plan option (explain above) - Other (explain above)	- Deceased - Laid off - Left employment - Declined coverage - Other insurance - Transferred to: • Spouse's plan • Plan 65 • BlueCHiP for Medicare	- Change to: • Enrollee (subscriber only) • Enrollee and spouse • Enrollee and child(ren) • Enrollee medical/family dental • Family • Family medical/enrollee dental **Application Required

Employees that wish to join one of our health plans—even those who that have been members in the past—must complete the **Large Group Member Application.** Please see Appendix D for an example of a complete application. All eligible members must list their legal name as validated by their government-issued identification (i.e., Social Security card, birth certificate, or passport). After your employees complete this form, they must return it to you.

LARGE GROUP MEMBER APPLICATION



Large Group Member Application for Health, Dental, and Vision Insurance

Blue Cross Blue Shield of Rhode Island

Please be sure ALL information below is complete to avoid delays in processing.
Please **print clearly** using blue or black ink, or type information.

Section 1 Employer Information (To be completed by plan administrator.)

Group name: ABC Company		Effective date (mm/dd/yyyy): 01/01/19	Date of hire (mm/dd/yyyy): 12/15/18
Group number: 123456789	Dept. number: 01		

Choose one: ☐ Open enrollment ☑ New hire ☐ COBRA ☐ Loss of coverage (Certificate of Creditable Coverage required) ☐ Other _____

or

Add dependent(s) ☑ Spouse ☑ Dependent

Date of event (mm/dd/yyyy) _____ **(Must add within 30 days of marriage, birth, or adoption of dependent.)**

Section 2 Employee Information

Last name: Smith	Suffix:	First name: John	M.I.: M
Home address (street/apartment number): 123 Main Street	City/town: Providence	State: RI	ZIP code: 02903
Mailing address (street/apartment number, city/town, state, ZIP code—if different from above)			
Date of birth (mm/dd/yyyy): 06/01/1970	Gender: ☑ M ☐ F	Social Security number (xxx-xx-xxxx)*: 000-00-0000	What is your primary spoken language?: English
Home phone number: 000-000-0000		Cell phone number: 000-00-0000	
Email address: john.smith@abccompany.com			

Marital status (please check one)
☐ Single ☑ Married ☐ Divorced ☐ Civil union ☐ Common law ☐ Domestic partner

Race (please check one)
☐ Prefer not to answer ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☑ Native Hawaiian or other Pacific Islander ☐ White ☐ Multiracial

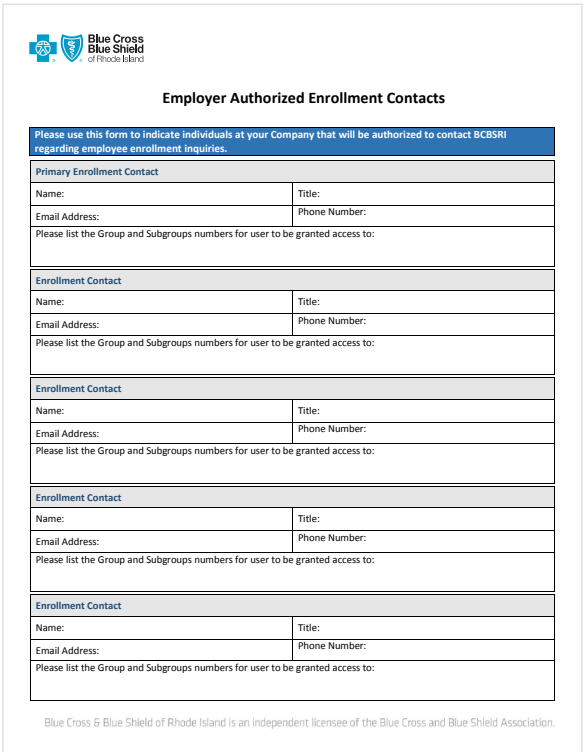
Primary care provider (PCP) name, street, city/town, state, and ZIP code (**Required**: You must select a PCP for yourself and anyone on your plan, otherwise your enrollment may be delayed and your benefits may be reduced.)
Dr. Jane Doe, 1 Central Ave, Providence, RI 02903

Are you a current patient of the PCP listed above? ☑ Yes ☐ No — Provider ID: 0123456789

*Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Overview.html

Group APP (08/17)

EMPLOYER AUTHORIZED ENROLLMENT CONTACTS



Blue Cross Blue Shield of Rhode Island

Employer Authorized Enrollment Contacts

Please use this form to indicate individuals at your Company that will be authorized to contact BCBSRI regarding employee enrollment inquiries.

Primary Enrollment Contact	
Name:	Title:
Email Address:	Phone Number:
Please list the Group and Subgroups numbers for user to be granted access to:	
Enrollment Contact	
Name:	Title:
Email Address:	Phone Number:
Please list the Group and Subgroups numbers for user to be granted access to:	
Enrollment Contact	
Name:	Title:
Email Address:	Phone Number:
Please list the Group and Subgroups numbers for user to be granted access to:	
Enrollment Contact	
Name:	Title:
Email Address:	Phone Number:
Please list the Group and Subgroups numbers for user to be granted access to:	
Enrollment Contact	
Name:	Title:
Email Address:	Phone Number:
Please list the Group and Subgroups numbers for user to be granted access to:	

Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

Please Note: If enrollment is submitted via BCBSRI's online Electronic Enrollment tool, CSV file, or electronic enrollment file, then a Group Activity Report (GAR) and Member Application are not required.

Specific questions regarding our enrollment policies should be directed to Membership Services at (401) 459-2341.

Please make sure:

√ The application is legible.

√ All the appropriate spaces are filled in.

√ The application is physically signed by the employee.

Return completed GAR and Large Group Member Application(s) (if applicable) to:

BCBSRI Membership Department
500 Exchange Street
Providence, RI 02903-2699

Email: bcbsri-enrollmentintake@bcbsri.org
Fax: 401-459-2385

Employer Authorized Enrollment Contacts

To ensure confidentiality for your employees, your company must identify the individuals authorized to contact Membership Services. These individuals will be authorized to speak to our membership representatives regarding enrollment inquiries by phone or email. Please submit to your account manager the **Employer Authorized Enrollment Contacts Form** to complete this process.

