Claims Payment Policies & Other Information

Use This Document Along with Your Summary of Benefits and Coverage

Your healthcare product is an Exclusive Provider Organization (EPO).

What that means to You is services **must** be provided by an In-Network Provider to be covered except for Emergency Services and certain Mental Health office visits. You may pay 100% of the Out-of-Pocket Cost up to Your Out-of-Pocket Maximum for these limited Covered Services provided by Out-of-Network Providers.

In-Network

- Means a Hospital, Pharmacy, Physician, or other provider of medical services and supplies participating under a contract with Us as named in the provider directory.
- Such In-Network Provider will bill Us directly for Covered Services You receive. However, You are responsible for amounts incurred for Non-Covered Services or in excess of any Benefit limits of the Contract, as well as any applicable Cost-Sharing.

Out-of-Network

- Means a Hospital, Physician or other provider of medical services and supplies that does not have a contract to provide services at negotiated rates for Your coverage under an In-Network Provider contract with Us.

When accessing health care services, there are many items to consider determining if the services will be covered by your plan.

- The service must be considered a Covered Service and not excluded.
- The service must be considered Medically Necessary for You.
- The service must be provided by an In-Network Provider.
- The service may be subject to other rules when your claim is processed. Examples of such rules may include clinical edits (i.e., if the service is appropriate for your age or gender), medical policy limits, or provider reimbursement rules.

If a health care service is covered, You may still be required to pay Cost-Sharing for that service. Cost-Sharing may include a Deductible, Coinsurance, or Copayment.

- Deductible is the amount You will pay for a service before Blue KC pays.
- Coinsurance is a percentage You will pay for a service. This is based on the Allowable Charge.
- Copayment is a flat dollar amount that You will pay for a service.
- Your Cost-Sharing will stop once You reach Your Out-of-Pocket Maximum for the year (i.e., the most You will be required to pay for Covered Services in a single Calendar Year).

Medical Necessity

- Means services and supplies which Blue KC, utilizing additional authoritative sources of information and expertise, determine are essential to the health of a Covered Person:
    - Appropriate and necessary for the symptoms, diagnosis, and treatment of a medical or surgical condition.

Blue Cross and Blue Shield of Kansas City is an independent licensee of the Blue Cross Blue Shield Association

    - In accordance with Blue KC local medical policies, and the medical policies of Blue KC Delegates, which are consistent with acceptable medical practice according to the national Blue Cross and Blue Shield Association's uniform medical policy.

- Medically necessary and appropriate care helps ensure that you receive the right type of care, in the right place, and for the proper length of time. Medically necessary and appropriate care:
    - Must be generally accepted as medical practice standards
    - Must be clinically appropriate in type, frequency, extent, site, and duration
    - Must be considered effective for your illness, injury, or disease
    - Must not be for your or your provider's convenience
    - Must not be more costly than another service that may give you similar results

- No benefits will be provided unless it is determined that the service or supply is medically necessary and appropriate. If we denied coverage of a service or claim, you have the right to appeal the denial decision. More information about this process is included in the benefit booklet that you will receive after you enroll.

Prior Authorization

- Means the procedure whereby Blue KC determines:
    - Based on medically recognized criteria, whether or not an Admission to a Hospital as an inpatient is reasonable for the type of services to be received; or,
    - whether any service to be performed is reasonable and Medically Necessary for the condition being treated and the type of services to be provided, or
    - a certification made pursuant to a Prior Authorization Review or notice as required by Us or utilization review entity prior the provision of health care services.

Prior Authorization Review

- Means Utilization Review conducted prior to an Admission or a course of treatment, including but not limited to pre-admission review, pretreatment review, Utilization Review, and Case Management.

Retrospective Review

- Means Utilization Review of Medical Necessity that is conducted after services have been provided to a patient. Does not include the review of a Claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

Concurrent Review

- Means Utilization Review conducted during a Covered Person's Hospital stay or course of treatment.

Case Management

- Means a method of review whereby a Covered Person's health, or catastrophic or complex health problem or general health is evaluated, and a plan of care is developed and implemented which meets that Covered Person's particular needs and is the most cost effective.

Covered Drugs

- We provide Benefits for Outpatient Prescription Drugs as identified in the Benefit Schedule. To determine the applicable category and respective Cost-Sharing level for a drug, call the telephone number listed on Your ID card for a copy of the Prescription

Drug List. You may also visit Our website at www.BlueKC.com for the most current information. The list of drugs is subject to change without prior notice. Any changes will be based on the recommendations of community Physicians and pharmacists.

