6 Member Eligibility and Coverage

Description This chapter provides information about member eligibility and coverage.

Contents

Important*:* Our Customer Service department provides information about member eligibility status and benefits plan coverage. Information provided by phone does not constitute an authorization or guarantee payment. Actual payment is subject to the subscriber's contract and eligibility at the time of service.

Section 1: Member Responsibilities

ID Cards

Members should present their ID cards at each time of service.

Depending on the plan, members are responsible for any applicable copayment (copay), coinsurance or deductible. Members are also responsible for the costs of non-covered services.

Copayments

The copay is a predetermined amount a member pays for a specific service (e.g., $20 for an office visit). Typically, copayments are fixed amounts for office visits, prescriptions or hospital services. Copays should be collected at the time of service from the member. If the member is admitted to the hospital from the emergency room, the emergency room copay may be waived.

The member's copay is calculated into the Premera Blue Cross payment.

Deductible

The deductible is a predetermined amount of eligible expense, designated by the subscriber's contract that the member must pay each year from his/her own pocket before the plan will make payment for eligible benefits.

Coinsurance

Coinsurance is the portion of covered healthcare costs for which a member is financially responsible, usually according to a fixed percentage of the allowed amounts for services rendered. Coinsurance often applies after first meeting a deductible requirement.

Note: Copay, coinsurance and deductible amounts vary by plan. Please check the member's ID card or call Customer Service, 877-342-5258, option 2 for the specific copay amount. For BlueCard members, please call 800-676-2583.

Non-covered Services

Members are responsible for the payment of services not covered by their contracts. Non-covered services (services that are not medically necessary or a covered benefit) can vary based on the member's plan. To verify if a service is covered, call 877-342-5258, option 3, to request a benefit advisory. For more information concerning benefit advisories, refer to **Chapter 8, Integrated Health Management**.

If a member decides to proceed with a non-covered service, before or following Premera's determination, the member should sign a consent form agreeing to financial responsibility before the service is provided. The consent form should clearly state the proposed service that will be rendered and the cost of the service. If the consent form is not obtained, services deemed not medically necessary would be the provider's financial responsibility.

Section 2: Eligibility and Benefits

Maximizing Member Benefits

Decisions on where and how to provide care are best made by the physician, or other provider, in consultation with the patient.

Verifying Eligibility and Benefits

The benefits of each plan vary widely by contract. Verifying eligibility and benefits can be done using one of the following:

- Online at premera.com/wa/provider
- Interactive Voice Response (IVR)
- Customer Service

Important: You can verify a member's eligibility and benefits in several ways. However, actual payment is subject to the subscriber's contract and eligibility at the time of service.

premera.com/wa/provider: Our secure provider portal offers the quickest avenue to contact us and obtain secure, personalized, easy-to-use information. You can verify member eligibility and benefits, including plan effective dates, basic demographic information, deductibles, and benefit limit accumulators. You can also obtain the status of a claim. **Chapter 2, Online Services** contains additional instructions for viewing eligibility, benefits and claim status information.

Customer Service: Our customer service representatives are a great resource for information about a member's benefits and eligibility. You can call them at the number listed on the back of the member's ID card for information about:

- Eligibility
- Claims status
- Claims payment
- Benefits

Note: Each customer service representative will verify the identity of the caller before discussing member claim information to ensure member confidentiality.

Interactive Voice Response

Interactive Voice Response (IVR): Provides self-service specific information and is available 24 hours a day, seven days a week. Many Customer Service numbers offer an IVR option. Callers enter the member's ID number, date of birth, and the physician or other provider's tax ID number to obtain eligibility, general benefit information, and claims information. Information available on the IVR system varies per plan.

Note: BlueCard eligibility is not available through IVR.

Tips for IVR Use:

- Enter the member's date of birth as month (two digits), day (two digits) and year (four digits). Do not use slashes or hyphens.
  Example: 03012012 represents March 1, 2012
- Once familiar with the script, you no longer need to listen to the complete prompt.
- If you request eligibility verification for more than one member at the same time, and you encounter subscriber or birth date errors, note them and wait until you have completed your inquiries before connecting to a customer service representative.
- If you do not respond to each prompt within five seconds, the system will repeat the prompt. If you do not respond in another five seconds, you will be routed to a customer

Interactive Voice Response *(continued)*

service representative (during normal Customer Service hours).

- If you make an error while keying in the member ID number, press the * key and the system will prompt you to re-enter it.

Waiting Periods

Healthcare plans generally have waiting periods for pre-existing conditions that must be satisfied before the member is eligible for benefits for that pre-existing condition.

The definition of a pre-existing condition is any physical or mental condition, regardless of the cause, for which medical advice, diagnosis, care or treatment was recommended or received by an individual prior to their enrollment date on the health plan.

The length of the waiting period varies by contract. Waiting periods may be reduced or eliminated based on a member's prior coverage. Some healthcare plans of national employers do not have pre-existing condition waiting periods.

Contact Customer Services for waiting period information specific to the member's plan.

