

6 Member Eligibility and Coverage

Description This chapter provides information about member eligibility and coverage.

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Important: Our Customer Service department provides information about member eligibility status and benefits plan coverage. Please note: 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 coinsurance or deductible. Members are also responsible for the costs of non-covered services and amounts beyond their program's maximum 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.
- 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.
- Non-covered Services** Members are responsible for the payment of services not covered by their contracts. Non-covered services (services that are not dentally necessary or not a covered benefit) can vary based on the member's plan. To verify if a service is covered, call the member's plan (phone number on back of ID card) to request a description of general benefit information or you may submit a predetermination of benefits.

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 dentally necessary would be the provider's financial responsibility.

Section 2: Eligibility and Coverage

Maximizing Member Benefits Decisions on where and how to provide care are best made by the dentist, or another healthcare 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 via one of the following:

- Online at our provider portal
- 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/ak/provider: Our secure provider portal offers the quickest method to contact us, and obtain secure, personalized, and easy-to-use information. You can verify member eligibility, including plan effective dates and basic demographic information. You can also obtain the status of a claim.

By visiting Premera's secure provider portal, you can obtain information about:

- **Eligibility and Benefits** – information about members, including deductible, and benefit limit accumulators.

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
- Benefits
- Claims status
- Billing
- Claims payment

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

Interactive Voice Response Unit (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 dentist's tax ID number to obtain eligibility, general benefit information, and claims information. Information available on the IVR system varies per plan.

Tips for IVR Use:

- Key in or say the member's identification number. The IVR will then prompt you for the member's date of birth. If you choose to key in the member's date of birth, enter the month (using two digits), day (using two digits), and year (using four digits). Do not use commas, 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.

Verifying Eligibility and Benefits
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- 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 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.

Contact IVR toll-free at 800-722-4714, option 2.

Waiting Periods

Dental plans may have waiting periods for Basic and Major services that must be satisfied before claims for these services will be paid. The length of the waiting period varies by contract. Waiting periods may be reduced or eliminated based on a member's prior coverage. If a dental plan includes an orthodontia rider, a waiting period would apply.

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

Exclusions and Limitations

Benefit plans typically have exclusions and limitations—services and supplies that plans do not cover. The following list is an example of some of the services that are excluded from our dental plans:

- Altering vertical dimension
- Behavior/patient management
- Cleaning of appliances
- Completion of claim form
- Duplicate appliances
- Duplicate x-rays
- Infection and bacterial control supplies
- Facility charges for dental procedures (except for members meeting certain medical criteria)
- Missed or broken dental appointments
- Personalization of appliances
- Plaque control programs (oral hygiene, dietary, and nutritional instruction/counseling)
- Precision attachments
- Supplies and material

Note: Plan limitations and exclusions 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.



Section 3: 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 dentists, 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



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

Premera processes member complaints and/or appeals. When a dentist 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 dental review, the complaint is reviewed by our professional dental 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, and the reasons, 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.

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 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

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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.

The appeal process for contracted dentists is handled through the “Provider Dispute Resolution” process. For more information, see **Chapter 7: Claims and Payment**.



Section 4: Member Rights and Responsibilities

Description A strong dentist-patient relationship benefits everyone involved in patient care. To promote that relationship, member benefit booklets for 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.

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.
- 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 5: 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 the number listed on the back of the member's ID card.