



Delta Dental of Oregon & Alaska

# Alaska Group Administrative Guide

[modahealth.com](http://modahealth.com)  
[deltadentalak.com](http://deltadentalak.com)

# Welcome

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

This guide explains our administrative procedures, your billing statements and forms we commonly use. By illustrating common administrative functions, such as enrollment and billing, as well as eligibility rules and responsibilities, we hope this guide will be a helpful tool for you. In explaining some of our administrative procedures, we've included some provisions from our standard contracts. If any provisions printed in this guide differ from those in your contract, the provisions in your contract or Member Handbook will apply.

All information is subject to change without notice, except when required by law. However, we will make every effort to provide advance notice, when appropriate. Our website, [modahealth.com](http://modahealth.com) or [deltadentalak.com](http://deltadentalak.com), is your best resource for the most current information.

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

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

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# Web resources

Moda Health and Delta Dental provide a wide range of web resources for our members. As a group administrator, you can find any of the below online resources by accessing our website at [modahealth.com/employers](http://modahealth.com/employers) or [deltadentalak.com/employer](http://deltadentalak.com/employer). Select the Resources tab.

## Moda Health/Delta Dental website

You and your employees can obtain the following:

- Provider search tools
- Enrollment forms
- Claim forms
- Customer service telephone numbers
- Overview of medical, dental, pharmacy and vision plans
- Plan administration information

## Employer Dashboard

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

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

Utilizing this valuable resource makes all of our jobs easier. To get more information on this service, please contact your membership accounting specialist or send us an email via [enroll@modahealth.com](mailto:enroll@modahealth.com) or [deltadentalak.com](http://deltadentalak.com)

## eBill services

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

With eBill, you can:

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

To learn more about this exciting service, please visit [www.modahealth.com/employers/ebill.shtml](http://www.modahealth.com/employers/ebill.shtml) or [www.deltadentalak.com/employer/resources/online-tools](http://www.deltadentalak.com/employer/resources/online-tools).

## Web resources available to our members

### Member Dashboard

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

- View claims status and payment information
- View current eligibility for themselves and family members
- View detailed benefit information specific to their plan
- Download their Member Handbook
- Order ID cards or print an eCard
- Search for participating providers
- Change their address
- Print Explanation of Benefits (EOB)
- Email customer service
- Use our Prescription Price Check Tool

# Eligibility

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

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

## Who is eligible?

### Employees

Qualified employees are eligible for your employer sponsored insurance-based policy. Each employee must satisfy any required waiting period and must work the minimum number of hours per week required by your group contract. Please see your contract for waiting period and minimum hour requirements.

### Spouse

If an employee is married, his/her legal spouse may be eligible for insurance. A valid marriage certificate must accompany the enrollment form when requesting special enrollment for a new spouse.

### Domestic partners

Our organization may offer domestic partnership coverage through a Registered Domestic Partnership or a Declaration of Domestic Partnership. Your group can use its own Declaration or use our form by downloading the Declaration from our website, [modahealth.com](http://modahealth.com) or [deltadentalak.com](http://deltadentalak.com), in the "I'm an employer" or "I'm a member" tab.

### Dependent children

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

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

## Dependents with disabilities

If a subscriber has a child who has sustained a disability rendering him or her physically or mentally incapable of self-support at even a sedentary level, that child may be eligible for coverage even though he or she is over the dependent maximum age. To be eligible, the child must be unmarried and principally dependent on the subscriber for support, and have had continuous health coverage. The incapacity must have arisen, and the required substantiating information must be received, before the child attains the dependent maximum age. Social Security Disability status does not guarantee coverage under this provision.

We will determine eligibility based on commonly accepted guidelines and documentation of the child's medical condition. Periodic review by Moda Health will be required on an ongoing basis except in cases where the disability is certified to be permanent. For dental-only coverage, Delta Dental will accept the member's medical carrier's disability certification as sufficient documentation for disability.

## Declining coverage

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

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

- Marriage (a valid marriage certificate is required upon enrollment)
- Entering into a domestic partnership (a valid Domestic Partnership Declaration is required upon enrollment)
- Birth
- Adoption (adoption paperwork is required upon enrollment) or placement for adoption
- Loss of other coverage or becoming eligible for a premium assistance subsidy
- Qualified Medical Child Support Order (QMCSO)
- A person's coverage under Medicaid, Medicare, Tricare, Indian Health Service, eligibility for premium subsidy or a publicly sponsored or subsidized health plan has been involuntarily terminated within 90 days prior to applying for coverage in a group health benefit plan.