General Group Enrollment Guidelines for Large Group Business (51 or more eligible employees)

These general guidelines outline the enrollment policies of BCBSRI for its large group employers. This information may be revised from time to time to comply with changes in laws, regulations, or BCBSRI policies.

Enrollment Additions, Changes, and Terminations

ADDITIONS

Newly hired employees may be added on the first day of the month following the date of hire or on the first day of the month following completion of a probationary period. Your group's probationary period for new hires can be changed upon renewal via written request or off-cycle once per year within a 12-month period with approval. The employee must apply for coverage within 60 days of the date of hire or within 60 days after the end of the probationary period. The application is submitted to Membership Services for approval and processing.

Changes and Special Enrollment Period

SPECIAL ENROLLMENT PERIOD

Reason for Enrollment	Who can be Enrolled	Requirements	Enrollment Period	Effective Date
Marriage	Employee, spouse, or dependent	• Employee is a participant or is eligible to participate, but not enrolled, and has met required waiting periods • A person becomes a dependent of the employee due to marriage (includes new spouse and children)	Within 60 days of the date dependent coverage is made available or the date of the marriage, whichever is later	First of month following date of marriage
Birth, Adoption, Placement for Adoption	Employee, spouse, or dependent	• Employee is a participant or is eligible to participate, but not enrolled, and has met required waiting periods • A child is born to, adopted by, or placed for adoption with the employee	Within 60 days of the date dependent coverage is made available or the date of the birth, adoption, or placement for adoption, whichever is later	The date of the birth, adoption, or placement for adoption
Loss of Coverage other than COBRA	Employee, spouse, or dependent	• Coverage was declined (for employee, spouse, or dependents) when offered because other health insurance coverage was available at the time • Eligibility for coverage is terminated (due to legal separation, divorce, death, termination of employment, or reduction in hours of employment) or employer contributions for coverage are terminated	Within 60 days of termination of eligibility or employer contributions, as applicable	Not later than the first day of the calendar month after the timely completed request is received
Loss of COBRA	Employee, spouse, or dependent	• Coverage was declined (for employee, spouse, or dependents) when offered because COBRA coverage was available at the time • COBRA is exhausted	Within 60 days of exhaustion of COBRA	Not later than the first day of the calendar month after the timely completed request is received

** A change in employee's benefit plan is only allowed on the group's renewal date, unless there is a qualifying event for a special enrollment right.*

You may also add employees that did not apply for coverage when first eligible, or you may change an employee's coverage from an individual to a family plan during the following enrollment periods:

- During your group's annual open enrollment period, to be effective on your group's renewal date.
- Through a special enrollment period, after the employee experiences one of the qualifying events described in the above chart.

Terminations

1. Employee coverage terminations become effective on the last day of the month following termination of employment or other termination event.
2. Termination of dependent coverage is allowed at any time and will be effective on the last day of the month following the dependent termination event.

3. If your group has a written leave policy which allows a person to remain in your employment while he or she is on sick leave or on leave of absence, the employee may continue coverage for up to six months. Additional documentation may be required if your leave policy exceeds six months, but in no case may the leave policy exceed one year. If your group does not have a written leave policy, the employee's health coverage must terminate after 13 weeks.
4. We may terminate enrollment immediately in the event of intentional misrepresentation of a material fact or fraud, or as otherwise stated in your group's Benefit Document.

Retroactive Additions, Changes, and Terminations

Retroactive additions and enrollment changes are allowed only if the request is due to an administrative oversight, and cannot go back more than 60 days. Please see Retroactive Enrollment Exception Process (below) regarding retroactive exceptions outside of the standard 60-day guidelines for self-funded groups. Retroactive changes cannot be made on the basis of health status.

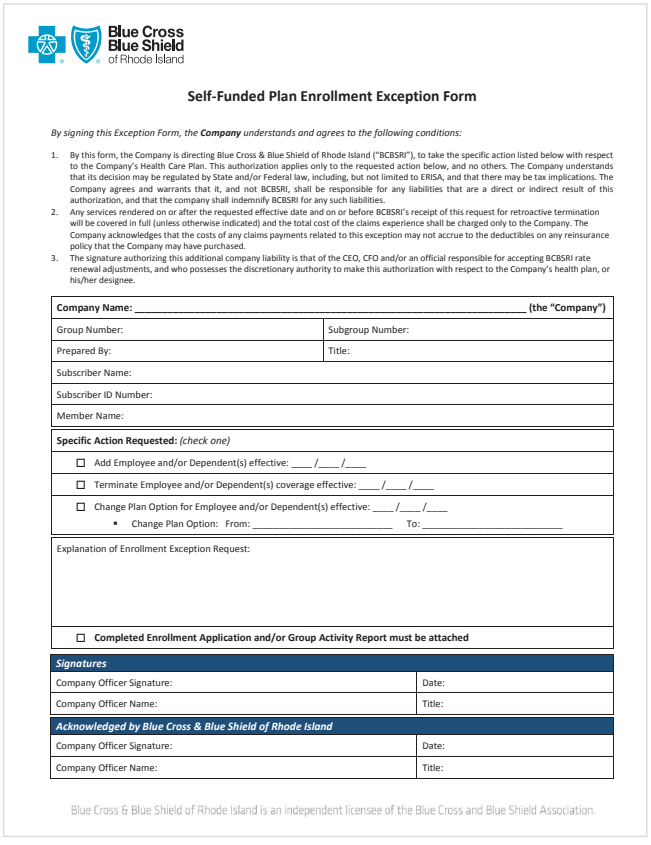
Retroactive Enrollment Exception Process

As a self-funded client, you have the ability to request retroactive enrollment changes outside of our standard 60-day guidelines, via submission of an **Enrollment Exception Form**. The form is available on the BCBSRI Employer Portal at Forms > Large Employers > Self-Funded Employers > Retroactive Enrollment Exception Form. When necessary, this form must be completed and emailed to your account manager (AM) along with a Group Activity Report (GAR). A sample GAR is located on page 14. The GAR can be downloaded from the BCBSRI Employer Portal at Forms > Large Employers > Group Activity Report (GAR). It will be provided to our Membership area for processing. Please note No. 3 on the form requires the signature of a CEO, CFO, and/or official responsible for accepting BCBSRI rate renewal adjustments, who possesses the discretionary authority to make the authorization with respect to your company's health plan, or his/her designee. These individuals may also provide written or emailed notification to their AM designating another employee as the person authorized to sign the enrollment exception forms.

