CHAPTER 2:

Member Eligibility and Member Services

Reviewed/Revised: 9/24, 1/24, 5/25, 12/25, 04/26

2.0 ACA STANDARDHEALTH WITH HEALTH CHOICE MEMBER SERVICES DEPARTMENT

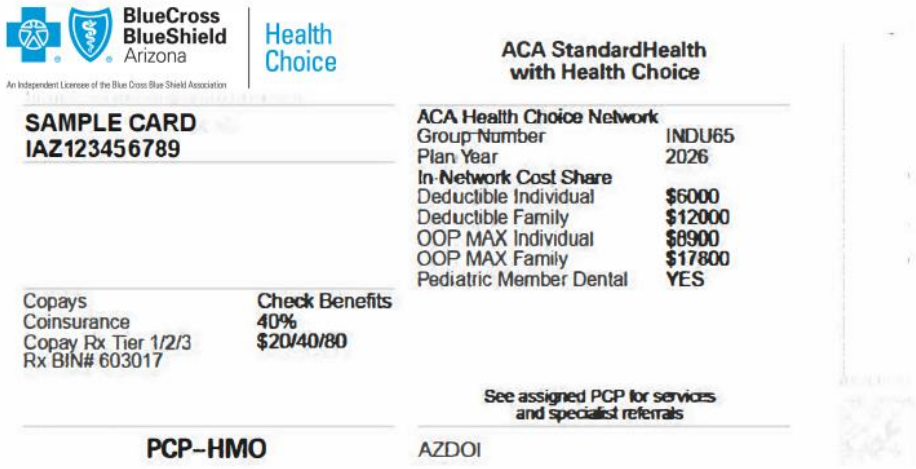
Our members and their medical care is very important to us. To ensure their needs are met, the ACA StandardHealth with Health Choice Member Services Department coordinates all membership activities. The primary functions of the Member Service Department include:

- Verification of member eligibility
- Primary care physician (PCP) assignment and changes
- General Health Plan questions
- Immediate Member issue resolution; referrals of other issues (grievances/complaints) to quality management for further investigation and resolution
- Conducting Member Satisfaction Surveys

The ACA StandardHealth with Health Choice Member Services Department is available from 8:00 AM to 5:00 PM, Monday through Friday (except holidays). Members will contact us at the number listed on their member ID card.

2.1 ELIGIBILITY AND MEMBER ID CARDS

ACA StandardHealth with Health Choice sample ID card:



Eligible enrollees ("members"): Each eligible member will receive an identification card that indicates the member's name, the member's identification number and assigned health plan. The ACA StandardHealth with Health Choice identification card does not guarantee eligibility.

Providers should request the member's identification card at the time of visit. **Services cannot be denied if the member does not have their ID card at the time of the appointment**. ACA StandardHealth with Health Choice recommends you ask for a second form of identification for members not known to you.

If a member loses their ID card they can call Member Services Department at 602-864-4115 or 800-232-2345 ext. 4115 M-F 8-5

NOTE: It is important to confirm the members' eligibility on the date of service

Members need to tell us about changes such as individuals being added to the benefit plan, alternate insurance coverage, address or phone number changes, other coverage that the member or their dependent's may add or lose, individuals removed from the dependent plan due to divorce or death, disability status of dependents.

Premium payment grace period

The grace period for premium payments varies depending on whether a member receives an advance premium tax credit.

No APTC

Members have a 31-day grace period to make the premium payment. ACA StandardHealth with Health Choice is not responsible or liable for any claims, including but not limited to pharmacy and medical claims, incurred during the grace period, unless ACA StandardHealth with Health Choice receives payment before the end of the grace period.

A premium not paid when due and not paid within the grace period is in default. If ACA StandardHealth with Health Choice provided prior authorization for a service during the grace period, that prior authorization is null and void if the plan is later retroactively terminated for non-payment of premium.

The member is responsible for all expenses incurred during the grace period if the plan is later retroactively terminated for non-payment of premium.

APTC

New ACA StandardHealth with Health Choice members are allowed a three-month grace period if the member has previously paid at least one full month's premium during the benefit year in which the non-payment of premium occurs.

Members renewing into the same product or plan and receiving advance payment of the premium tax credit will be allowed a total of a three-month grace period, including any months where premium was not paid at the end of the previous calendar year. Medical claims with dates of service during the second and third months of the grace period will be pended for payment of premium and denied if premium is not received by the end of the grace period. Retail and mail order pharmacy claims with dates of service during the second and third months of the grace period will be denied unless premium is paid by the end of the grace period.

