

Chapter 4. Membership and Benefits Information

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4.1 Verifying Eligibility

4.1.1 How to Identify a Member

Providers may verify that a patient is an eligible Highmark West Virginia member or FreedomBlue® member by:

- Asking to see the member's ID card;
- Contacting Highmark West Virginia Customer Service at 1-800-543-7822 or 1-800-535-5266 (Federal Employee Program); or
- Accessing eligibility information via NaviNetSM.

For BlueCard® members (i.e. members of a Blue Cross or Blue Shield plan other than Highmark West Virginia), you may verify eligibility through the member's home plan by contacting 1-800-676-BLUE (2583).

For a service to be reimbursable by Highmark West Virginia, the patient must be eligible under a Highmark West Virginia policy *on the date the service is provided*. Although each member should present his/her ID card upon request for service, this card was issued at the time of enrollment or when the group last changed its benefits, and thus does not ensure current eligibility. If you have any question about a patient's current eligibility, you should call Customer Service as close to the date of service as possible.

4.1.2 Limitations

It is the member's responsibility to timely notify his/her employer of eligibility changes (e.g. divorce, loss of student status), and the group's responsibility to notify Highmark West Virginia timely of such changes. Highmark West Virginia cannot accurately verify eligibility if the member or group does not timely notify us of eligibility changes.

On rare occasions, an insured group may be terminated retroactively by Highmark West Virginia for nonpayment of premiums (groups are allowed at least a 30-day grace period for payment of premiums). Similarly, a self-funded group may be terminated retroactively for nonpayment of claims or administrative expenses. In both cases, eligibility of the members is terminated as of the date the group is terminated. In all cases, a provider may bill the patient directly for the cost of any services provided after the effective date of termination. Also, Highmark West Virginia may terminate an individual member retroactive to the last day of the month the individual was eligible.



4.1.3 Identification Cards

All Highmark West Virginia members receive an identification card so that you may easily identify them and have important information about their coverage. The cards are different for each type of plan. In addition, there may be variations on cards depending on the employer group or benefit package.



It is important to note that with the name change from Mountain State Blue Cross Blue Shield ("Mountain State") to Highmark Blue Cross Blue Shield West Virginia, our members will continue to carry their Mountain State identification cards for an undefined period of time, but will gradually be transitioned to new ID Cards bearing our new company name and logo. As new cards are distributed they will be easily identified with the Highmark Blue Cross Blue Shield West Virginia branding.

Samples of PPO (SuperBlue Plussm), POS (SuperBlue Selectsm), indemnity (New Bluesm), Medicare Advantage PPO (FreedomBlue®) and Federal Employee Program member ID cards are shown below.

SuperBlue Plussm PPO↓

 <p>MOUNTAIN STATE Blue Cross Blue Shield A HIGHMARK AFFILIATE <small>An Independent Licensee of the Blue Cross and Blue Shield Association</small></p>  <p>RX GROUP NUMBER: MSBCBS1 medco For Prescription Drug Inquiries Please Call 1-800-820-9730</p> <p>SUPERBLUE Plus</p> <p>FIRSTNAME LASTNAME ID# ZPN109465762001 GRP# 09012345</p> <p>COPAY OV \$10 SP \$10 ER \$0</p> <p>BC Plan 443 BS Plan 943</p>	<p>Member Service/Benefit Questions: Call 1-888-809-9121</p> <p>Providers: All claims should be submitted to your local Blue Cross and/or Blue Shield plan.</p> <p>To Receive High Level Benefits: You must receive care from a network provider. If you choose to receive care through an out-of-network provider, for other than emergency care, you will receive payment at a reduced level of benefits.</p> <p>For Pre-Certification of Services: Mental Health/Substance Abuse call 1-800-344-5245 before an admission; all other admissions call 1-800-344-5245</p> <p>Member Submitted Claims: If the provider does not submit your claim to their local Blue Cross/Blue Shield plan, send your claim to Mountain State Blue Cross Blue Shield, P.O. Box 7026, Wheeling, WV 26003-7026.</p> <p>www.msbcbs.com BT0448</p>
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SuperBlue Selectsm POS↓