Employees wishing to enroll due to a special enrollment right must enroll within 31 days of the event. An employee who does not enroll within the 31 days will not be eligible to enroll until the next open enrollment period.

*Note: Newborns and those covered under Medicaid or CHIP who lose coverage or become eligible for a premium assistance subsidy have up to 60 days to enroll.*



# Enrollment

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

## Application process

We will provide you with the necessary enrollment forms for your employees. Completion of all fields on the enrollment form is critical to properly enrolling your employees in a timely fashion. You must receive a signed, dated and fully completed enrollment form within the 31-day window for a qualifying employee to be covered. For assistance with eligibility requirements, please see the Eligibility section of this guide.

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

### Checklist

- Have employee complete an enrollment application.
- Log in to Employer Dashboard and complete the enrollment process.  
Having trouble with the Dashboard, please contact your Membership Accounting Specialist for enrollment support.

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

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

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

Failure to complete enrollment forms correctly or submitting forms past their due dates may cause a delay in enrolling a new employee or dependent. We may not be able to enroll the new employee or dependent until the next enrollment period. Enrollment forms are available online at [modahealth.com](http://modahealth.com) or [deltadentalak.com](http://deltadentalak.com). You may request a supply by contacting your Membership Accounting Specialist.

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

## Using Employer Dashboard

When using Employer Dashboard for enrollment functions, employers must retain all enrollment materials, such as enrollment forms and special enrollment rights documentation, for a seven-year period and to provide us with reasonable access to such material.

### Checklist

- Receive a completed enrollment form.
- Log on to Employer Dashboard.
- Update Employer Dashboard with the enrollment information.
- Retain the documentation of the enrollment for seven years.

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

Group administrators can request direct access to our eligibility system. Enrollments such as new member additions, terminations and changes can be made 24 hours a day, seven days a week by group administrators. You can request access to the Employer Dashboard by notifying your Sales and Account Services representative. Once your account has been activated, you can access the Employer Dashboard by going to our website at [modahealth.com/employers](http://modahealth.com/employers) or [deltadentalak.com/employer](http://deltadentalak.com/employer).

## Enrollment for newly acquired dependents

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

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

### New spouse

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

### Domestic partner

If your plan offers Domestic Partnership through a declaration, the employee must complete an enrollment form and submit a Declaration of Domestic Partnership within 31 days of when the employee and his/her partner have signed the declaration. Coverage becomes effective on the date specified in the Member Handbook.

*Note: Refer to your Member Handbook to determine if your plan covers domestic partners through a declaration.*

## Spouse's or domestic partner's children

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

## Newborn children

A member's newborn child is eligible from birth. The employee must complete and sign an enrollment form for the newborn to begin coverage. The employee must complete and sign an enrollment form and submit payment within 31 days of the date of birth. If the required payment is not received, coverage for the child will end 31 days following birth. Proof of legal guardianship will be required for coverage of a grandchild beyond the first 31 days from birth if his or her parent is not an enrolled dependent under the Plan.

## Adopted children

A subscriber's adopted child, or a child placed for adoption, will be eligible on the date of placement. To enroll a new child, an enrollment form must be submitted. When a premium increase is required, the enrollment form and payment must be submitted within 31 days. If payment is not received, coverage for the child will end 31 days following adoption.

## Special enrollment

If coverage is declined for an eligible employee or any dependent(s) when initially eligible or at an open enrollment period because of other health coverage, they may enroll in the Plan outside of the open enrollment period if the other coverage is terminated as a result of involuntary loss of eligibility. Refer to the Member Handbook for specific criteria that must be met in order to be eligible.

## Identification cards (ID cards)

Member ID cards automatically generate for new employees enrolling in coverage or those making any changes to their coverage that affects their ID card.

Members may download ID cards onto their iPhone or Android Smartphone. In addition, a PDF eCard version can be obtained through their Member Dashboard. If additional ID cards are needed, you may request them using Employer Dashboard or call your Membership Accounting Specialist. Members may access their Member Dashboard or call our customer service department to request additional ID cards. ID cards should be mailed within three business days.

