

# ADMINISTRATIVE KIT



A REFERENCE MANUAL OF PROCEDURES AND POLICIES

ADMINISTRATIVE KIT

# THIS KIT WILL ASSIST YOU IN ADMINISTERING AND UNDERSTANDING THE DETAILS OF YOUR GROUP HEALTH PROGRAM.

## WHEN NEW EMPLOYEES CAN ENROLL

New employees may enroll at the time they are hired or at the completion of any probationary period your company may have. Applications must be received by Medical Mutual™ no later than 31 days after the date the employee becomes eligible for coverage under the company's contract. All eligible employees must complete an Application and Policy Change Form and, for groups of 50 or less employees, a Medical History Questionnaire. The Medical History Questionnaire will not be used to reject any applicant. It is used to establish the proper rate tier. If employees and/or dependents do not want coverage, they must sign a waiver.

## LATE ENTRANTS

If employees or dependents do not enroll at the time they are initially eligible, they can enroll as late entrants (as defined in your group contract), but they must submit a Medical History Questionnaire with their applications. These individuals cannot be declined coverage for health reasons according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. Employees and dependents may also enroll during a special enrollment period as defined by HIPAA. Late entrants may apply for coverage during their employer's annual election period, which coincides with the employer's renewal. The late entrant will have the month prior to the effective date of the renewal, as well as the month in which the renewal is effective, to enroll. If the application is received outside of the two-month open-enrollment period, that application will be returned.

## COMPLETING THE APPLICATION

Each new applicant should complete an Application and Change Form as close to the effective date of coverage as possible. The employer group official should indicate the appropriate group number and coverage effective date on all applications. Incomplete or inaccurate applications may delay the enrollment process.

### Change In Group Information

The employer's group official should notify the Medical Mutual Membership department of group changes such as company name change, company address change, group official change, telephone number or fax number change.

## Eligibility

### Medicare Eligibility

The group official should notify the Medical Mutual Membership department if a certificate holder or spouse approaches age 65 or is eligible to receive Medicare benefits. Depending on the certificate holder's age, employment status and Medicare status, coverage may be continued. (see *COBRA section*)

### Student Certification

For groups with student riders, Medical Mutual will certify that dependents over the limiting age are students. When a dependent reaches his/her maximum age, student verification forms are sent to the dependent's home. Once the form has been certified and returned by an accredited school, Medical Mutual will change the dependent's classification to "student." After that, annual recertifications are also required by Medical Mutual.

### Disabled Dependent Children

The plan allows for continuation of coverage for dependent children beyond the dependent limiting age if the child is incapable of employment because of mental retardation or physical handicap that started before the limiting age was reached. Written verification of disability from a physician may be required. The employer group official must notify Medical Mutual when such a child meets the limiting age so that a Continuation of Dependency form can be sent to the certificate holder for completion.

### Retired Employees

Upon retirement, employees can continue their coverage through:

- o Retiree coverage if your group policy with Medical Mutual was in effect prior to March 1, 2006, and retiree coverage is offered your group
- o Medicare if the employee is Medicare-eligible
- o COBRA if the employee is not Medicare-eligible
- o Direct non-group plan from Medical Mutual  
(see the *Conversion/Continuation of Coverage section*)



## WHEN TO MAKE ADDITIONS

### MARRIAGE

A certificate holder may add a spouse to his or her coverage if the plan is notified within 31 days of the event. The coverage will be effective as of the date of marriage. After 31 days, the spouse can be added as a late entrant.



### BIRTH OF A CHILD

Coverage for a newborn child is effective for a period of 31 days from the date of birth. To continue coverage for a newborn child beyond the 31-day period, the certificate holder must notify us within that period. After 31 days, if the addition of the child will increase the premium, the child must be added as a late entrant.



### ADOPTION

If notification is received within 31 days after the child's adoptive placement, the child will be covered as of the date of placement. After 31 days, the child can be added as a late entrant. Written verification of the placement date from the adoption or placement agency must accompany notification.

## WHEN TO MAKE DELETIONS

### CHILDREN REACHING THE LIMITING AGE

When a dependent child reaches the limiting age as specified in the Subscriber Certificate, the child will no longer be eligible for coverage under the employer group contract. The child may then apply for conversion to a non-group plan within 31 days of reaching the limiting age (see Conversion section). If applicable, continuation under the Consolidated Omnibus Budget Reconciliation Act (COBRA) is possible. COBRA requires employers with 20 or more employees to offer continuation of coverage to employees, their spouses and dependents if they are eligible (see COBRA section).

### DEPENDENT CHILDREN MARRYING

Children who marry are not eligible for coverage under a parent's contract, but they can apply for conversion to a non-group plan in their own names (see COBRA section).

### DIVORCE

If a certificate holder divorces, notification must be sent to the Medical Mutual Membership department. Termination of coverage under the current certificate holder's program will be effective on the date of divorce and continuation of coverage must be offered to the divorced spouse (see COBRA section).