 <p>MOUNTAIN STATE Blue Cross Blue Shield A HIGHMARK AFFILIATE <small>An Independent Licensee of the Blue Cross and Blue Shield Association</small></p>  <p>RX GROUP NUMBER: MSBCBS1 medco For Prescription Drug Inquiries Please Call 1-800-820-9730</p> <p>SUPERBLUE Select</p> <p>FIRSTNAME LASTNAME ID# ZPW109465762001 GRP# 09012345 PCP/PCP NAME HERE , MD</p> <p>COPAY PCP \$0 SP \$0 ER \$0</p> <p>BC Plan 444 BS Plan 944</p>	<p>Member Service/Benefit Questions: Call 1-800-344-4767</p> <p>Providers: All claims should be submitted to your local Blue Cross and/or Blue Shield plan.</p> <p>Blues On Call: Call 1-888-BLUE-428 for 24-hour access to nurses who provide health education and support services.</p> <p>Emergencies: Must contact PCP first unless life threatening. Notify your PCP within 48 hours or as soon as reasonably possible for follow up care.</p> <p>For Pre-Certification of Services: For Mental Health/Substance Abuse call 1-800-344-5245, for all other admissions call 1-800-344-5245</p> <p>To receive maximum coverage, all medical care must be provided or authorized by your Primary Care Physician (PCP). If not coordinated by your PCP, the level of benefits will be reduced.</p> <p>Member Submitted Claims: If the provider does not submit your claim to their local Blue Cross/Blue Shield plan, send your claim to Mountain State Blue Cross Blue Shield, P.O. Box 7026, Wheeling, WV 26003-7026.</p> <p>www.msbcbs.com BT0455</p>
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NewBlueSM Indemnity ↓

 <p>MOUNTAIN STATE Blue Cross Blue Shield A HIGHMARK AFFILIATE <small>An Independent Licensee of the Blue Cross and Blue Shield Association</small></p>	 <p>RX GROUP NUMBER: MSBCBS1 medco For Prescription Drug Inquiries Please Call 1-800-820-9730</p>	<p>Present this card to the provider at the time of service.</p> <p>Providers: All claims should be submitted to your local Blue Cross and/or Blue Shield plan.</p> <p>Member Service/Benefit Questions: Call 1-888-809-9121</p> <p>For Pre-Certification of Services: For Mental Health/Substance Abuse call 1-800-344-5245, for all other admissions call 1-800-344-5245</p> <p>Member Submitted Claims: If the provider does not submit your claim to their local Blue Cross/Blue Shield plan, send your claim to Mountain State Blue Cross Blue Shield, P.O. Box 7026, Wheeling, WV 26003-7026.</p>
<p>FIRSTNAME LASTNAME ID# ZPW109465762001 GRP# 09012345</p>		
<p>BC Plan 444 BS Plan 944</p>		<p>www.msbcbcs.com BT0440</p>