Retroactive terminations/deletions/changes cannot go back further than one year from the date of the request or the date you became self-funded, whichever came first.

NOTE: For retroactive terminations, the client will be credited the administrative fee, but will not be reimbursed for any claims that may have been paid.

ENROLLMENT EXCEPTION FORM



Blue Cross Blue Shield of Rhode Island

Self-Funded Plan Enrollment Exception Form

*By signing this Exception Form, the **Company** understands and agrees to the following conditions:*

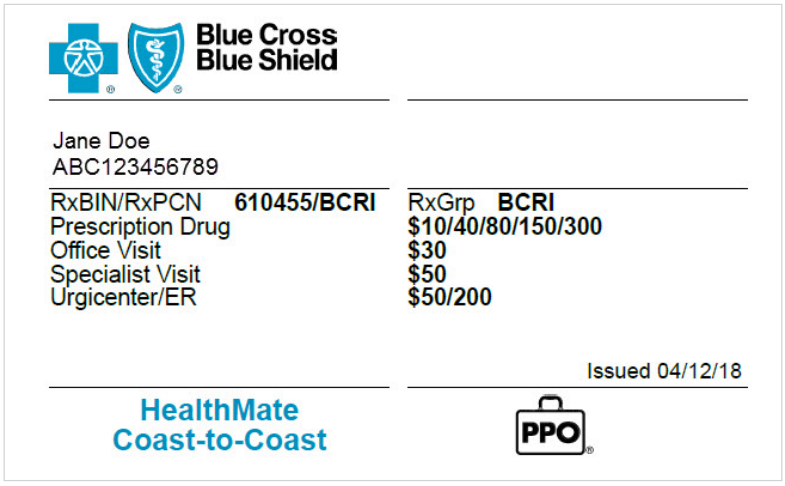
1. By this form, the Company is directing Blue Cross & Blue Shield of Rhode Island ("BCBSRI"), to take the specific action listed below with respect to the Company's Health Care Plan. This authorization applies only to the requested action below, and no others. The Company understands that its decision may be regulated by State and/or Federal law, including, but not limited to ERISA, and that there may be tax implications. The Company agrees and warrants that it, and not BCBSRI, shall be responsible for any liabilities that are a direct or indirect result of this authorization, and that the company shall indemnify BCBSRI for any such liabilities.
2. Any services rendered on or after the requested effective date and on or before BCBSRI's receipt of this request for retroactive termination will be covered in full (unless otherwise indicated) and the total cost of the claims experience shall be charged only to the Company. The Company acknowledges that the costs of any claims payments related to this exception may not accrue to the deductibles on any reinsurance policy that the Company may have purchased.
3. The signature authorizing this additional company liability is that of the CEO, CFO and/or an official responsible for accepting BCBSRI rate renewal adjustments, and who possesses the discretionary authority to make this authorization with respect to the Company's health plan, or his/her designee.

Company Name: _____ **(the "Company")**	
Group Number:	Subgroup Number:
Prepared By:	Title:
Subscriber Name:	
Subscriber ID Number:	
Member Name:	
Specific Action Requested: *(check one)*	
☐ Add Employee and/or Dependent(s) effective: ____ /____ /____	
☐ Terminate Employee and/or Dependent(s) coverage effective: ____ /____ /____	
☐ Change Plan Option for Employee and/or Dependent(s) effective: ____ /____ /____ ▪ Change Plan Option: From: _____ To: _____	
Explanation of Enrollment Exception Request:	
☐ **Completed Enrollment Application and/or Group Activity Report must be attached**	
Signatures	
Company Officer Signature:	Date:
Company Officer Name:	Title:
Acknowledged by Blue Cross & Blue Shield of Rhode Island	
Company Officer Signature:	Date:
Company Officer Name:	Title:

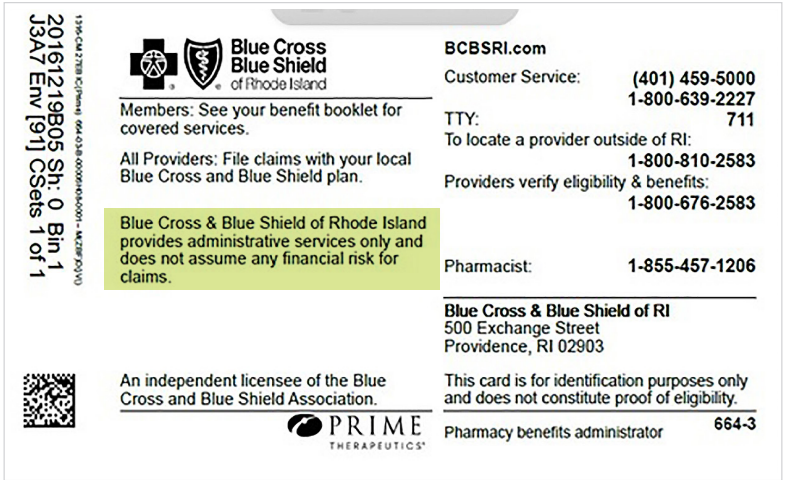
Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

ID Cards

BCBSRI provides ID cards to all members. The language on the back of the card is unique to self-funded arrangements. For clients converting from a fully insured arrangement to a self-funded arrangement, all members should expect to receive new ID cards. An example of the language related to BCBSRI providing administrative services only is highlighted on the back of the card shown below. As part of our ASC/self-insured process, samples of the card will be shared with you prior to mailing it to members. ID cards are typically mailed 10 days prior to your effective date.



FRONT



BACK

Financial Settlements

There are various financial settlements that may occur as part of your negotiated contract with BCBSRI. The standard delivery of settlements—including performance guarantees, in-network medical, pharmacy discount guarantees, and annual Hospital Settlement—can vary by type and contract. Please refer to your Administrative Services Only contract for full details.

Value-based Programs and Fees

Self-funded clients that have employees attributed to Blue Cross Blue Shield (BCBS) value-based care programs will be responsible for the cost of their employees' portion of the provider incentives (including care coordination fees) related to these programs. Value-based programs are designed to reduce unnecessary care and claims costs, while improving the overall quality of care.