### DEATH

The Medical Mutual Membership department must be notified in writing about the death of any person covered under the contract. The notification should be sent within 31 days after the date of death (see COBRA section).

### TERMINATION OF EMPLOYMENT

When an employee terminates employment, he or she will no longer be eligible for employer group coverage. The Medical Mutual Membership department must be notified within 31 days of the termination date to receive proper credit on the group's monthly invoice (see COBRA section).

### Change In Employee Information

When employees are added to your group contract, or there are any changes in their personal information (name, address, etc.), status or covered dependents, an Application and Change Form must be submitted to the Medical Mutual Membership department within 31 days of the change. In some cases, certificate holders will receive new identification cards.

## PRE-EXISTING CONDITIONS

In accordance with your group contract, a waiting period clause for pre-existing conditions can be applied for all new enrollees, except newly acquired dependents (by birth or adoption). Under this clause, no payment will be made for services related to a pre-existing condition as defined in the subscriber certificate. HIPAA allows for crediting the time a person was covered under previous health coverage if there was no more than a 63-day gap in coverage before the effective date of the new coverage (probationary periods excluded). To receive credit for previous coverage, submit a Certificate of Creditable Health Coverage with the new enrollee's application. Medical Mutual can assist you if you have trouble obtaining a certificate.

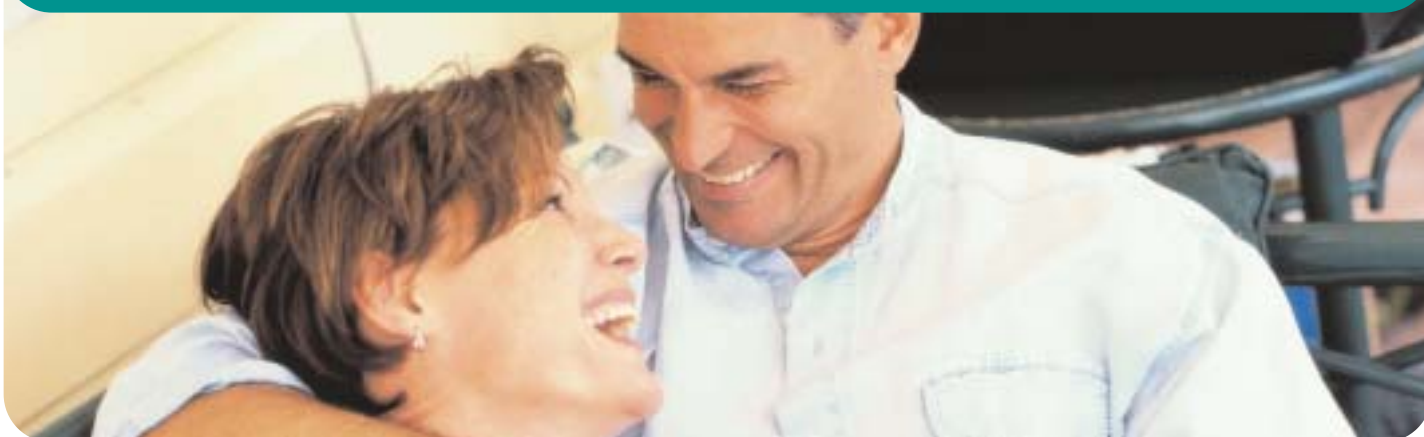
## COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies in situations where Medical Mutual certificate holders and/or dependents are covered by more than one health benefit plan. COB allows enrollees to receive the most complete coverage available to them while assuring that payments are shared equitably by the insurance plans involved. COB eliminates duplicate payments and helps to keep premiums down. When the employer group official becomes aware of employees who are also covered by another group insurance plan, he or she should notify the Medical Mutual Membership department.

### Order of Benefit Determination

Under the COB program the following procedures are used to determine which insurance company is to pay a claim first when a certificate holder and/or dependents are covered by more than one health insurance plan:

- The plan covering the patient as an employee pays before the plan covering the patient as a dependent.
- The plan covering the patient (or dependents) as an active employee pays before the plan which covers the patient (or dependents) as a laid-off or retired employee.
- If a patient is a dependent child, the plan of the parent whose birthday falls earlier in the year pays before the plan of the parent whose birthday falls later in the year. If both parents have the same birthday, the plan in existence the longest period of time pays first.
- If the patient is a dependent child of parents who are separated or divorced:
  - ◆ The plan of the parent with custody pays first.
  - ◆ The plan of the spouse of the parent with custody (the step-parent's plan) pays next.
  - ◆ The plan of the parent without custody pays last.
- If the specific terms of a court decree state that one of the parents is responsible for the child's healthcare expenses, that parent's plan pays first.



## CONVERSION/CONTINUATION OF COVERAGE

### COBRA

Under provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA), an employer with 20 or more employees is required by law to offer continuation of coverage to employees, their spouses and dependents if they lose coverage due to a COBRA-qualifying event. If you are unfamiliar with this law, we urge you to speak with your legal counsel to determine your specific responsibilities.