FreedomBlue[®] Medicare Advantage PPO ↓

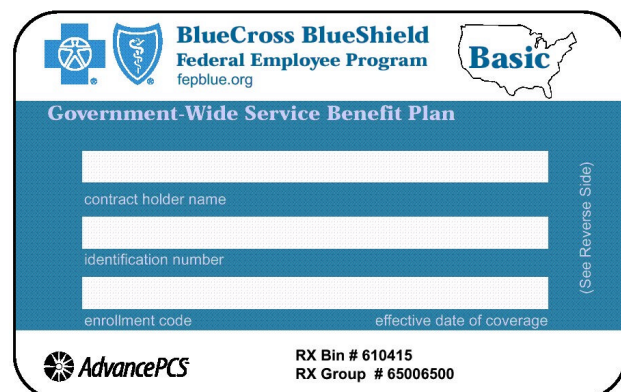
 <p>HIGHMARK FREEDOM BLUE A Medicare Advantage PPO from Highmark Health Insurance Company <small>Highmark's Health Insurance Company is an Independent Licensee of the Blue Cross and Blue Shield Association</small></p>	<p>MEDICARE ADVANTAGE PPO</p>	<ul style="list-style-type: none"> • For additional information, call Member Service at 1-888-459-4020. Hearing impaired TTY users, call 1-800-855-1155. • To receive the highest level of benefits, you must receive care from a network provider. If you choose to receive care through an out-of-network provider, for other than emergency care, urgently needed care or renal dialysis services, you will receive payment at a reduced level of benefits. • In an emergency, go to the nearest emergency room or call 911 or your local emergency number for help. • Out-of-Network Pre-Certification: You or your provider must call 1-800-344-5245 prior to any elective admission, elective outpatient surgery, outpatient rehab therapy, home health care, oxygen supplies, non-emergency ambulance transport and diabetes self-monitoring training. For out-of-network mental health and substance abuse services, call 1-800-344-5245 and select the Behavioral Health option from the menu. • Providers: All claims should be submitted to your local Blue Cross and/or Blue Shield plan. Medicare charge limitations may apply.
<p>MEMBERFST LASTNAME ID# ZPM109465762001 GRP# 01900005</p>		
<p>COPAY OV \$20 ER \$50</p>		
<p>BC Plan 443 BS Plan 943</p>		<p>www.highmark.com BT0505</p>

Federal Employee Program (FEP) ↓

PPO



Basic



4.1.4 Anatomy of an Identification Card

Front

- **Product name and logo, (e.g. SuperBlue Plussm, FreedomBlue®):** This will help you determine which plan rules to follow.
- **Pharmacy program:** This will be on the top right of the ID card (or at the bottom for Medicare Advantage plans) whenever a Highmark West Virginia prescription drug program is included.
- **Suitcase logo:** indicates a member of the BlueCard® program. For more information, please see the BlueCard® provider manual on the Highmark West Virginia website at www.highmarkbcbswv.com under

the Provider tab and then select “Resource Center.”

- **Member name:** The individual member’s name will appear here. Verify that you have the card that corresponds with your patient and not that of another family member/dependent.
- **Identification number:** Unique Member Identifier (UMI). The alpha prefix varies by employer group or account (not applicable to Medicare Advantage products).
- **Group number:** Most often, this will be a number assigned to the group. Sometimes it will be an alpha prefix followed by a number.
- **PCP:** For POS only. If a valid primary care physician (PCP) is chosen, the PCP’s name will appear in this field.
- **Copay:** PCP, specialist office (SP), office visit (OV), and emergency room (ER) co-payments are listed when applicable. Pharmacy co-payments are not listed. Network pharmacies can verify co-payment amounts online. Specialist co-payments do not apply to behavior health care specialists. Those co-payments may be found via NaviNetSM or the Member Services telephone number on the back of the ID card.

Back

The back of the member’s identification card contains information for both the member’s and provider’s use. Different products will have different information on the card. Types of information that may be useful to providers are described below.

Member Service/Benefit Questions: A Member Services telephone number is shown. Either the member or provider may call this number to check on benefits or eligibility.

For Pre-Certification of Services: Telephone numbers are given for pre-certifying mental health/substance abuse admissions and all other types of admissions.

Blues On Call: Gives a telephone number that members may call for information about Highmark West Virginia’s disease management programs, for general health information, or to speak with a health coach.

Providers: Advises providers that, generally, all claims should be submitted to the local Blue Cross and/or Blue Shield plan with which the provider contracts. Please see Chapter 7 of this *Provider Manual* or call Office of Provider Relations for guidance regarding submission of claims in contiguous counties to West Virginia for situations where the provider contracts with more than one Blue Cross and/or Blue Shield plan.

Self-Funded Accounts: Advises providers that Highmark West Virginia provides administrative claims payment services and does not assume any financial risk or obligation with respect to claims.

4.2 Benefit Information

Providers may obtain information about what benefits are covered and what copayments or deductibles apply for a particular member by contacting the Highmark West Virginia Customer Service telephone number on the back of the member's ID card. This information may also be accessed through NaviNetSM.