Attribution is the methodology used to determine who a member utilizes as their primary care provider and is typically based on the member's claims history. Provider incentives are calculated upon a provider's ability to meet certain quality and cost metrics for their attributed members.

When applicable, per attributed member per month (PMPM) payments will be included as part of your weekly claims charges and illustrated on the Detailed Claims Listing report. Payments are only made to participating providers that have treated your attributed employees and dependents.

There are no administrative fees associated with these payment programs.

State Taxes/Fee Assessments Summary

Many states impose taxes and/or assessments on premiums, claims, and/or the number of covered residents in the state. The taxes and assessments are established by state law for purposes of funding specific programs or raising general revenue. The following is a summary of the current assessments as of January 1, 2018.

BCBSRI invoices the amounts paid on behalf of each self-funded group health plan to the appropriate client as part of their Weekly Claims invoice.

While most states allow BCBSRI to remit in this fashion without formally designating BCBSRI as the payer, the State of New York assessments are handled differently. For the New York Public Health Law for Graduate Medical Education (GME), New York requires clients to officially designate BCBSRI as the payer via the submission of certain DOH forms. First-time filers need to complete and submit required forms (DOH 4399 and DOH 4264) and clients changing their healthcare administrator need to submit form (DOH 4403). Your client implementation manager (CIM) will provide you with these forms.

The Indigent Care Surcharge (NYHCRA) is collected via a percentage tax on particular claims. The New York Blue's plans collect the payment as part of the claim and in turn remit it to the State of New York.

BCBSRI is happy to assist clients with the completion and submission of these forms. The completed forms can be submitted to your CIM.

State	Program Name	Citation	Amount (most recent level for those that vary)
Alaska	Vaccination Assessment Program	Alaska Statute 18 09 200	The current assessment rate for covered children <19 years is $8.61 per child. The assessment rate for covered adults 19 years and older is $0.88 per adult.
Idaho	Immunization	Idaho Code, Chapter 60, Title 41	Varies, $52/per child under 19 residing in Idaho (effective until July 1, 2019)
Massachusetts	Vaccine Assessment	Chapter 111 § 24I	Varies, 3.44% of claims, from hospital and ambulatory surgery centers
	Child Psychiatry Access Program (MCPAP) Assessment	Part I, Title II Chapter 19 Section 16A	Varies, .11% of claims, from hospital and ambulatory surgery centers
	Health Care Safety Net Fund	Chapter 118e, § 66-68	Varies, 1.56% of claims from hospital and ambulatory surgery centers
	Surcharge payer Assessment	Chapter 12C § 7, Regulation 957 CMR 3.00	Annual surcharge assessment on all Qualifying Surcharge Payers: 9.5%
Michigan	Health Insurance Claims Assessment (supports Medicaid)	Act 142 of 2011 §550.1731	Statutorily set at 1% of claims on a broad array of medical services and drugs
New Hampshire	Vaccine assessment	Chapter 260, Section 126-Q	Varies, the monthly assessment rate through February 2019 is $6.70 (6.70 x 4 x the sum of the number of assessable lives in each month)
New York	Graduate Medical Education	New York Public Health Law, § 2807-t	Varies, annualized rate based on covered lives and region (from $8.32 to $555.48)
	Indigent Care	New York State Health Care Reform Act	Varies, 9.63% of hospital and diagnostic and treatment center claims
Rhode Island	Rhode Island Vaccine Assessment Program	Rhode Island General law § 23-1-46 and § 42-7.4-3	Paid quarterly. July 1, 2018 through June 30, 2019 rates are $16.35 for under age 19 and $3.03 for 19 and over
	Children's Health Account – Rhode Island	Rhode Island General Laws § 42-12-29	Paid quarterly. July 1, 2018 through June 30, 2019 rate is $8.23 for under age 19

Stop Loss

A self-funded client may elect to purchase stop loss from BCBSRI or from a third-party carrier (non-preferred carrier). There will be an administrative charge assessed if you utilize a non-preferred stop loss carrier. When a self-funded client purchases BCBSRI stop loss insurance there are significant advantages:

- Immediate credit of member claims that exceed the stop loss deductible level (via the weekly claims invoicing process)
- No waiting for reimbursement from non-preferred stop loss carriers
- No paperwork for you to complete

Should a self-funded client prefer an external stop-loss carrier over our integrated solution, you must provide BCBSRI with the following information during the implementation process:

- Stop loss carrier contact information
- Stop loss contract with other carrier

This information can be provided to BCBSRI by completing the Finance Intake Form available on the BCBSRI Employer Portal at Forms > Large Employers > Self-Funded Employers > Finance Intake Form

If you are transitioning from another stop loss carrier to BCBSRI, we may require claims reporting (run in/run out) from the previous carrier. This will be dependent upon the type of coverage purchased through BCBSRI.

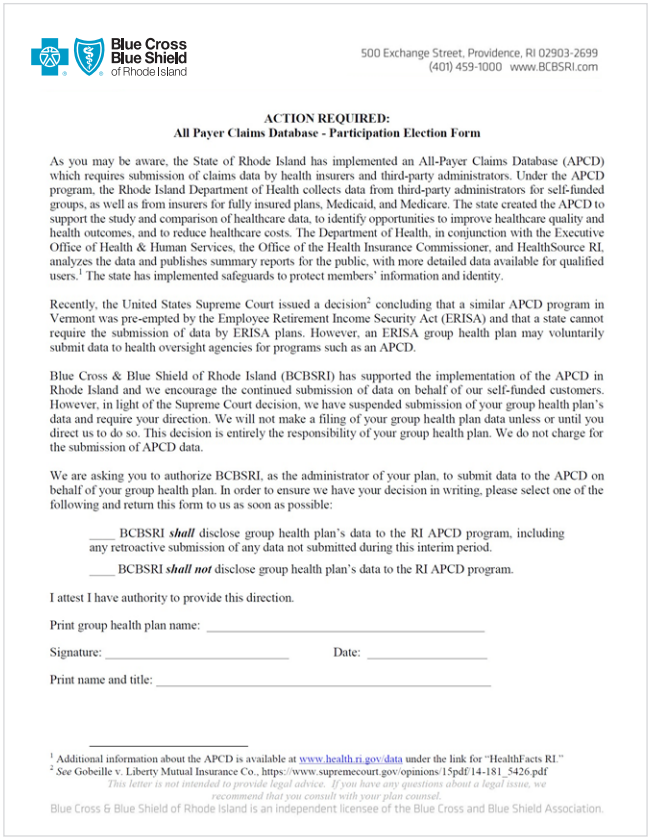
Stop Loss Reporting will be provided for any integrated stop loss written by BCBSRI via email to the authorized individuals.