How to File a Claim

- Hospital and Other Facility Services
    - In-Network or Participating Providers will file Your Claims for You. The facility will be paid directly by Us. You may be asked to make arrangements with such a facility to pay for any non-Covered Services or Cost-Sharing amounts.
    - If You receive care from an Out-of-Network Provider that is Non-Participating, it will be Your responsibility to make payment arrangements with the facility. Some of these Providers will submit Your Claim for You. If not, You can obtain a Claim form from Our Us. You can do so by calling the telephone number listed on Your ID card. The form will give You instructions for filing the Claim. If such forms are not furnished to You within 15 days after Your requesting the forms, You will have complied with the requirements of this Contract as to proof of loss upon submitting, within the required time period herein mentioned for filing Claims, such other written proof covering the occurrence, the character, and the extent of the loss for which Claim is made.

- Physician Services
    - In-Network or Participating Providers will file Your Claim for You. The Physician will be paid directly by Us. After the Physician receives Our payment, the Physician may bill You for any non-Covered Services or Cost-Sharing amounts for which You are responsible.
    - Out-of-Network Physicians who are Non-Participating will sometimes file Your Claim for You. If such a Physician declines to file Your Claim for You, You can obtain a Claim form from Us. You can do so by calling the telephone number listed on Your ID card. The form will give You instructions for filing the Claim. If such forms are not furnished to You within 15 days after Your requesting the forms, You will have complied with the requirements of this Contract as to proof of loss upon submitting, within the required time period herein mentioned for filing Claims, such other written proof covering the occurrence, the character and the extent of the loss for which Claim is made.

- Services Received from Providers other than Hospitals, Physicians, and Facilities
    - It is necessary for You to file a completed Claim form with Us for these services. Contact Us at the telephone number listed on Your ID card for the proper Claim forms. The form will give You instructions for filing the Claim. If such forms are not furnished to You within 15 days after Your requesting the forms, You will have complied with the requirements of this Contract as to proof of loss upon submitting, within the required time period herein mentioned for filing Claims, such other written proof covering the occurrence, the character and the extent of the loss for which Claim is made.

- Time Limits for Filing Claims
    - We must receive proof of a Claim for payment for Covered Services no later than 365 days after the end of the Calendar Year in which the service is received. We will deny any Claim not received within this time limit. We will extend the 365 day limit if it was not reasonably possible to give notice of proof within this time.

- Processing of the Filed Claim
    - We make Our Claim payment decisions based on the information We have when We receive a Claim. We make every effort to process Claims as quickly as possible. Claims will be paid immediately upon receipt of due written proof of loss. If We deny all or part of Your Claim, We will send You an Explanation of Benefits form or a letter. This will explain why it was denied under the terms of the Contract. We will also notify You if additional information is necessary to process the Claim. Payment of Claims for Covered Services received from Non-Participating Providers will be payable to the Covered Person.

- Claim Forms
    - You may request Claim forms from Us by calling the telephone number listed on Your ID card. If such forms are not furnished to You within 15 days after You request them, You shall be deemed to have complied with the requirements of this policy as to proof of loss if You submit written proof within the Time Limits for Filing Claims. This proof must cover the occurrence, the character, and the extent of the loss for which the Claim is made.

Grace Period

- If You do not Qualify for an Advance Payment of Premium Tax Credits
    - You shall have a grace period of 31 calendar days for the payment of any Premium due except the first. During this time the Contract shall continue in force. In no event shall the grace period extend beyond the date the Contract terminates. The Contract will automatically terminate at 11:59 p.m. on the last day of the period for which Premiums have been paid if the grace period expires and any Premium remains unpaid.

- If You Qualify for an Advance Payment of Premium Tax Credits
    - If You qualify for an Advance Payment of Premium Tax Credit through the Health Insurance Marketplace and provided You paid Your initial first month's Premium, then You shall have a grace period of 3 months for the payment of any Premium due except the first. During this time, the Contract shall continue in force. In no event shall the grace period extend beyond the date the Contract terminates. The Contract will automatically terminate at 11:59 p.m. on the last day of the first month of the grace period if the grace period expires and any Premium remains unpaid.

Need help:

- If You have any questions, comments, or concerns, call Blue KC Customer Service at the phone number listed on Your member ID card. They are available Monday through Friday from 8 a.m. to 8 p.m. Central Time.

- In addition, You are encouraged to register with **MyBlueKC.com** as a member today. It's quick and easy. Simply use the information from Your Blue KC member ID card to gain access to Your MyBlueKC.com portal. Your portal allows You to manage Your personalized information and take advantage of the tools and resources available from Blue KC to help You achieve your best health.