If you do not have access to the ID card, you may call Customer Service at 800-543-7822.

4.3 Member Rights and Responsibilities

4.3.1 Member Rights and Responsibilities for Medicare Advantage

Members in FreedomBlue® Medicare Advantage PPO plans are informed through their Evidence of Coverage that they have certain rights and responsibilities.

Members have the right to:

1. Not be discriminated against because of race, color, age, religion, national origin, or mental or physical disability.
2. To receive help with communication, such as help from a language interpreter.
3. Be treated with dignity, respect, and fairness at all times.
4. Privacy of medical records and personal health information. Generally, health information will not be released to anyone who is not providing or paying for the member's care without written permission from the member, except where allowed or required by law.
5. Review and obtain copies of medical records, and to ask providers to make additions or corrections to the records.
6. Obtain care from network and non-network providers. To choose a network provider (and be informed which physicians are accepting new patients). To see a women's health specialist (such as a gynecologist) without a referral or prior authorization.
7. Timely access to providers and to see specialists when care from a specialist is needed. "Timely access" means to get appointments and services within a reasonable amount of time.
8. Get full information from providers when obtaining medical care and to participate fully in decisions about their care. Providers must explain things in a way the member can understand. The member's rights include knowing about all of the treatment choices that are recommended for the member's condition, regardless of

- cost or coverage. This includes the right to be told about any risks involved. Members must be told in advance if any proposed treatment is part of a research experiment, and be given the choice of refusing experimental treatments.
9. Refuse treatment, including the right to leave a hospital or other medical facility against a physician's advice, and to stop taking medication. The member accepts responsibility for the consequences of refusing treatment.
 10. Ask someone, such as a family member or friend, to help make health care decisions. This includes executing advance directives, such as a living will or power of attorney for health care, or to authorize someone to make decisions in the event the member becomes unable to make decisions for himself/herself.
 11. Make a complaint if the member has concerns or problems related to coverage or care.
 12. Get information about Highmark Health Insurance Company ("HHIC") which offers the FreedomBlue® product, health care coverage and costs and network providers. Members may contact Member Services to request the following types of information:
 - What services are covered and what the member has to pay;
 - Explanation of any bills for services not covered;
 - HHIC's financial condition;
 - Network providers and their qualifications;
 - How FreedomBlue® pays physicians;
 - Member rights and protections; and
 - Summary of appeals and grievances FreedomBlue® has received.

Member Responsibilities

Members have the responsibility to:

1. Become familiar with their coverage, the rules they must follow to obtain care, and what they have to pay.
2. Give their physician and other health care providers the information they need to provide care. To follow the treatment plans and instructions that the member and his/her physicians agree upon. To ask questions of their physician or other provider if they have them.
3. Act in a way that supports the care given to other patients and helps the smooth operation of the physician's office, hospital or other office.
4. Pay plan premiums and any copayments the member owes for covered services they receive.
5. To contact Highmark West Virginia Member Services with any questions, concerns, problems or suggestions.

4.3.2 Member Rights and Responsibilities for Point of Service Plans

Members have the right to:

1. Receive health care from their network provider in a timely manner and a medically appropriate setting.
2. Receive considerate and courteous care from their health care provider with respect for their personal privacy and dignity.
3. Receive all benefits to which they are entitled under SuperBlue Selectsm.
4. Considerate and courteous services from SuperBlue Selectsm and accurate, timely, and clear responses to their inquiries.
5. Select their personal physician from the SuperBlue Selectsm PCP network.
6. Expect their PCP's team of health care staff to provide or coordinate all care that they need.
7. Request and receive enough information to enable them to make informed decisions before they receive any recommended medical treatment.
8. Be well informed of their diagnosis and treatment plan in terms they understand.
9. Participate in decisions involving their medical care.
10. Reasonable access to appropriate medical services.
11. Be informed of available services, as well as where, when and how they can obtain these services.
12. Request and receive information from their health care provider, staff, and SuperBlue Selectsm to help them prevent illness and injury and maintain a healthy lifestyle.
13. Have their health care records kept confidential except when disclosure is required by law or permitted in writing by them with adequate notice.
14. Request and review their medical records with their health care provider.
15. Express a complaint to their health care provider or SuperBlue Selectsm and receive an answer to the complaint within a reasonable period of time.