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

# Making changes

As employee's lives and work situations change, their eligibility for coverage under your company's Moda Health or Delta Dental plan may change. This section of your manual guides you through the process of maintaining proper records. It also serves as a reference tool enabling you to guide your employee when completing necessary forms. Your assistance ensures that the benefit coverage made available by your company remains in force and accurate throughout an employee's relationship with your company and us.

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

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

Such events may require a change such as:

- Enrolling a new member
- Terminating, converting or transferring coverage
- Changing a home address and contact information
- Issuing a new ID card

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

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

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

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

If the change is processed using Employer Dashboard, please ensure that the exact date of termination, (last day of employment) is used. This will ensure the correct termination is reflected in our system.

Your employees may make the following changes by accessing their Member Dashboard or by calling our Customer Service Department.

- Name changes
- Address changes

# Retroactive eligibility

Retroactive eligibility refers to an eligibility event (which may include a new enrollment, reinstatement or termination) with an effective date prior to the current date. We monitor retroactivity on all groups, regardless of contract type or eligibility administration responsibility.

Retroactive time limits are typically 90 days. Time limitations refer to the amount of time you have to submit eligibility changes to us. All eligibility rules regarding signature dates, qualifying events and documentation apply. See your Member Handbook for eligibility guidelines. We encourage processing terminations as soon as possible in order to stop claims payment. However, we will typically allow retroactivity up to 90 days.

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

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

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

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

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

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

An example of a situation that cannot be processed retroactively: if an employee loses eligibility due to a reduction in hours, but the employer, in error, continues to collect any employee contribution and pays the carrier, once the error is discovered, the termination can be processed only prospectively.

Because only employers know the specifics about the termination (e.g. if payment of an employee contribution was made or if the termination was requested by the subscriber), We will accept retroactive termination requests from groups, with the mutual understanding that the group is only submitting requests that are consistent with the regulations.

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

## New enrollments/reinstatements

Employees must sign, date and submit enrollment forms to you within the timeframe in your group's contract. This is generally 31 days from the eligibility date. You are responsible for forwarding that information to us via an enrollment form upon receipt. The retroactive time limitations apply. We must receive the enrollment form within 90 days. This allows for cases of delays/errors by you with a qualifying event and if all other eligibility rules are met. Otherwise, a late enrollee must wait for a new qualifying event or open enrollment.

## Premium or administrative fee impact

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

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

## When coverage ends

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

Coverage ends when one or more of the following occurs:

- Group plan termination
- Death
- Loss of eligibility
- Termination, layoff or reduction in hours of employment (including a strike or lockout)
- Divorce or termination of domestic partnership
- Nonpayment of premium by the employee
- Coverage termination request by the employee

### Checklist

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

## Group plan termination

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

## Death

If an employee dies, coverage for their insured dependents ends on the last day of the month in which the employee's death occurred. However, surviving dependents may extend their insurance for up to three years if they meet the requirements listed in the Continuation of Coverage section of this guide. Remember to notify the surviving dependents of their rights to continue coverage. If they choose to continue coverage, a completed enrollment will need to be submitted and you will need to notify your Membership Accounting Specialist.

## Loss of eligibility

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

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

## Layoff or reduction in hours

In the case of a loss of coverage due to lay-off or reduction in hours of employment, coverage ends for the employee and their insured dependents on the last day of the month in which the layoff or reduction of hours occurred. However, if the employee is laid off and returns to active work within six (6) months, they and any previously enrolled dependents may re-enroll in the group plan on the date they are rehired. Coverage will begin on the date of rehire. If they experience a reduction in hours and within six (6) months hours increase and qualify for benefits, the employee and any previously enrolled dependents may re-enroll in the group plan on the date they qualify. You must notify us that you have an employee who has been rehired following a layoff or that their hours have increased, and the necessary premiums for the coverage must be paid.

## Divorce or legal separation

Insurance ends on the last day of the month in which the divorce decree is final or date of Legal Separation. For optional plans that cover domestic partners, insurance ends on the last day of the month in which a partnership no longer meets the requirements of the Declaration of Domestic Partnership filed with the employer. Please remember to notify the spouse or domestic partner losing coverage of his/her rights to continue coverage.