ACA StandardHealth with Health Choice will provide the member with a notice of termination due to non-payment of premium at least 31 days prior to the last day of coverage.

2.2 ACCESSING BENEFIT PLAN INFORMATION

Providers can obtain member eligibility and benefit plan information through any of the following:

- **Electronic inquiries** through secure provider portals

- **HIPAA electronic transactions 270/271**
- **Phone inquiries,** by calling: Provider Services: 1-800-322-8670

Secure Provider Portal: Log in - Health Choice Provider Portal (healthchoiceaz.com)

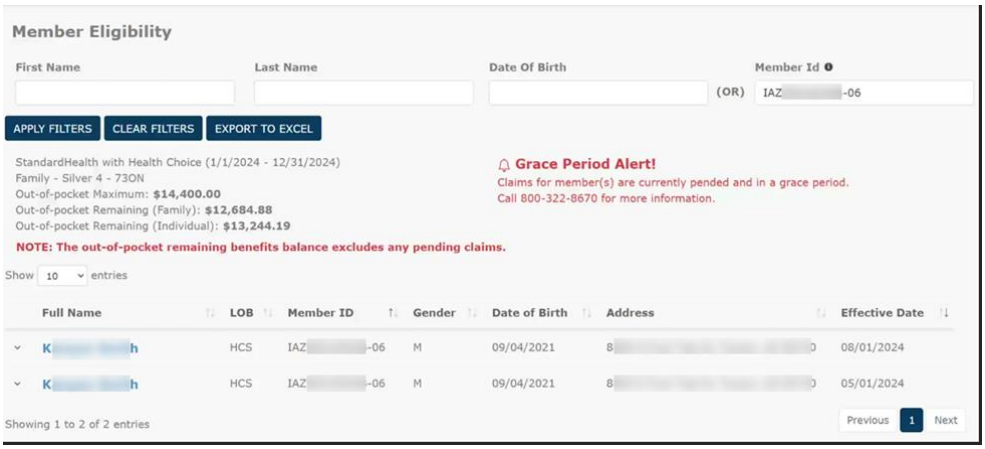
Instructions for using the Provider Portal: From the "Eligibility" screen, you'll search for an individual by name and date of birth, or by member ID number to identify additional subscribers. We'll be enhancing the eligibility portal specifically for ACA StandardHealth with Health Choice so you'll find information such as deductible, coinsurance and copay, out-of-pocket, benefit limits and accumulations applicable to the member's benefit plan in effect for the date of service entered.

Grace Period and Claim Payment Notice

Federal regulations 45 CFR 156.270(d)(3) require health and dental plans to notify providers that claims may be denied for services rendered during months two and three of a member's three-month grace period when the member is receiving Advance Premium Tax Credits (APTC).

Providers may receive this notice beginning in the first month of the grace period and continuing through months two and three. This information may be communicated in multiple ways and is often included when eligibility is verified.

Providers are encouraged to verify member eligibility prior to rendering services, as eligibility status during the grace period may impact claim payment.



If the information obtained from the summaries or inquiries differs from the applicable member benefit plan book, the terms of the benefit plan book apply. The availability of eligibility or benefit information is not a guarantee of payment for services.

The member's designated PCP will be included on the Portal.

Initial and Annual Open Enrollment: ACA StandardHealth with Health Choice has an initial open enrollment period. ACA StandardHealth with Health Choice also has an annual open enrollment period in subsequent years. In an open enrollment period, people would be free to sign up for a Plan or switch Plans. Only in

limited circumstances would people be able to enroll in or switch plans outside of an open enrollment period.

If a qualified event occurs, Members have 60 days to enroll or change coverage options through ACA StandardHealth with Health Choice.

Please refer the Member Benefit Book Guide for additional details regarding eligibility and termination of coverage.

For information about pharmacy benefits, including specialty medications, visit the online pharmacy pages at Prescription Drugs | AZBlue

For additional information regarding coverage of services (dental, vision, DME) refer to the Member Benefit Book or see Chapter 1 of this provider manual.

2.3 COPAYMENTS, DEDUCTIBLES, AND COINSURANCE

Cost Sharing Obligations

ACA StandardHealth with Health Choice uses claims to track whether the member has met some or all of their cost sharing obligations. We apply claims based on the order in which we process the claims and not based on the date of service.