All-Payer Claims Database

The State of Rhode Island has implemented an All-Payer Claims Database (APCD), which requires health insurers and third-party administrators to submit claims information for the purposes of studying and comparing healthcare data, identifying opportunities to improve healthcare quality and health outcomes, and reduce healthcare costs.

As a self-funded client, your claims data will not be automatically submitted to the State of Rhode Island's APCD. BCBSRI encourages self-funded clients to allow their data to be submitted. The **Participation Election Form** must be signed and submitted to your client implementation manager for authorization.

PARTICIPATION ELECTION FORM



Blue Cross Blue Shield of Rhode Island

500 Exchange Street, Providence, RI 02903-2699
(401) 459-1000 www.BCBSRI.com

ACTION REQUIRED:
All Payer Claims Database - Participation Election Form

As you may be aware, the State of Rhode Island has implemented an All-Payer Claims Database (APCD) which requires submission of claims data by health insurers and third-party administrators. Under the APCD program, the Rhode Island Department of Health collects data from third-party administrators for self-funded groups, as well as from insurers for fully insured plans, Medicaid, and Medicare. The state created the APCD to support the study and comparison of healthcare data, to identify opportunities to improve healthcare quality and health outcomes, and to reduce healthcare costs. The Department of Health, in conjunction with the Executive Office of Health & Human Services, the Office of the Health Insurance Commissioner, and HealthSource RI, analyzes the data and publishes summary reports for the public, with more detailed data available for qualified users.[1] The state has implemented safeguards to protect members' information and identity.

Recently, the United States Supreme Court issued a decision[2] concluding that a similar APCD program in Vermont was pre-empted by the Employee Retirement Income Security Act (ERISA) and that a state cannot require the submission of data by ERISA plans. However, an ERISA group health plan may voluntarily submit data to health oversight agencies for programs such as an APCD.

Blue Cross & Blue Shield of Rhode Island (BCBSRI) has supported the implementation of the APCD in Rhode Island and we encourage the continued submission of data on behalf of our self-funded customers. However, in light of the Supreme Court decision, we have suspended submission of your group health plan's data and require your direction. We will not make a filing of your group health plan data unless or until you direct us to do so. This decision is entirely the responsibility of your group health plan. We do not charge for the submission of APCD data.

We are asking you to authorize BCBSRI, as the administrator of your plan, to submit data to the APCD on behalf of your group health plan. In order to ensure we have your decision in writing, please select one of the following and return this form to us as soon as possible:

____ BCBSRI ***shall*** disclose group health plan's data to the RI APCD program, including any retroactive submission of any data not submitted during this interim period.

____ BCBSRI ***shall not*** disclose group health plan's data to the RI APCD program.

I attest I have authority to provide this direction.

Print group health plan name: _____

Signature: _____ Date: _____

Print name and title: _____

[1] Additional information about the APCD is available at www.health.ri.gov/data under the link for "HealthFacts RI."
[2] *See* Gobeille v. Liberty Mutual Insurance Co., https://www.supremecourt.gov/opinions/15pdf/14-181_5426.pdf

This letter is not intended to provide legal advice. If you have any questions about a legal issue, we recommend that you consult with your plan counsel.

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Healthcare Reform Requirements

As a self-funded client, your organization is subject to the following taxes and requirements under the Affordable Care Act (ACA):

Tax/Fee/Requirement	Effective Date	Responsibility	Due Date
High Cost Insurance	Tax years beginning January 1, 2022 and future years	The employer is responsible for submitting the fee, which is a tax of 40% on health plan costs that exceed "Cadillac" plan thresholds of $10,200 for single coverage or $27,500 for family coverage. These thresholds are subject to adjustments. We will provide additional information after final regulations are issued.	The IRS has yet to issue guidance on this requirement, and it is not clear to date whether this tax will be implemented or eliminated. If/when regulations are issued, BCBSRI will provide additional information.
Summary of Benefits and Coverage (SBC)	Starting with plans beginning on or after September 23, 2012, and future years	BCBSRI will provide to the employer in an electronic format.	Prior to group's effective date.
Reporting Employer Provided Health Coverage in Form W-2	Starting with tax year 2012, and future years	Employers are required to report the cost of health coverage on an employee's Form W-2, Wage and Tax Statement, in Box 12, using Code DD.	January 31 of the year immediately following the calendar year to which the information relates.
Health Insurance Coverage Reporting (Form 1094-C and 1095-C)	Starting with tax year 2015, and future years	Employers are required to provide information reporting to the IRS and employees regarding health coverage offered during the tax year.	Form 1095-C must be provided to each full-time employee on or before January 31 of the year immediately following the calendar year to which the information relates. Form 1094-C must be filed with the IRS by February 28, if filing on paper, or March 31, if filing electronically, of the year immediately following the calendar year to which the information relates.

Disclosure of Protected Health Information

As part of its contractual arrangement with self-funded employers, BCBSRI requires an agreement that addresses Health Insurance Portability and Accountability Act (HIPAA) obligations and includes certain employer certifications. If you choose to have a third party manage some task(s) which will require sharing member protected health information (PHI), then the following agreements may be necessary:

- Broker: Broker Confidentiality Agreement and Broker of Record Letter
- Consultant/Carrier/Re-insurer/other third party: Consultant Confidentiality Agreement and a written authorization of release from the Client

Right to Audit

BCBSRI must be provided with at least sixty (60) days notice, in writing, of a client's intent to conduct an audit. The request should be made to the client implementation manager. Audits are limited to the most recently completed Rating Period, and must be completed no later than eleven (11) months after the end of that Rating Period. Clients may not request or conduct more than one (1) audit, claims or financial, per Rating Period. Clients may not conduct more than one (1) on-site audit during any 12-month period.