If a certificate holder qualifies for continuation of coverage and has not yet advised the group official that he or she wants COBRA, they should be removed when coverage would otherwise end. The certificate holder can be retroactively reinstated with no gap in coverage if the certificate holder decides to exercise his or her rights within the grace period. The certificate holder must fill out a new application form.

If the certificate holder elects to receive continuation of coverage, he or she will remain part of the employer group and will be eligible to receive the same coverage as they had on the last day of coverage of the group coverage.

### STATE CONTINUATION FOR FULLY-INSURED GROUPS



Regardless of the size of your group, employees may also be eligible to continue coverage on the employer's policy for six months. State law allows the employee to continue coverage for himself/herself and any dependents when his or her employment terminates. This continuation is not available separately for dependents. You must notify your employees of this right of continuation. Please contact your legal counsel

for further details regarding this state law (Ohio Revised Code Section 3923.38. For SuperMed HMO® or HMO Health Ohio®, see ORC Section 1751.53).

#### To qualify for state Continuation of Coverage, the employee must:

- Have been covered for three months prior to termination
- Be eligible for unemployment benefits
- Not be eligible for Medicare
- Not be eligible for any other group coverage

### CERTIFICATES OF CREDITABLE HEALTH COVERAGE

Medical Mutual will provide a Certificate of Creditable Health Coverage upon notification of cancellation of an employee and/or dependent. The notification will be sent directly to the certificate holder's home. This notification is a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In addition, members may send written requests for copies of certificates to the Medical Mutual Membership department.

## BILLING

### FULLY INSURED GROUPS

The monthly billing is mailed during the month prior to the period for which payment is due. For example, coverage for the month of June would be billed by May 15. The billing reflects the employer group's membership status as of the date that the billing was prepared. Because Medical Mutual provides prepaid healthcare coverage, the group's monthly payment must be submitted before the first day of the month for which the coverage applies. Late payments can result in delayed verification for hospital admissions, delayed claims payment and other services, or cancellation of the policy.

### SELF-FUNDED GROUPS

Please refer to the Invoicing Addendum in your group contract.

### CONTRACT AND RATE NOTIFICATION

Each new group enrolling with Medical Mutual will receive both an application for group coverage and a contract listing rates for the first year. At least 30 days prior to the renewal date, a rate notification will be forwarded to the employer's group benefits official. If the group wishes to make changes in coverage, it must be done at renewal time through your Medical Mutual Service Representative or Broker.



### Documents

When your group health plan is finalized, Medical Mutual will provide the following documents:

#### Master Group Contract:

A Master Group Contract is issued to each employer group at the time of enrollment. The contract includes eligibility provisions, payment schedules and terms, coordination of benefits and other terms agreed between Medical Mutual and the employer group.

#### Certificate of Coverage Benefit Book:

Certificates of Coverage are issued to each employee enrolling. The certificate describes the coverage and the terms and conditions of the employer's group policy.

#### Identification Cards:

Two identification cards are issued to each certificate holder. The cards can be mailed directly to the certificate holder's home or distributed by the employer's group official. To order additional identification cards, the certificate holder can visit the *Members'* section on our Web site: [MedMutual.com](http://MedMutual.com).

#### Billing Invoices

Medical Mutual bills in advance for coverage. Payment is due in advance of the first day of the coverage period. Late payments can result in delays in verification for hospital admissions and other services, delays in claims payment or cancellation of the policy.

#### Provider Directories

Enrolled employees can order a regional directory of physicians by calling 888/241-2583. Or they may locate a physician at Medical Mutual's Web site at [MedMutual.com](http://MedMutual.com).

*Please refer to the group contract and/or certificate for more detailed information about your group policy with Medical Mutual and /or your HMO policy through Medical Mutual. HMO products are offered through Medical Health Insuring Corporation of Ohio, a licensed health insuring corporation that is a wholly owned subsidiary of Medical Mutual.*

## Medical Mutual Offices

### Akron-Canton

3560 West Market Street  
Suite 115  
Fairlawn, Ohio 44333-2660  
800/423-6891  
330/665-2065

### Columbus

9961 Brewster Lane  
Powell, Ohio 43065-7571  
800/228-2583  
614/932-7260

### Cleveland

6393 Oak Tree Boulevard  
Suite 300  
Independence, Ohio 44131-6957  
800/245-5272  
216/642-3130

### Dayton

6450 Poe Avenue  
Suite 111  
Sand Lake Plaza Office Building  
Dayton, Ohio 45414-2647  
800/422-8339  
937/890-8680

### Cincinnati

Three Centennial Plaza  
895 Central Avenue  
Suite 700  
Cincinnati, Ohio 45202-1961  
800/228-2583

### Toledo

3737 Sylvania Avenue  
Toledo, Ohio 43623-4482  
800/782-3651

### Youngstown

6715 Tippecanoe Road  
Building C, Suite 201  
Canfield, Ohio 44406-8404  
800/221-2640  
330/702-2890

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If you need information that is not covered in this kit, please contact your  
Medical Mutual Service Representative or Broker.