Members have a responsibility to:

1. Treat all network providers and personnel with respect and courtesy as partners in good health care.
2. Talk openly with their physician and develop a physician-patient relationship based on trust and cooperation.

3. Coordinate all of their health care services through their PCP, unless otherwise specified.
4. Help maintain their own good health and prevent illness and injury.
5. Ask questions and make certain they understand the explanations and instructions they are given by their physician and SuperBlue Selectsm as applicable.
6. Consider the potential consequences if they refuse to comply with treatment plans or recommendations.
7. Keep scheduled appointments or give adequate notice of delay or cancellation.
8. Identify themselves as a member of SuperBlue Selectsm when scheduling appointments, seeking consultations with their health care provider and upon entering any network provider's office.
9. Read all program materials carefully and immediately after they receive them and to ask questions when necessary.
10. Help the network physicians maintain accurate and current medical records by being honest and complete when providing information.
11. Understand how to access health care in routine and emergency services situations.
12. Know their health care benefits as they relate to out-of-area coverage, deductibles, copayments, and coinsurance.
13. Express their opinion, concern, or complaints in a constructive manner to their health care provider, staff, or SuperBlue Selectsm member services.
14. Pay any applicable deductibles, copayments, and coinsurance at the time of service.
15. Furnish their health care provider and SuperBlue Selectsm any information about other health insurance coverage.

4.3.3 Rights of Members Receiving Case Management Services

Members receiving case management services from Highmark West Virginia are informed by letter at the initiation of services that they have the following rights:

1. Right to access needed health and social services.
2. Right to be informed of choices regarding services.
3. Right to be informed of available health care benefits, as well as where, when, and how they can obtain these benefits.
4. Right to treatment with dignity and respect.
5. Right to have their health care records kept confidential except when disclosure is required by law or permitted in writing by them with adequate notice.

6. Right to be well-informed of any treatment plan in terms they understand, and to have input regarding decisions involving their medical care and treatment plan.
7. Right to comprehensive and fair assessment, and notification of alternative approaches.
8. Right to receive notification and rationale of discharge, termination, or change of service.
9. Right to withdraw from a case management program.
10. Right to an appeal/grievance procedure.
11. Right to choose a particular community service agency or long-term care provider.
12. Right to refuse treatment or services, including case management services, and be informed of the implications of such a refusal relating to benefits eligibility and/or health outcomes.
13. Right to obtain information regarding the plan's criteria for case initiation and case closure.
14. Right to have informed consent for services, advance medical care directives (including end of life directives) and power of attorney documents to be followed in the case management process.
15. Right to have assistance in seeking additional resources for resolution of legal questions.
16. Right to have services/treatment rendered consistent with the Americans With Disabilities Act, worker's compensation and other laws protecting the rights of consumers as applicable.
17. Right to have alternative approaches to care if the member and/or family are not able to participate in the assessment process.

4.4 Senior Health Risk Questionnaire

New Medicare Advantage (FreedomBlue®) members receive a *Senior Health Risk Questionnaire* within 30 days of enrollment. The questionnaire is designed to be completed at home in about 15 minutes. There is a toll free number if the member needs assistance. Those members who do not return the survey promptly are followed-up with a second mailing and phone calls.

The questionnaire is administered by National Research Corporation, LLC. The questions address important factors that interact to create risk in the senior population. Key indicators include:

- Self-described health status;
- Prior utilization;

- Severe memory loss;
- Housing and family status;
- Significant depression;
- Multiple medications;
- Chronic diseases;
- Mobility limitations;
- Adult daily living limitations;
- Special equipment needed;
- Unexplained weight loss or gain; and
- Advance directives.

Completed surveys are analyzed and members with chronic conditions (diabetes, congestive heart failure, coronary artery disease, asthma, chronic obstructive pulmonary disease) or at other significant risk may be referred to the Blues on Call disease management/chronic care improvement program or to a case manager for further assessment.