Limitations and Exclusions

Benefit plans typically have exclusions and limitations—services and supplies that plans do not cover.

The following is an example of services that are generally not covered by health plans:

Benefits are not provided for services, treatment, surgery, drugs or supplies for any of the following:

- Conditions arising from acts of war, or service in the military
- Cosmetic or reconstructive services, except as specifically provided
- Experimental or investigative services
- Orthognathic surgery
- Services determined by us to be not medically necessary
- Services in excess of specified benefit maximums
- Services payable by other types of insurance coverage
- Services received when the member is not covered by the program
- Sterilization reversal
- Treatment for work-related conditions for which benefits are provided by Workers' Compensation or similar coverage.

Note: Plan limitations and exclusions vary widely by contract, and are subject to change. This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms under which the program may be continued in force. This manual is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions, please contact Customer Service.

Benefit Level Exceptions

Sometimes it is reasonable and desirable for a member to receive services from a provider or facility not in his/her network. Depending on the member's benefits, out-of-network services may be covered at a lower rate, or not at all.

In certain situations a benefit level exception can be requested to pay out-of-network services at the in-network service reimbursement rate. A benefit level exception should be requested **prior** to the service. If determined to be medically necessary, Premera may allow out-of-network services at an in-network benefit level. Examples include:

- Capacity
- Distance
- Emergency care
- Unique service

Note: A benefit level exception is subject to a review process prior to approval or denial. See **Chapter 8, Integrated Health Management** for information about Prospective Review.

Section 3: Medical Emergency

911

Important: Members are instructed to call 911 or seek care immediately if they have a medical emergency condition. Our plans cover emergency care 24 hours a day, anywhere in the world.

Definition

A "medical emergency condition" means the sudden and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. (A "prudent layperson" is someone who has an average knowledge of health and medicine.)

Medical emergency examples include severe pain, suspected heart attacks and fractures. Examples of non-emergencies include minor cuts and scrapes.

Emergency Care

In a medical emergency, members can go to any physician or other provider office, urgent-care center or hospital emergency room.

The hospital's emergency department must perform a medical screening examination for any individual seeking evaluation for treatment for a medical condition. For presenting conditions that are not a medical emergency, the emergency department must have the authorization of the member's treating physician or other provider to treat past the point of screening and stabilization. In such cases, we expect the treating physician or other provider to respond within 30 minutes of being called, or we will assume there is authorization to treat, and the emergency department will treat the member.

Follow-up Care

If a member is treated in the emergency department, the member's physician or other provider needs to provide any necessary follow-up care (e.g., suture removal).

Section 4: Member Appeals

Complaints and Appeals Policy

Members have the right to voice and/or submit their complaints when they have a problem or a concern about claims, quality of care or service, network physicians and other providers, or other issues relating to their coverage. The plan is committed to resolving problems in a timely, equitable and confidential manner.

Appeals must be handled within set time frames per regulatory requirements. If an office receives a request in support of its patient's appeal, please expedite the request.

Process

Complaint ⇨ **Appeal** (Level I and II) ⇨ **Independent Review**

A member has the right to appeal decisions we have made regarding claims, service, quality of care or service from a physician or other provider, benefit coverage, or other issues relating to the plan.

Premera processes member complaints and/or appeals. When a physician or other provider office receives a request for information or records in connection with a member complaint and/or appeal, the information requested must be forwarded within the time period specified in the request.

Complaint

A complaint occurs when a member or member representative communicates an issue verbally to Customer Service or in writing to Customer Service Correspondence. Premera resolves complaints related to claims, benefits, provider access and behavior-related situations in approximately 30 calendar days from the date received by Premera. The member is advised of the decision by phone or letter.

In cases that require a medical review, the complaint is reviewed by our professional medical staff.

Appeals

If the complaint is not resolved to the member's satisfaction, he/she may submit an appeal. We must receive appeals within 180 days of the date we notify the member of the adverse determination. Members may provide additional information not previously submitted with their appeal.

Level I Appeal: Premera appoints a panel that evaluates all the information and makes a decision. We send the member written notice of our decision, including a reason, within 30 calendar days of the date we received the appeal. Providers submitting a Level I request on the member's behalf must provide a signed authorization of release form from the member. Premera will not accept Level I requests from providers on the member's behalf without this authorization. If the member is not satisfied with the outcome from the first review, he/she may request a second review or independent review (Level II Appeal or IRO).

Level II Appeal: If a member is not satisfied with the Level I decision, and if their contract provides the option, he/she may request a Level II review. We must receive the request for a second review in writing, from the member, within 60 days of the date they received notice of the Level I Appeal decision. Providers submitting a Level II request on the member's behalf must provide a signed authorization of release form from the member. Premera will

Appeals *(continued)*

not accept Level II requests from providers on the member's behalf without this authorization. A different Premera panel is appointed to review the Level II appeal. The member and/or his/her representative may meet with the panel in person or via phone. The panel review will occur within 30 calendar days of receiving the request. The panel evaluates all the information and makes a decision. Written notice of the decision is sent to the member within five business days of the review.

