blue of california

2014 DMHC/Blue Shield IFP Provider Directory Settlement Member Letter
FREQUENTLY ASKED QUESTIONS (FAQs)
December 2015

OVERVIEW

On Tuesday, November 3, 2015, the DMHC announced a settlement with Blue Shield on its Non-Routine Survey of Blue Shield's provider directories for non-grandfathered 2014 Individual and Family Plans (IFP). As part of the settlement, Blue Shield will notify certain ON and OFF Exchange Individual & Family plan members that they are eligible to resubmit out-of-network claims for covered services received in 2014 if they feel they were led to believe that their provider was in their plan's network. Should their claims qualify, Blue Shield will reprocess and pay them as if they were from an in-network provider.

Below please find FAQs that have been prepared for you to use in response to incoming questions from members regarding these letters and the claim re-submission process.

FREQUENTLY ASKED QUESTIONS

1) **What was the settlement about?** Blue Shield of California and the Department of Managed Health Care recently settled the enforcement action that followed the DMHC's November 2014 Final Report of Non-Routine Survey related to Blue Shield's 2014 IFP provider directories. Blue Shield did not agree with the DMHC's conclusions, but believes that the settlement is in the best interest of its members. As part of the settlement, Blue Shield agreed to pay a penalty, continue its longstanding efforts to educate providers, perform outreach to providers regarding their network participation, and continue to update its provider directory, as warranted. Blue Shield also agreed to send notice to certain IFP members identified as eligible under the settlement agreement that they may re-submit out-of-network claims for covered services in 2014 if they feel they were led to believe that their provider was in their plan's network by Blue Shield or the provider.

2) **What type of notification will members receive and when will it be distributed?** Blue Shield will mail a letter and claims review form to members who are eligible to resubmit 2014 claims for review under the settlement on or before December 31, 2015. We will also be notifying brokers with potentially-impacted members prior to distribution for informational purposes.

3) **How will these members know if they potentially qualify for the reprocessing of a claim?** Potentially-eligible members will receive a letter and claims review form. Members should send Blue Shield a completed claims review form for out-of-network covered services received in 2014 if they feel that they were led to believe their provider was in their Individual & Family Plan's network by Blue Shield or the provider. Should their claims qualify under the settlement, Blue Shield will reprocess and pay them as if they were from an in-network provider.

4) **What type of information must these members provide in order to resubmit a claim?** The Claims Review Form outlines the necessary information required for a member to resubmit claims for review. The key requirements members must provide are as follows:

- Identify the provider and dates of service, and *either* enclose an Explanation of Benefits, *or* provide the claim number so we may research the claim.
- Attest to the following:
  - Their provider was listed in Blue Shield's Find a Provider online provider directory as participating in their plan's network; someone at Blue Shield told them that their provider was in their plan's network; or their provider mistakenly informed them that he or she was participating in their plan's network.
  - They visited this particular provider because they believed he or she was in their plan's network based on this misinformation.
  - They have *either* already paid the provider, *or* that the provider is actively seeking payment from them. If they have not yet paid the provider, they must enclose the provider's most recent communication seeking payment, such as a letter or invoice.
- Include the source of, and approximate time frame in which they received the misinformation that led them to believe their provider was in their plan's network.

5) **What if the member needs help locating an EOB or claim number?** The claim number can be found on the Explanation of Benefits (EOB) for the claim. A member can retrieve the EOB from Blue Shield's member portal: www.blueshieldca.com.

6) **Can a member submit more than one claim for review?** Yes, members can resubmit more than one claim, however, they must use one claims review form per claim. The member letter will arrive with one printed claims review form and provide a link to a landing page where eligible members can download and print more if necessary. Here is the link to the landing page: Blue Shield Claims Review Form.

7) **Can a member resubmit a claim on behalf of another family member?** A parent or guardian may submit a claims review form for their minor child if the child is eligible and receives a letter from Blue Shield.

8) **Is there a deadline for resubmitting a claim?** Yes, claim review forms must be mailed by **February 12, 2016** in order to be considered for eligibility.

9) **Where should members send their claims to be resubmitted?** All claims review forms must be sent to: ***Blue Shield of California, PO Box 272600, Chico, CA 95927***

10) **Who should members contact if they need assistance?** Members can call member services at: (855) 836-9705 (on exchange members) or (888) 256-3650 (off exchange members).

11) **Will Blue Shield respond to all members who resubmit a claim whether they qualify or not?** Yes. Blue Shield will send notice as it reviews the claims review forms for eligibility. If members do not hear from Blue Shield regarding the status of their claims within 60 days of mailing Blue Shield a claims review form, they may contact Customer Service. For those who qualify for reprocessing, an adjusted Explanation of Benefits and notice will be sent no later than October 2016 as per the settlement.

12) **If a member qualifies, how will the reimbursement process be handled?** The claim will be reprocessed at the in-network benefit level, subject to any cost-sharing (deductible, copayment, coinsurance) applicable to in-network services. Any additional payment will be made to the individual or entity who received Blue Shield's initial claims payment when the claim was processed at the out-of-network benefit level.

13) **What if a member has already paid the provider more than the new member responsibility amount?** The provider should reimburse the member any amounts in excess of the new member responsibility. Blue Shield will send the member a notice following reprocessing that includes a number to call for assistance if the member is owed a refund from a provider and does not receive one.

14) **Does this mean that these out-of-network providers are now participating in the IFP Exclusive Network?** No. This is a one-time reprocessing of 2014 claims only, and does not affect a provider's in or out-of-network status going forward. Some providers who were out-of-network in 2014 may be in-network today, but others are still out-of-network. The settlement does not depend on the provider's current network participation status. The best way for a member to verify whether a provider is currently participating in his or her plan's network is to log-in as a member on Blue Shield's website before searching for a provider.

15) **What has Blue Shield done to improve its provider directories?** Throughout 2014 and 2015, Blue Shield worked hard to lessen the confusion in the provider community around the new networks built for the Covered California marketplace and to better communicate information about the networks to our members. We believe that the consumer experience in 2015 was vastly improved, and we will continue to help our members make informed decisions about their health coverage for 2016. The DMHC settlement agreement recognizes this and states that we will continue to engage in efforts to improve contracted providers' understanding of the IFP Exclusive PPO network in which they participate, improve the accuracy of provider information in Blue Shield's systems, and make it easier for members to access accurate information regarding participating providers.

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