Primary care physicians identified by members on the survey will receive a *Health Profile Risk Factor Report*. This report incorporates three validated risk probability scales: the PRA Score (probability of repeated hospital admission, University of Minnesota), Frailty Score (probability of long-term care needs) and Depression Scale Score. The report is presented in a user-friendly, one-page format. Providers are encouraged to use the data to:

- address members' immediate medical needs;
- prevent or reduce future healthcare episodes; and
- match members with programs and services that can improve their health and enhance their quality of life.

Members are also sent a letter about their survey results, and may contact their physician with questions.

4.5 Notice to Members of Provider Termination

Members in a POS plan and FreedomBlue® Medicare Advantage are issued a written notification when a PCP or specialist (for FreedomBlue® members only) has been terminated from the provider networks. Timely notice of these changes is important to the member to allow selection of a new PCP or to make arrangement for future services provided by specialists. Please keep Highmark West Virginia notified of all changes related to your participation status.

4.6 Confidentiality of Member Information

4.6.1 Provider Responsibility to Protect Confidentiality

Network providers are obligated to protect the confidentiality of their Highmark West Virginia and FreedomBlue® members' patient information and medical records. More specifically, providers must:

- Comply with all federal and state laws and regulations regarding confidentiality and disclosure of patient information, medical records and other health information;
- Establish procedures for the maintenance, storage, security and use of patient information and records that preserve confidentiality and protect against unauthorized disclosure; and
- Provide members timely access to the records and information that pertain to them consistent with applicable laws.

Highmark West Virginia may verify that procedures are in place as part of an onsite review or audit of a network provider.

4.6.2 Highmark West Virginia's Privacy Practices

The Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") imposes restrictions on the use and disclosure of "protected health information" ("PHI"). Highmark West Virginia has adopted comprehensive policies and procedures to ensure compliance with this law and related regulations.

Highmark West Virginia's privacy practices are described in a Privacy Notice which can be found on our website at www.highmarkbcbswv.com. Click on the "Privacy Policy" link at the bottom of the homepage.

Highmark West Virginia will use or disclose PHI only as permitted or required by HIPAA. In general, this is the minimum information necessary for treatment, payment and health care operations. Examples of such activities include:

<ul style="list-style-type: none"> • Claims processing • Customer service • Eligibility determinations • Premium collection • Coordination of benefits • Appeals • Quality assessment and improvement 	<ul style="list-style-type: none"> • Utilization management • Care and Case management • Accreditation • Audits • Fraud and abuse detection • Underwriting • Business planning and development • Administrative and management
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<ul style="list-style-type: none"> • Disease management • Credentialing • Evaluating provider performance • Medical review 	<ul style="list-style-type: none"> activities • Legal services • Informing members of health-related services
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Highmark West Virginia has established extensive safeguards to protect the use of data it maintains. This includes establishing comprehensive policies and procedures for the protection and use of members' PHI, conducting privacy and security training for Highmark West Virginia employees, requiring employees to sign statements in which they agree to protect member confidentiality, using computer passwords and firewalls to limit access to member PHI, and including confidentiality language in contracts with vendors and other business associates.

4.6.3 Provider Disclosure of PHI to Highmark West Virginia

HIPAA authorizes health care providers to disclose PHI to health plans such as Highmark West Virginia for payment purposes and health care operations. Neither the provider nor Highmark West Virginia is required under HIPAA to obtain specific authorization from the member for such purposes. Payment to a network provider for covered services is contingent upon the provider submitting to Highmark West Virginia any requested PHI. A provider may rely on Highmark West Virginia's determination of what is the minimum necessary PHI.

In some situations, providers may be subject to more stringent privacy and confidentiality laws (e.g. regarding disclosure of mental health, substance abuse, or HIV-related information). It is the provider's obligation to obtain any consents or releases necessary under such laws to disclose information requested by Highmark West Virginia or to otherwise meet the provider's obligations under its agreements with Highmark West Virginia.