## When dependent children lose eligibility

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

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

Note: Remember to notify terminated members of their rights to continue coverage through Continuation of Coverage or COBRA plans.

*Also, remember to terminate any covered dependent children from the Moda Health plan when they lose eligibility. Be sure to notify terminated dependents of any rights to continue coverage through COBRA.*

## Notification guidelines

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

# Continuation of coverage

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

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

## COBRA

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

Qualifying events, maximum of 18 months of COBRA coverage:

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

Qualifying events, maximum of 36 months of COBRA coverage:

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

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

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

- Within 14 days of the date you receive a qualifying event notice from an employee
- Within 44 days of the employee's termination of employment, reduction in hours, death or becoming entitled to Medicare, or the employer filing for Chapter 11 reorganization
- You are also responsible for notifying us within 60 days of the qualifying event and collecting the initial premium from your employee within 45 days after the qualified beneficiary elects COBRA

Eligible employees and their dependents who elect COBRA will need to pay their monthly premiums directly to you, their employer group. Members must pay their premiums within 45 days of the date they elect COBRA and 30 days for each month's due date or coverage will terminate without the option to reinstate.

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

COBRA premiums are based on the premiums charged to plan participants who are not on COBRA. However, you may require the COBRA beneficiary to pay the full cost of the premium (no employer contributions) plus an administrative fee of two (2) percent.



## Checklist

- Notify members of COBRA eligibility.
- Notify Moda Health/Delta Dental of triggering event.
- Collect premium from your COBRA member.
- Notify Moda Health/Delta Dental when members terminate coverage.

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

## Conversion plan (ACHIA)

Employees and/or dependents may be eligible to convert from COBRA coverage to an individual Conversion plan (ACHIA). Groups should be prepared to provide information on Conversion plans to their employees upon request.

The group is responsible for notifying members of the availability, terms and conditions of the Conversion plan within 15 days of a member's termination. ACHIA recommends that members apply with ACHIA through an agent or broker or get information from the Alaska Division of Insurance. Visit [www.achia.com](http://www.achia.com) or call 888-290-0616 for more information.

However, if the group terminates its policy or replaces coverage under the plan with another carrier, members are not eligible for a Conversion plan. Benefits and premiums of a conversion plan are different from those in the plan offered by the group.

# Billing

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

For more information on eBill, please see the eBill section of this guide. You may also visit [modahealth.com/employers/ebill.shtml](http://modahealth.com/employers/ebill.shtml) or [deltadentalak.com/employer/resources/online-tools](http://deltadentalak.com/employer/resources/online-tools).

## What you will receive

### Billing statement

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

### Billing summary

The billing summary provides the premium breakdown by subgroup. The amount due to us is listed in the column labeled "Total Due." This is your total premium payment. You will receive two copies of the summary. One copy is to be sent in with the premium payment, the other is for you to retain for your records. We encourage you to pay as billed. Changes will be reflected in subsequent month's bills.

### Billing change form

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

### Checklist

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



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

**Billing Statement Totals**

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

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

Due Date : MM/DD/20CC

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

SAMPLE

BLPR  
 0000010206G000





**Billing Statement**

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

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

XYZ Company, Inc.