Members are responsible for paying a share of the cost of covered services. Cost share varies based on services received, and the provider's network status.

Some member cost-share amounts are displayed on the member's ID card. To obtain detailed cost-share information, do an eligibility and benefits inquiry.

Deductible, copayment and/or coinsurance apply for covered services unless the specific benefit section says it does not apply. Members are responsible for paying a share of the cost of covered services. Cost share varies based on the member's specific benefit plan, the services received, and the provider's network status.

The terms of the member's benefit plan control the specifics of that member's cost share. The amount due from the member can vary based on whether the member has met a deductible or reached an out-of-pocket limit.

Deductible or Calendar-Year Deductible (Individual and Family)

A deductible is the amount a member must pay for covered services each contract year before the benefit plan begins to pay for covered services. Some group plan deductibles apply to the plan year (according to the policy renewal date) rather than the calendar year. The deductible may not apply to every covered service.

If a member has family coverage, there is typically a deductible for the family. Amounts counting toward an individual's deductible will also count toward any family deductible. When the family satisfies its

deductible, it also satisfies the deductible for all the individual members. An individual member cannot contribute more than his or her individual deductible toward the family's deductible.

The deductible is calculated based on the allowed amount. Amounts a member pays for copays, access fees, and precertification penalty charges do not generally count toward the deductible.

Balance bill

Balance bill refers to the amount that a provider outside the member's network may charge the member representing the difference between the non-contracted provider's billed charges and the allowed amount.

In general, providers who are not contracted for the member's network have no obligation to accept the allowed amount. In many instances, the non-contracted provider may charge members in full for billed charges at the time of service or seek to balance bill for the difference between billed charges and the amount of contract reimbursement.

Any amounts paid for the balance bill do not count toward deductible, coinsurance or the out-of- pocket maximum.

Copayment

A copay (or copayment) is a specific dollar amount that a member must pay to the provider for some covered services when the services are received. Different services may have different copay amounts and are shown on the members' (Summary of Benefits and Coverage) statement. Usually, if a copay does not apply, the member will pay applicable deductible and/or coinsurance.

In most cases, if the copay amount is greater than the allowed amount for the services rendered, the provider may not collect more than the allowed amount. If the provider knows the allowed amount at the time of service, the provider can simply collect the allowed amount. If the amount is less than the copay, the provider must either refund the difference to the member or credit the difference to the member's account.

Coinsurance

Coinsurance is a percentage of the allowed amount that a member pays for many covered services. The percentage is calculated after any required access fees (e.g., emergency room visits) and deductible amounts have been applied. Coinsurance applies to every covered service unless the benefit materials state that it does not apply.

Out-of-Pocket Maximum

An out-of-pocket maximum is the amount members must pay each contract year before their plan begins paying 100 percent of the allowed amount on covered services for the remainder of the contract year. Certain types of payments do not count toward the out-of-pocket maximum.

Members must continue making the following payments even after the out-of-pocket maximum has been reached:

- Amounts above a coverage limit
- Any amounts for balance billing
- Any amounts for non-covered services

Out-of-pocket coinsurance maximum

This is the amount members must pay each year as coinsurance before paying 100 percent of the allowed amount on covered services that are subject to coinsurance, for the remainder of the calendar year. Only certain coinsurance payments count toward an out-of-pocket *coinsurance* maximum.

If members have family coverage, the amounts applied to each member's out-of-pocket maximum accrue toward the family out-of-pocket maximum. When the family has met its family out-of-pocket maximum, the out-of-pocket maximum requirements for all the individual members is also satisfied.

Benefit plans can have both an in-network and out-of-network out-of-pocket maximum or out-of-pocket coinsurance maximum with separate accruals.

Coverage limits (benefit maximums)

Some benefits may have a specific coverage limit or maximum based on the number of days or visits, type, timeframe (calendar year or benefit plan year), age, gender, or other factors. If a member reaches a coverage limit, any further services are not covered under that benefit, and the member might have to pay the provider's billed charges for those services. However, if a member reaches the coverage limit on a *particular line* of a claim, the member will be responsible for paying only up to the allowed amount for the remaining charges on that line of the claim. All coverage limits are included in the applicable benefit description.