Clients may not conduct any audit for the same scope, timeframe, or portion of a timeframe previously audited unless one or more of the following conditions exists:

- Client is required to audit such time period by a governmental agency
- Reasonable evidence exists of fraud
- A prior audit identified a systemic discrepancy that is acknowledged by BCBSRI and strongly suspected to have existed prior to the audit period; provided, however, that even in this event the audit is limited to the three most recently completed Rating Periods, including the current audit period, and may be conducted solely for the purpose of examining such suspected systemic discrepancy.

Audits shall be conducted during normal working business hours at the offices of BCBSRI by an auditor mutually acceptable to the Parties.

Unless otherwise agreed upon, all expenses incurred by BCBSRI and Client relating to an audit shall be borne by Client. BCBSRI may charge the Client an additional fee for any on-site audit.

Once a request for an audit is received, BCBSRI will refer to its External Audit Policy to ensure a consistent process is used for responding to the request for external audits by the Client and/or their consultants.

Appendices

Blue Cross Blue Shield of Rhode Island

Invoices

ABC Company
123 Main Street
Suite 123
Providence, RI 02903

Paid Claims For the Week of _____

GROUP	HOSPITAL*	SURGICAL MEDICAL*,**	DRUGS	Total
00000000-0001	0.00	0.00	0.00	0.00
00000000-0002	0.00	0.00	0.00	0.00
00000000-0003	0.00	0.00	0.00	0.00
Total Due	$0.00	$0.00	$0.00	0.00

* Hospital and Surgical Medical Claims include BlueCard Access fees, Administrative Expense Allowance (AEA) Fees, Non-Standard AEA Fees, and fees associated with Negotiated National Arrangements as described in your Administrative Service Contract.

**Includes payments made pursuant to any arrangements with service or healthcare providers, including payments for Value Based Programs, as described in your Administrative Service Contract.

If you have any questions, please contact corp.accounting@bcbsri.org

Corporate Accounting Dept. A/R/S
500 Exchange Street
Providence, RI 02903-2699

Blue Cross Blue Shield of Rhode Island

CONFIDENTIAL

Finance Intake Form

For Self-funded Clients

Parent Group Name: _____ **Parent Group Number:** _____

Remittance Methods

Weekly Paid Claim Invoices *ACH Debit is initiated 24 hours subsequent to claim invoice notification and funds deposited to BCBSRI bank 24 hours thereafter.	✓ Please check one: ☐ **ACH Debit*** ☐ **Wire****
Monthly Administrative Fee Invoices *ACH Debit is initiated for Administrative Fees by the first business day of each month	✓ Please check one: ☐ **ACH Debit*** ☐ **Wire****
Required Deposit	✓ Please check one: ☐ **ACH Debit** ☐ **Wire**** ☐ **Check**

**BCBSRI Chief Financial Officer or Vice President of Finance will present a signed letter to Client on BCBSRI letterhead as affirmation to deposit funds to the BCBSRI bank account.

Banking Information: ACH Debit

If electing to utilize the ACH Debit method of payment, please complete all fields to ensure proper banking set-up.	
Bank Name:	Bank Account Name:
ABA/Routing Number:	Bank Account Number:

Employer Authorized Billing Contacts

Monthly administrative invoices are provided to the individual by mail. The weekly claims invoices are provided by email.

Primary Billing Contact

Name:	Title:
Email Address:	Phone Number:
Please list the Group and Subgroups numbers for user to be granted access to:	

✓ **Please check applicable invoices to be received :**	☐ Weekly Claims Invoice	☐ Monthly Administrative Invoice

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Billing Contact		
Name:	Title:	
Email Address:	Phone Number:	
Please list the Group and Subgroups numbers for user to be granted access to:		
✓ **Please check applicable invoices to be received :**	☐ Weekly Claims Invoice	☐ Monthly Administrative Invoice

Billing Contact		
Name:	Title:	
Email Address:	Phone Number:	
Please list the Group and Subgroups numbers for user to be granted access to:		
✓ **Please check applicable invoices to be received :**	☐ Weekly Claims Invoice	☐ Monthly Administrative Invoice

Billing Contact		
Name:	Title:	
Email Address:	Phone Number:	
Please list the Group and Subgroups numbers for user to be granted access to:		
✓ **Please check applicable invoices to be received :**	☐ Weekly Claims Invoice	☐ Monthly Administrative Invoice

Billing Contact		
Name:	Title:	
Email Address:	Phone Number:	
Please list the Group and Subgroups numbers for user to be granted access to:		
✓ **Please check applicable invoices to be received :**	☐ Weekly Claims Invoice	☐ Monthly Administrative Invoice

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Stop Loss Information
Please provide the contact information for Monthly Stop Loss 50% Reporting:
Contact Name:
Contact Phone Number:
Contact Email:

If utilizing a third party Stop Loss Carrier, please provide the following information:
Company Name:
Contact Name:
Contact Phone Number:
Contact Email:
☐ Please also include copies of client's contract with the third party Carrier and the Carrier's forms. Forms must be completed by BCBSRI for initial and supplemental filings.

Employer Portal: Staff User Access to Claims Detail Report		
✓ **Please select if Employer would like access to all data elements or suppression of data elements in Claims Detail Report:** *Important: Selection will apply to all users granted access to Employer Reports on the BCBSRI Employer Portal.*	☐ Include all data elements in Claims Detail (PHI) Report	☐ Suppress **all** data elements below in Claims Detail (PHI) Report*

***Claims Detail Elements to be Suppressed:**

#	Data Element Name	Data Type	Field Length	Description of Data element
14	LID-Number	Character(45)	45	An ID from the source system that represents a member with Blue Cross & Blue Shield of Rhode Island coverage. This field is used to develop the Surrogate ID for member, MEMBER_ID. There is a one to one mapping of the Legacy Member ID to the Member ID.
15	First-Name	Character(30)	30	This is the first name of the member.
16	Last-Name	Character(30)	30	This is the last name of the individual.
17	Dependent No	Character(3)	3	This is the number of dependents of the primary policyholder.
18	Relationship	Character(3)	3	Relationship between member and subscriber.
19	CLAIM- NUMBER	Character(93)	23	This is the plan specific identifier for a claim. Within the plan, this identifier may vary by source.