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

Due Date : MM/DD/20CC

Description: Active

Subscriber ID #	Subscriber SSN	Employee Name	Coverage Date	Dental				Total
								





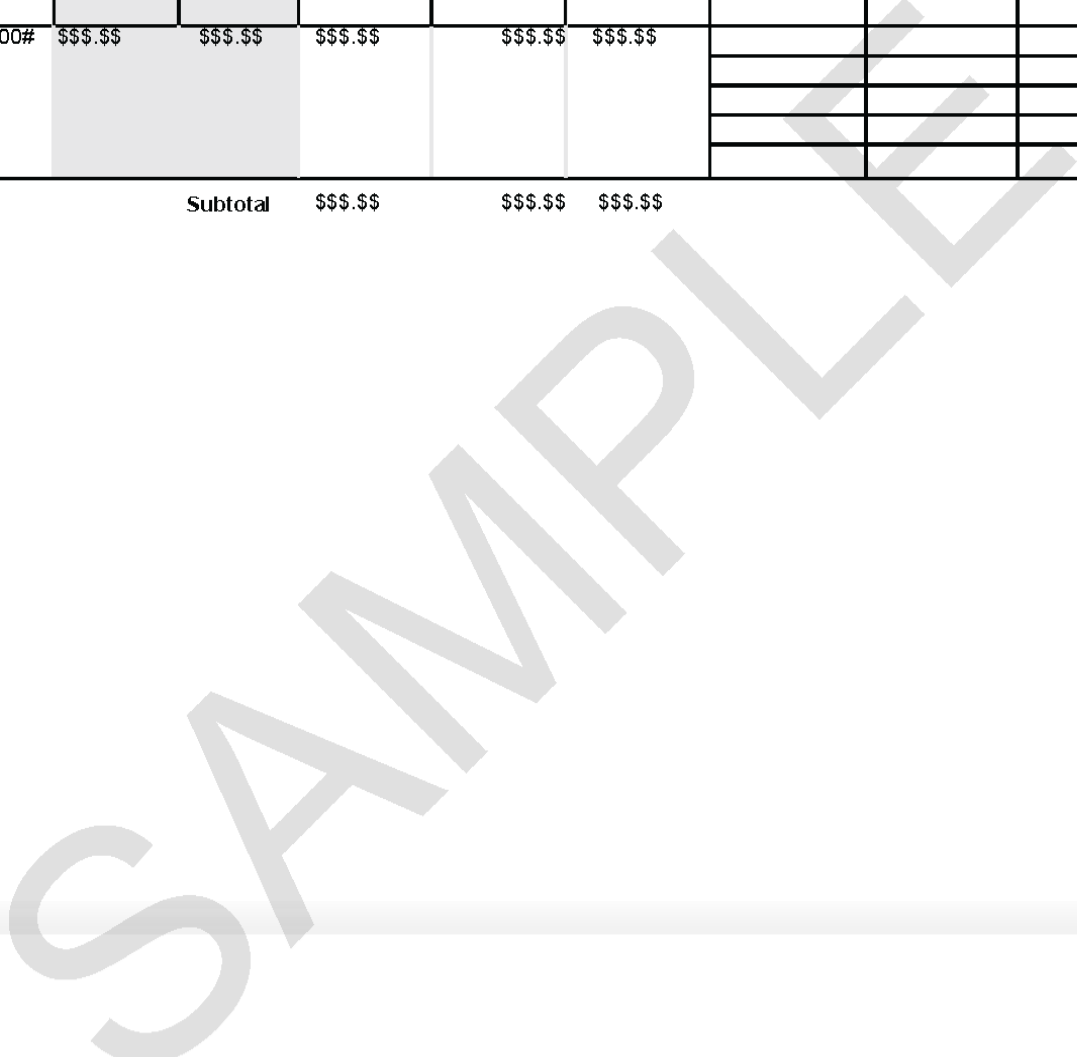
# Moda Health Billing Summary

10008525 Due Date:  
MM/DD/20CC

Bill Print Date : MM/DD/20CC

Month of Coverage : MM/DD/20CC

Bill Summary							Adjustment Worksheet (Complete only if making adjusted payment - not if paying in full)		
Group	Sub-group	Current Month Amount	Retroactive Amount	Subgroup Total	Outstanding From Prior Month	Total Due	Adjustment for Adds (+)	Adjustment for Terms (-)	Adjusted Total (Total due +/- Adjustments)
1000####	000#	\$\$\$.\$\$	\$\$\$.\$\$	\$\$\$.\$\$	\$\$\$.\$\$	\$\$\$.\$\$			
<b>Subtotal</b>				\$\$\$.\$\$	\$\$\$.\$\$	\$\$\$.\$\$			



Please retain this copy for your records





**Group ID:** 1000#### **Group Name:** XYZ Company, Inc **Subgroup ID:** 000# **Subgroup Name:** Active

**Billing Change Form for Month of** \_\_\_\_\_

**Adds** (New enrollments, dependent adds, and adding coverage) - Applications Required for Adds

Subgroup	Effective Date	Subscriber Name	Subscriber ID / SSN	Description of Change	Adjustment Amount	Comment
				Total for Adds	\$	