Member cost share and provider reimbursement for out-of-network emergency services

ACA StandardHealth with Health Choice follows the requirements of the No Surprises Act (NSA) in reimbursing out-of-network providers for emergency, air ambulance, and other professional services that are in scope for the NSA.

- For in-scope claims, we calculate member cost share using the in-network level of benefits and based on the qualifying payment amount, which is determined according to a formula specified in federal rules.
- In most cases, the initial payment to the out-of-network provider is also based on the QPA, less the member cost-share amount. Providers have the right to dispute the initial payment amount. If the provider disputes the amount, the parties attempt to negotiate a resolution. If the parties can't agree, the dispute is referred to a certified independent dispute resolution entity. In this type of dispute scenario, the NSA negotiation/arbitration process replaces the der grievance process for disputing the claim payment amount.

Member cost share for multi-provider telehealth consultations

Members receiving multi-provider telehealth consultations may have multiple doctor visits associated with their telehealth service. Cost share is based on claim information indicating:

- Place of service (member location at the time of service)
- Number and type of providers involved in the visit

2.4 PRIMARY CARE PHYSICIAN (PCP) SELECTION

ACA StandardHealth with Health Choice contracts with General Practice, Family Practice, Internal Medicine, and Pediatric physicians to provide PCP services to enrolled ACA StandardHealth with Health Choice members.

Each new member enrolled with ACA StandardHealth with Health Choice receives written notification of their PCP by mail. In addition to the letter with the PCP information, an Evidence of Coverage (EOC) is provided that outlines the Member's Rights and Responsibilities. The EOC is a resource that provides assistance for members on how to obtain health care services through ACA StandardHealth with Health Choice.

***PCP/PCO Assignment Change**:* Providers may request a member be removed from his/her roster. This must be submitted in writing and signed by the physician, the provider must provide emergency services for a period of thirty (30) days from the notice or until the member is assigned and able to establish with a new PCP, whichever comes first. A copy of the notice needs to be provided to the member and ACA StandardHealth with Health Choice. Rather than remove these members from your roster; we prefer to collaborate with you in managing their health care. Depending on the issue, ACA StandardHealth with Health Choice will either contact the member directly or coordinate with our Case Management Department in an attempt to resolve the issue. It is important for your office to continue providing care to the member during this process. If no improvement is achieved after our interventions, it may be agreed that the member needs a new primary care physician. Member removal from your roster should be considered as a last resort.

Member assignment changes are effective the first of the month following notification. You can fax both provider and member letters to 480- 760-4708, Attention Provider Services.

2.5 PRIMARY CARE OBSTETRICIAN (PCO) SELECTION

Pregnant Members may choose a Primary Care Obstetrician (PCO) during the course of their pregnancy. The PCO is the primary source of care for these members. For more information on PCO assignments.

2.6 NEWLY ADOPTED AND NEWBORN CHILDREN

2.6.1 ADOPTED CHILD

Coverage under this Policy for newly adopted child will become effective from the date of Placement for the purpose of adoption and will continue unless:

- Placement is disrupted prior to legal adoption; and
- The child is removed from Placement.

"Placement" means the transfer of physical custody of a child who is legally free for adoption to a person who intends to adopt the child.

In order for the newly adopted child to be insured under this Policy, the member must, within sixty (60) days of acquiring the newly adopted child, provide ACA StandardHealth with Health Choice with the following:

- Written notification of the Placement of the adopted child;
- Submit an application and contact member services for more information;
- Payment of any additional Premium required for the adopted child's coverage under this Policy.

2.6.2 NEWBORN CHILD

Coverage under this Policy will be provided for each newborn child of a Member from the moment of birth for thirty (30) days.

The member must give us:

- Written notification of the birth of the child; and
- Submit an application and contact member services for more information;
- Any additional Premium due for the newborn child's coverage; within sixty (60) days of birth of the newborn child in order to have the newborn child's coverage extended beyond the 30-day period. If notification and any required Premium are not paid within the grace period, no further coverage will be provided for the newborn child after the 30-day period.

2.7 INVOLUNTARY DISENROLLMENT

ACA StandardHealth with Health Choice may remove (disenroll) members from the health plan. Some reason for removal might include:

- If the member is abusive, threatening or act violent
- If member does not follow medical advice or does not keep a good relationship with their physician
- If the member allows someone else to use their Member ID Card
- If the member does not pay premiums

2.8 PATIENT'S BILL OF RIGHTS

The Affordable Care Act puts consumers back in charge of their health care. Under the law, a new "Patient's Bill of Rights" gives the American people the stability and flexibility they need to make informed choices about their health.