To see a complete list of data elements included in the Detailed Claims Listing, please refer to the Self-Funded Administrative Manual.

Signature	
Company Officer Signature:	
Company Officer Name:	Date:
Title:	Email Address:

Please return completed form to Corporate.Accounting@bcbsri.org

Group Activity Report (GAR)

for Additions, Cancellations & Changes

Blue Cross Blue Shield of Rhode Island

The Group Activity Report (GAR) form is used to enroll new subscribers, cancel coverage for subscribers, process changes in family status, (such as the birth of a child or marriage), or to change plan coverage. This form should also be used to transfer subscribers from one group within an account to another group within the same account. Upon completion of the form, please make and retain a copy for your records.

See the back page for instructions on completing this Group Activity Report Form. If you have questions, please contact your broker or BCBSRI account representative.

1

Group Name: ABC Company

Group Number: 12345678 Subgroup Number: 0001

Date: 12 / 15 / 18

Prepared By: Thomas Jones Title: Benefits Admin

Phone Number: 401-123-4567

Email Address: thomas.jones@abccompany.com

2

BCBSRI Membership Number	Name of Employee (First Name, Last Name, Middle Initial)	Effective/ Termination Date	Process Code*	Explanation of Request**	Application Attached (check)	PCP Selection Form Attached (check)
	Samuel Sample, Q.	01/01/19	1	Add Medical and Dental	✓	
ABC123454321	Frank Fake, L.	12/31/18	2	Left employment		
ABC987654321	Elizabeth Example, T.	01/01/19	3	Change to Enrollee and spouse	✓	

Instructions

1. Complete all entries on this form
2. Include the corresponding application(s) and PCP Selection form(s) (if applicable)
3. Return completed form, application(s), and PCP Selection form(s) (if applicable) or mail to:

   BCBSRI Membership Department
   500 Exchange Street
   Providence, RI 02903-2699

email: bcbsri-enrollmentintake@bcbsri.org or fax 401-459-2385

For Member Services Use Only
Date Received: 12 / 15 / 18

*Please use these process codes:
1-Benefit change 2-Termination 3-New addition 4-COBRA addition

**Please use these explanations:

1-Benefit Change	2-Termination	3-New Addition**
- Add: • Medical • Dental • Vision - Drop: • Medical • Dental • Vision - Change plan option (explain above) - Other (explain above)	- Deceased - Laid off - Left employment - Declined coverage - Other insurance - Transferred to: • Spouse's plan • Plan 65 • BlueCHiP for Medicare	- Change to: • Enrollee (subscriber only) • Enrollee and spouse • Enrollee and child(ren) • Enrollee medical/family dental • Family • Family medical/enrollee dental **Application Required

Completing a Group Activity Report (GAR) Form

1 Employer Group Information:

Group Name: The legal name of the Employer Group.

Group Number: BCBSRI stores employer group information by Group Number. There may be multiple affiliate groups under one Parent Group Number. Please enter the Parent Group Number to which this request applies. This number can be found on the premium bill. Group IDs are 8 alpha-numeric characters.

Subgroup Number: Enter the subgroup number for the Group to which the request applies. This number may be found on the premium bill. Subgroup IDs are 4 alpha-numeric characters. If this information is unavailable, you may leave this section blank.

Date: Enter the date the form is being submitted.

Prepared By: Enter the name of the person who is completing the form. Forms should be completed by an authorized HR Administrator or Designee.

Title: Enter the title of the person preparing the form.
(e.g. HR Admin, Broker, etc.)

Phone Number: Enter the phone number of the person who can be contacted in the event there are questions on processing the request.

Email Address: Enter the email address of the person preparing the form who can be contacted in the event there are questions on processing the request.

2 Subscriber/Member Information Section:

BCBSRI Membership Number: Enter the identification number of the person for whom the change is being performed. This can be found on the premium bill or on the member ID card. If adding a new member to a group, please be sure to attach an application and all required supporting documentation (i.e., divorce decree, birth certificate, etc.).

Name of Employee (first name, last name, middle initial): Enter the legal name of the employee for whom the change is being requested. The name can be found on the premium bill or on the member ID card. If adding a new member to a group, please be sure to attach an application and all required supporting documentation (i.e., divorce decree, birth certificate, etc.).

Effective Date: Enter the date coverage becomes effective. For example, if an employee starts work on January 1, but has a one month probationary period, the effective date would be February 1.

Termination Date: Enter the last day of the month in which termination occurs. For example, if employee terminates employment on January 1, the effective termination of coverage is January 31.

Process Code: Enter 1 for benefit changes; 2 for termination of coverage; 3 for new addition; and 4 for COBRA addition.

Package/Class/Plan: Enter the classification of benefits a subscriber is being enrolled in. Plan is the specific name of the benefits product (e.g. HMC2C 500). Package/Class/Plan names can be found on the employer group bill. If this information is unavailable, you may leave this section blank.

Explanation of Request: Use the legend on the form, and enter a written explanation of the change request that is being submitted.

Primary Care Provider (PCP) Selection Form Attached:
Check this box if a PCP Selection Form is being included. Additional copies of the form are available online:

Large group employers (50 employees or more) go to: https://www.bcbsri.com/understand-my-plan/forms/large-employers

Small group employers (less than 50 employees) go to: https://www.bcbsri.com/understand-my-plan/forms/small-employers

Notes:

Group-to-Group Transfers: For Group-to-Group Transfer requests, be sure to enter the group number that the member is moving from and the group number that the member is moving to in the Explanation of Request field. Also note that two GARs need to be completed for Group-to-Group Transfers: one for ending member coverage in the current group, and another for adding coverage to a new group.

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10/18 PER-278516•8490

Large Group Member Application for Health, Dental, and Vision Insurance

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Please be sure ALL information below is complete to avoid delays in processing.
Please **print clearly** using blue or black ink, or type information.

Section 1 Employer Information (To be completed by plan administrator.)

Group name		Effective date (mm/dd/yyyy)	Date of hire (mm/dd/yyyy)
ABC Company		01/01/19	12/15/18
Group number: 123456789	Dept. number: 01		

Choose one:
- ☐ Open enrollment
- ☑ New hire
- ☐ COBRA
- ☐ Loss of coverage (Certificate of Creditable Coverage required)
- ☐ Other _____

or

Add dependent(s)
- ☑ Spouse
- ☑ Dependent

Date of event (mm/dd/yyyy) _____
(Must add within 30 days of marriage, birth, or adoption of dependent.)

