TIPS ON OBTAINING OUT-OF-NETWORK SERVICES THROUGH YOUR MANAGED CARE HEALTH INSURANCE PLAN

Overview of Managed Care Health Insurance Plan Operations and Terms to Know Managed Care Health Insurance Plans (MCHIPs) offer a network of preferred or participating providers. These participating providers and your MCHIP have contracted with each other to offer services to MCHIP members at a predetermined rate of payment. The set charges agreed to in the contract allow your MCHIP to better manage costs incurred by its members. The MCHIP member receives greater coverage benefits by using the MCHIP's participating providers. Some MCHIPs, such as HMOs, require the member to receive services from participating providers in order for the member to receive any coverage benefits, except in emergency or extraordinary cases. Others, such as PPOs and point-of-service plans offer greater coverage benefits (In-Network benefits) when the member utilizes participating providers, but members can choose to receive care from non-participating providers at a reduced level of benefits (Out-of-Network benefits). For specialty services, some PPOs or point-of-service plans might require a referral from the member's participating primary care physician to a participating specialist in order for the member to receive services at the In-Network benefit level. Make sure to read your Evidence of Coverage provided by your MCHIP to determine whether or not you must receive a refferal obtain specialist services at the In-Network benefit level.

When you decide to receive services Out-of-Network In some circumstances, an MCHIP member may believe it is to his or her advantage to receive care from a non-participating provider. This could be because of the proximity, ease of location, or possibly the member believes the non-participating provider will be better able or be better equipped to meet his or her medical needs. For example, suppose an MCHIP member develops a rare illness. The participating providers within the MCHIP's network may have not had much experience treating this particular illness, but the member has heard of a specialist in another state that has had much success treating this illness. The member requests to be able to go to the non-participating provider and receive benefits as if the provider participated in the MCHIP network. If the member is covered by a PPO or point-of-service plan, the member is entitled to receive benefits covered under his or her policy from the non-participating specialist at the Out-of-Network benefit level. In an HMO, the member may be able to formulate an effective appeal that would allow him or her to receive authorization for services from a non-participating provider, at the In-Network level of benefits.

Be careful of charges over and above the Usual, Customary and Reasonable (UCR) charge
(PPOs and Point-of-service Plans - Out-of-Network Benefits)
The usual, customary and reasonable charge, often referred to as UCR, has many other names: allowable charge, eligible expenses, covered expenses, etc. It generally means the provider's usual charge for the particular service, or the charge determined by your MCHIP in its sole discretion to be the covered charge, whichever is less. If the provider is a participating provider, it will be the contractually agreed upon rate. If your MCHIP offers coverage for services received from non-participating providers, make sure you know what will be covered before the services are rendered. For example, your plan may offer to pay 70% UCR when you visit a non-participating provider. You should be aware that this generally does not mean the plan will pay 70% of your entire bill. UCR is determined by the MCHIP, and is developed using much of the same pricing information the MCHIP uses to develop rates it pays to its participating providers. The MCHIP may use such factors as the rate the plan would pay to one of its participating providers to provide the service, the region in which the services are delivered, the product type under which the services are rendered, and the circumstances under which the services are delivered.

Your MCHIP's UCR determination can be well below the actual billed charge. For a large bill, it would not be uncommon for the difference between the billed amount and UCR to be several thousand dollars. For example, you may receive services with a billed charge of $8,500. Assume your plan pays 70% coinsurance for most Out-of-Network services. Your MCHIP will pay 70% of UCR, not 70% of the actual billed charge. Your responsibility then, is 30% UCR and all amounts over UCR. If your MCHIP determines the UCR is $6,000 for the service, your payment responsibility will be calculated as follows:

> $6,000 x 30% = $1,800 (your coinsurance share)
> $8,500 - $6,000 = $2,500 (amount over UCR)
> Your payment responsibility for this service would be: $1,800 + $2,500 = $4,300

In this example, your payment responsibility of $4,300 of a $8,500 billed charge is actually closer to 50% than 30%. You should also be aware that, in general, any amounts you pay for charges over UCR do not contribute to your deductible or out-of-pocket maximum.

<u>Request for Preauthorization to visit a Non-participating Provider</u>

If you are covered by an HMO, and you believe you require services from a non-participating provider, you will need to request preauthorization. Here are some suggestions as to what to include in your request:

A recommendation from a participating provider - An effective appeal may be built if you visit a participating provider to discuss your treatment. After discussion, you may find that the participating provider is equipped to handle your situation. If not, the participating provider may recommend that you be treated by the non-participating provider you are requesting. The participating provider can write a letter to the MCHIP on your behalf giving the medical reasons why the requested provider would be better able to treat your condition.

Adequacy of existing provider network - If the only choice you are being given to visit a participating provider is a substantial drive and you know of a non-participating provider who has a practice close to where you live or work, or if an appointment with a participating provider cannot be made in a timely manner, you should add this information to your appeal. If your illness prohibits you from traveling the distance or waiting the length of time needed in order to visit a participating provider, include this information in your appeal.

If your request remains denied: There are options even if you do not win your appeal. If you still wish to obtain services from the non-participating provider, you can contact the non-participating provider and request that you be able to receive services at a discounted rate. If this is not an option, you should at least get a clear determination from the provider of the actual charge for the services before you begin treatment. If you have concerns about your MCHIP's provider network adequacy, you may contact the Center for Quality Health Care Services and Consumer Protection at (800) 955-1819 (toll-free in Virginia), or (804) 367-2102.

For assistance with your appeal, you may contact:

Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218

Toll-Free: (877) 310-6560
Local: (804) 371-9032
E-Mail: Ombudsman@scc.virginia.gov
Website: http://www.scc.virginia.gov