- Provides coverage to Americans with Pre-existing conditions
- Protects choice of doctors: Allows choice of the primary care doctor they want from the plan's network.
- A child is eligible for dependent coverage until the end of the policy year in which the child turns 30.
- Ends lifetime limits on coverage: Lifetime limits on most benefits are banned for all new health insurance plans.
- Ends Pre-Existing Condition exclusions for children: Health Plans can no longer limit or deny benefits to children under 19 due to a pre-existing condition.
- Ends arbitrary with drawls of insurance coverage: Insurers can no longer cancel their coverage just because they make an honest mistake.
- Reviews premium increases: Insurance Companies must now publicly justify any unreasonable rate hike.
- Helps enrollees get the most from premium dollars: Premium dollars must be spent primarily on health care – not administrative costs.
- Removes insurance company barriers to emergency services: Members can seek emergency care at a hospital outside of their health plan's network.
- Since the Patient's Bill of Rights was enacted, the Affordable Care Act has provided additional rights and protections.

The health care law:

- Covers preventive care at no cost: Members may be eligible for recommended preventive health services with no copayment.
- Guarantees the right to appeal: Members now have the right to ask that the plan reconsider its denial

of payment.

Member Rights and Responsibilities

- Be treated with respect and dignity.
- Have their health information kept private, unless allowed by law.
- Get medical care without being treated unfairly – this means that ACA StandardHealth with Health Choice treats all members with respect. It means that all members have equal access to all ACA StandardHealth with Health Choice services. This includes the way they are spoken to and treated. ACA StandardHealth with Health Choice does not discriminate against any member on the basis of race, color, national origin, disability, sex, religion or age.
- Have services and materials provided in a way that helps members understand. These may include help with:
    - Language needs: This may include having information translated into their own language. We have providers who speak languages other than English. If members need information in another language, please let us know.
    - Visual Needs: This may include recorded materials, such as a CD, or materials in Braille. They can also ask for larger print.
    - Hearing Needs: If needed, we can get an interpreter. This is a person who can perform sign language for those who have hearing impairment. If members are hard of hearing, you can call Arizona Relay Services at 711 or 1-800-367-8939 (toll free). This telephone relay, or TTY/TDD, is a free public service. It is at no cost.
- Choose a PCP and other providers from the ACA StandardHealth with Health Choice network list. This also includes the right to refuse care from providers. Members also have the right to a second opinion.
- Make decisions about their healthcare. This includes agreeing to treatment. It can also include the right to refuse treatment.
- Be free from any form of control or isolation used as a means of force, authority, convenience, or retaliation. This means members cannot be held against their will. They cannot be forced to do something they do not want to do.
- Create a plan that tells health care providers what kind of treatment they do or do not want if they become too sick to make their own health care decisions. These are called advance directives. We can provide members with information so that they can create their own advance directives.
- Obtain information about grievances, appeals and requests for a hearing.
- The right to complain about ACA StandardHealth with Health Choice. They cannot be denied services if they filed a complaint.
- Can request to see medical records and request that they be amended or corrected.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to their condition and ability to understand.
- Be furnished health care services in accordance with access to care and quality standards.
- Be sure that ACA StandardHealth with Health Choice will not hold it against members who choose to

use any of their rights.

If a member feels they have been treated unfairly for any reason, you (or they) may call the number on the back of the member ID card and ask to speak with ACA StandardHealth with Health Choice's Grievance Coordinator to report it.

Member Responsibilities

As a ACA StandardHealth with Health Choice provider, our members have the responsibility to:

- Know the name of their Primary Care Provider (PCP). Tell their doctor about their health history, and be sure to include any medical problems or concerns to help you give them the best possible care.
- Follow their health care provider's (doctor) advice. This includes:
  1. Taking their medicine as ordered
  2. Talking to you, the doctor about their medical care
- Make sure you get prior approval for services when needed.
- Make appointments during office hours when possible. Try to see the doctor for routine care. Try not to use urgent care centers or emergency rooms for routine care.
- Get to their appointment on time. Call the doctor ahead of time if they cannot make their appointment. Arrive at the office early if they are seeing the doctor for the first time.
- Bring records of their children's shots to every appointment. This includes all members who are 18 years of age or younger.