Independent Review

If a member is not satisfied with a Level I or Level II decision, and if his/her contract provides the option, he/she may request an independent review. Premera must receive the request in writing from the member within 60 days of the date the member received notice of the Level I or Level II Appeal decision. Providers submitting a request for independent review on the member's behalf must provide a signed authorization of release form from the member. Premera will not consider the provider's request for independent review without the signed authorization.

An independent review organization (IRO) conducts independent reviews. An IRO is an organization of medical and contract experts not associated with Premera that is qualified to review appeals. Premera submits the member's file to the IRO, and for fully insured groups, pays the costs of the review. The IRO gives the member its decision in writing, and Premera promptly implements the IRO's determination.

Expedited Appeal

Expedited appeals are warranted when following the routine appeals process might jeopardize the life or health of the member. The member can hand-deliver, mail or fax the request to us.

Level I Expedited Appeal: Premera appoints a panel to evaluate all the information and make a decision. We will notify the member of our decision, and the reasons for it, within 72 hours after we receive the appeal. If a member is not satisfied with the Level I decision, and if his/her contract provides the option, he/she may request a Level II expedited review.

Level II Expedited Appeal: We must receive the request for a second review from the member in writing. Providers requesting an expedited Level II appeal on the member's behalf must provide a signed authorization of release form from the member. Premera will not accept an expedited Level II request from a provider on the member's behalf without this authorization. A different Premera review panel is appointed to review the Level II appeal. We will notify the member of the panel meeting. The member and/or his/her representative may meet with the panel. We will notify the member of our decision, and reasons for it, within 72 hours of the request for a second review. If the member is not satisfied with the appeal determination, the next level of action is non-binding mediation.

The appeal process for contracted physicians or other providers is handled through the Physician and Provider "Provider Dispute Resolution" process. For more information, see **Chapter 7**.

Section 5: Member Rights and Responsibilities

Description

A provider-patient relationship benefits everyone involved in patient care. To promote that relationship, member benefit booklets for all our plans include the following rights and responsibilities for members.

Rights

Each member has the right to:

- Get information about the organization, its services, its practitioners and providers.
- Get information about their rights and responsibilities.
- Be treated with respect by the health plan. The health plan will recognize the member's dignity and right to privacy.
- Work with their healthcare provider to decide on treatment options needed for their conditions.
- Talk honestly about what treatment options are right and needed for their conditions, regardless of cost or benefit coverage.
- Make complaints or appeals about the health plan or the care or service the health plan provides.
- Recommend changes to the health plan's member rights and responsibilities policy.
- Choose their healthcare providers.
- Have the health plan keep things they tell the health plan about their health plan claims and other related information private.
- Have their healthcare and healthcare coverage information protected.
- Review and get copies of their personal information on file.
- Get screening and stabilization emergency services when and where they need them. A member does not need prior authorization, regardless of cost or benefits coverage. This applies if severe pain, injury, or sudden illness convinces the member that their health is at great risk.
- Continue to get care from their specialty provider for up to 90 days or until they complete their care. This applies if the member is getting treatment for a chronic or disabling condition. It applies if the member is in their second or third trimester of pregnancy. It applies when the member involuntarily changes their healthcare plan. It applies if the member's provider leaves the network for any reason other than cause.

Responsibilities

Each member has the responsibility to:

- Give as much of the information as they can that health plan and its providers need in order to provide care.
- Follow plans and instructions for care that they have agreed to with their providers.
- Try to understand their health problems.
- Work as much as possible with their healthcare providers to develop treatment goals they can agree on.
- Try to keep healthy habits, such as exercising, not smoking, and eating a healthy diet.
- Disclose relevant information. Members must try to communicate clearly what they want and need.
- Avoid knowingly spreading disease.
- Understand their healthcare provider's obligation to provide care equally and efficiently to other patients and the community.
- Learn about their health plan coverage and options, including all covered benefits, limitations and exclusions, and rules about the use of information.
- Understand how to appeal coverage decisions.
- Show respect for other patients, health workers, and health plan employees.

Responsibilities *(continued)*

- Make a good-faith effort to meet financial obligations.
- Follow the administrative and operational procedures of their health plan and healthcare providers.
- Report wrongdoing and fraud.

Section 6: Non-English-speaking Members

Member Communications

To better serve members who do not speak English, we offer translation services. We let members know about this service through member communications and personal correspondence.

The member information we provide offers particulars about how to access services, a description of covered and non-covered services, grievance procedures and customer service information.

Language Translation Line

Our customer service representatives make every effort to help members on a one-on-one basis over the telephone. They can also develop correspondence in many languages.

We prefer telephone contact for a more personalized approach. This method also permits members to ask questions about their plan. We offer a language translation line, which expands our translation capabilities to 140 languages. For more information, please call Customer Service at 877-342-5258, option 2, or the number listed on the back of the member's ID card.