Section 2 Employee Information

Last name	Suffix	First name	M.I.
Smith		John	M

Home address (street/apartment number)	City/town	State	ZIP code
123 Main Street	Providence	RI	02903

Mailing address (street/apartment number, city/town, state, ZIP code—if different from above)

Date of birth (mm/dd/yyyy)	Gender	Social Security number (xxx-xx-xxxx)*	What is your primary spoken language?
06/01/1970	☑ M ☐ F	000-00-0000	English

Home phone number	Cell phone number
000-000-0000	000-00-0000

Email address: john.smith@abccompany.com

Marital status (please check one)
☐ Single ☑ Married ☐ Divorced ☐ Civil union ☐ Common law ☐ Domestic partner

Race (please check one)
☐ Prefer not to answer ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Hispanic or Latino ☑ Native Hawaiian or other Pacific Islander ☐ White ☐ Multiracial

Primary care provider (PCP) name, street, city/town, state, and ZIP code (**Required**: You must select a PCP for yourself and anyone on your plan, otherwise your enrollment may be delayed and your benefits may be reduced.)

Dr. Jane Doe, 1 Central Ave, Providence, RI 02903

Are you a current patient of the PCP listed above?	Provider ID
☑ Yes ☐ No	0123456789

*Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Overview.html

Section 3 Health Plan Options

Plan type

- ☑ Medical: ☐ Enrollee only ☐ Enrollee and spouse ☐ Enrollee and child(ren) ☑ Enrollee, spouse, and child(ren)
- ☑ Dental: ☐ Enrollee only ☐ Enrollee and spouse ☐ Enrollee and child(ren) ☑ Enrollee, spouse, and child(ren)
- ☑ Vision: ☐ Enrollee only ☐ Enrollee and spouse ☐ Enrollee and child(ren) ☑ Enrollee, spouse, and child(ren)

What product(s) are you selecting?

- ☐ BasicBlue
- ☐ BlueCHiP
- ☐ BlueSolutions
- ☐ Blue Choice New England
- ☐ Classic (if available)
- ☑ HealthMate Coast-to-Coast
- ☐ HealthMate Coast-to-Coast Deductible
- ☐ HealthMate Coast-to-Coast Coinsurance
- ☐ Network Blue New England
- ☐ VantageBlue
- ☑ Blue Cross Dental
- ☑ Blue Cross Vision
- ☑ Pharmacy 4-Tier
- ☐ Pharmacy 5-Tier
- ☐ Other _____

Section 4 Spouse or Domestic Partner Information

Last name	Suffix	First name	M.I.
Smith		Mary	J

Home address (street/apartment number, city/town, state, ZIP code—if different from employee)
n/a

Date of birth (mm/dd/yyyy)	Gender	Social Security number (xxx-xx-xxxx)*	What is your primary language spoken?
07/01/1970	☐ M ☑ F	000-00-0001	English

Home phone number	Cell phone number
000-000-0000	000-000-0000

Email address
mary.smith@zmail.com

Race (please check one)

☐ Prefer not to answer ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander ☑ White

Primary care provider (PCP) name, street, city/town, state, and ZIP code (**required**)
Dr. Jane Doe, 1 Central Ave, Providence, RI 02903

Is this dependent a current patient of the PCP listed above?	Provider ID
☑ Yes ☐ No	0123456789

*Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Overview.html

Section 5 Dependent Information (If necessary, please attach dependent addendum.)			
Dependent #1 First name Smith	Last name Susan	M.I. I	Relationship ☐ Son ☑ Daughter
Date of birth (mm/dd/yyyy) 08/01/2000	Social Security number (xxx-xx-xxxx)* 000-00-0002	Email address susan.smith@zmail.com	
Primary care provider (PCP) name, street, city/town, state, and ZIP code (**required**) Dr. Judy Doe,			
Is this dependent a current patient of the PCP listed above? ☑ Yes ☐ No	Provider ID 0123456788		
Dependent #2 First name	Last name	M.I.	Relationship ☐ Son ☐ Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*	Email address	
Primary care provider (PCP) name, street, city/town, state, and ZIP code (**required**)			
Is this dependent a current patient of the PCP listed above? ☐ Yes ☐ No	Provider ID		
Dependent #3 First name	Last name	M.I.	Relationship ☐ Son ☐ Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*	Email address	
Primary care provider (PCP) name, street, city/town, state, and ZIP code (**required**)			
Is this dependent a current patient of the PCP listed above? ☐ Yes ☐ No	Provider ID		
Dependent #4 First name	Last name	M.I.	Relationship ☐ Son ☐ Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*	Email address	
Primary care provider (PCP) name, street, city/town, state, and ZIP code (**required**)			
Is this dependent a current patient of the PCP listed above? ☐ Yes ☐ No	Provider ID		
☐ **Check here if Group Dependent Addendum form will be attached.**			

*Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Overview.html

continued ➤

Section 6 Other Insurance

Are you or any of your dependents covered by other insurance?
☐ Yes ☑ No

Name of other insurance company and name(s) of covered person(s):

Covered person 1 _____
Insurance company _____
Member ID #1 _____

Covered person 2 _____
Insurance company _____
Member ID #2 _____

What is the name of your prior health insurance carrier?
BCBSMA
BCBSMA

What was the date of termination? (mm/dd/yyyy)
12/31/18

If loss of coverage, please attach a copy of the Certificate of Creditable Coverage.

Is anyone named in this application eligible for Medicare?
☐ Yes ☐ No

If yes, name of eligible person _____

Is the eligible person
☐ Over 65 ☐ Disabled

Retired date (if applicable) _____

Medicare number ☐☐ ☐☐ ☐☐☐☐ ☐☐☐☐

Effective dates: (mm/dd/yyyy)
Part A (hospital): _____ Part B (medical): _____

Section 7 Signature

By signing this form, I certify the information is true and complete to the best of my knowledge.

SIGN HERE

John Smith
Signature of applicant

12/18/18
Date

Application rec'd date_____ ID #_____

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NOTES

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