**Terms** (Termination of subscribers, dependents or coverage)

Subgroup	Termination Date	Subscriber Name	Subscriber ID / SSN	Description of Change	Adjustment Amount	Comment
				Total for Terminations	\$	

**Changes** (Changes in eligibility, benefits, or subgroup)

Subgroup	Change Effective Date	Subscriber Name	Subscriber ID / SSN	Description of Change	Adjustment Amount	Comment
				Total for Changes	\$	

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

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



# Premium payment

## Payment due dates

Since your benefit plan is a prepaid health plan, it is important to remember that your payment is due to Moda Health by the first of each month for that month's eligibility period. If payment is not received by the first of the month, your next month's billing statement will not generate and delinquency may take effect.

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

## Delinquency

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

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

## Final bills

Upon termination of coverage, we will provide a final bill indicating the ending balance. If there are outstanding premiums owed to us, you will have 30 days to remit payment. If money is owed to your group, a refund check will be requested and mailed within 30 days of the termination with us.

## Payments options

### eBill services

Through eBill you can pay online and schedule reoccurring payments. To learn more about this exciting service, please visit [modahealth.com/employers/ebill.shtml](http://modahealth.com/employers/ebill.shtml).

### Automated Clearing House (ACH)

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

## Check

We will include a return envelope with each month's bill for your convenience. Please remit your premium payment to the following address:

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

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

## Enrollment Census Report

The Enrollment Census Report lists current eligible members in our system for your group. This report is helpful for auditing purposes to ensure your eligibility records and our eligibility records match. You can download this report from your Employer Dashboard.



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

MESB\_021  
Date: 04/01/2017  
Time: 8:13 pm  
Page 3 of 1215

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

Subscriber ID	Subscriber SSN	Relation	Member Name	Date of Birth	Student	Termination Date	D
*****	111223333	C	Doe, John	05/02/1991		05/31/2017	Y
*****	444556666	C	Joly, Raul	04/18/1998		04/30/2017	Y
*****	777889999	C	Vida, Soza	03/06/1991		03/31/2017	Y

D=Dental

Billing and Eligibility Specialist: Name



# Subscriber ID numbers

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

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

# Turnaround times

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

## Enrollment forms

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

## Member ID cards

Member ID cards automatically generate for new employees enrolling in coverage or those making any changes to their coverage that affects their ID card. Identification cards will be mailed to the subscriber within an average of five (5) business days from the date we receive a request.

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

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

## Email response time

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

## Phone response time

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

## BenefitHelp Solutions (BHS)

We offer a variety of services to our qualifying customers. BenefitHelp Solutions, a Moda Health subsidiary, provides full third-party administration services, such as Flexible Spending Account (FSA) and COBRA administration. Since BenefitHelp Solutions is a Moda Health subsidiary, your Membership Accounting Specialist and your BenefitHelp Solutions Member Specialist will work in tandem to ensure a smooth transition for your employees to a COBRA policy. For more information, please contact your Sales and Account Services representative or visit [benefithelp solutions.com](http://benefithelp solutions.com).

# Terminology

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

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

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

**Billing summary:** Document sent to employer groups providing a grand total by subgroups and due date for the month billed.

**Carrier:** An insurance company.

**COBRA:** COBRA stands for Consolidated Omnibus Budget Reconciliation Act of 1985. This is a federal law that requires employer group health plans of 20 or more employees on 50% of the typical business days in the prior calendar year to allow people whose coverage would ordinarily end under their group plan to continue coverage under the plan for certain qualifying events.

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

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

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

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

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

**Maximum child age:** The ages at which dependents lose their eligibility on the subscriber's plan. Typically, our plans allow dependent coverage through age 25. Sometimes the age allowed is different if the dependent is a full-time student at an accredited college.

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

**Member Handbook:** A handbook made specific to each group outlining their particular contract guidelines.

**Open enrollment:** A specified time period when subscribers have the opportunity to make changes to their health coverage.

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

**Primary care physician (PCP):** Is the participating physician, or women’s healthcare provider, whom an individual chooses to be responsible for their continuing medical care.

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

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

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

**Special enrollment right:** A qualifying event, outside of Open Enrollment, that makes an employee or dependent eligible for enrollment in the Plan.

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

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