FAQs

New EBMS-Administered Health Plan Members

EBMS' professional staff is pleased to have the opportunity to serve you. We look forward to assisting you in receiving the benefits to which you are entitled, and helping you to become a wise healthcare consumer.

EBMS works hard to meet customer service goals established for all areas of our organization. We believe the first part of service starts with educating our members about their benefit plan. We hope these FAQs will answer your benefit questions, and help you to navigate your benefit plan with EBMS.

Q: What information is included on my EBMS ID Card?

A: Your health plan ID card includes all the information necessary to submit claims or obtain information regarding your benefits and other healthcare services:

- ELIGIBILITY INFORMATION - such as Policy Holder's Name, Group Name and Number and Policy ID Number.
- PREFERRED PROVIDER ORGANIZATION (PPO)-logo and contact phone number to locate a preferred provider: You need to make sure your provider is contracted with the PPO to insure the highest benefit level and best rates or cost to you.
- PHARMACY INFORMATION - includes your RX Vendor and contact phone number as well as your BIN/PCN Numbers, which allow the pharmacy to submit claims for you.
- CUSTOMER SERVICE INFORMATION - includes the phone number and website for all questions regarding benefits, claims and eligibility.
- PROVIDER CUSTOMER SERVICE INFORMATION - includes a phone number for providers to call with questions about your health plan, a number to call for all inpatient pre-authorizations, and an address for claims submittal

Health plan ID cards may be requested through the Client Service Center during regular business hours or through your personal account within miBenefits! Visit www.ebms.com to access miBenefits

CUSTOMER SERVICE

Q: What is miBenefits?

A: miBenefits is designed to provide enrolled members and their dependents with access to benefits and claims information, 24/7, from the convenience of their home or office. Enrolling is easy, and miBenefits provides access to the following:

- Real-time information on claims status
- Electronic EOB's (Explanation of Benefits) to print or save
- Benefit Summaries
- Easy to use search engine to find in-network providers
- Access to valuable health resource tools
- Accumulators for your deductible and out of pocket as well as Consumer Reimbursement Accounts, when applicable
- HIPAA Authorization forms

Q: How do I contact someone at EBMS if I have questions about my benefits or claims?

A: Members can call their group's dedicated toll-free number (found on their health plan ID card), or they can contact a knowledgeable, friendly member of EBMS' Client Service Center through email or chat within miBenefits.

REGISTRATION IS EASY!

- Visit **www.ebms.com**.
- Click on the "Login" button at the top of the screen.
- Complete our simple registration using your health plan ID card.
- That's it! Use your own user name and password every time you access your account!

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UNDERSTANDING YOUR BENEFITS & SELECTING HIGH-QUALITY, LOW-COST PROVIDERS

Q: What benefits are available through my employer's benefit plan?
A: You can access a copy of your company's Summary Plan Description (SPD) on your personal miBenefits account. Or, you can speak with one of the representatives in our Client Services Department.

Q: How do I know if my services are going to be covered?
A: If you are questioning whether your services will be covered, you always can refer to your Benefits Booklet or call our friendly customer services representatives. Some services require what is called "pre-authorization" before they can be rendered by your physician. A pre-authorization is generally a letter from your provider that explains the medical necessity of the treatment and/or medical records to prove medical necessity. Once we receive pre-authorization, EBMS will make a determination so that you have clear understanding of what will be covered.

Q: What is a Preferred Provider Organization PPO?
A: As part of your company's commitment to provide its members with a high-quality, cost-effective health benefit plan, they have secured contracts with certain hospitals, physicians and other healthcare providers, known as Participating Providers. Because these Participating Providers have agreed to charge reduced fees to persons covered under your health benefit plan with EBMS, your company can reimburse a higher percentage of their fees.

Q: How do I know if my Provider is a participant in one of our group's PPO networks?
A: You may access Participating Provider information from the PPO website, or by contacting the Customer Service Department of each PPO (this information is available at www.ebms.com.). Click on the "Find A Provider" link, on the left side bar of the EBMS home page. The website information and customer service phone number, when available, also is included on your EBMS ID card.

CLAIMS AND PAYMENTS

Q: How will my claims be submitted to EBMS?
A: When you receive services from a provider, you or your provider must submit a claim for those services in order to receive reimbursement. EBMS handles the processing of those claims on behalf of your benefit plan. To make sure the claim is paid correctly, EBMS uses numerous resources, including your plan document, billing practice resources, and claim payment practice guidelines. You and your provider will receive an Explanation of Benefits (EOB) notification of the outcome for the processing of the claim. (EOBs are posted electronically in your personal miBenefits account).

Q: How long does it usually take to process a claim?
A: EBMS must process all claims within 30 days from the date the claim is received in our office. However, to date, EBMS averages a 7- to 9-day turnaround on all claims. Some claims require additional information, i.e., medical records or other supporting detail, which can extend that time. However, EBMS works hard to gather this information on behalf of our members to ensure timely processing and strong customer service.

Q: How do I know if a claim has been paid?
A: You can access this information on miBenefits (refer to the Employee Benefit Plan booklet or the miBenefits brochure for login instructions). You can also speak with a Client Service Representative at the toll free number listed on your ID card. Prescription claims number is located on the front of your ID card, medical/dental claims number is located at the bottom of the back of your ID card.

Q: What is UCR?
A: UCR stands for Usual and Reasonable Charge. Usual and Reasonable Charge is a charge that does not exceed the usual charge made by most providers of like services in the same area. If your provider is not an in network provider, your plan will not pay any amount that is billed over usual and reasonable charges.

Q: What is medical necessity?
A: Even when prescribed by a provider, medical necessity is not a guarantee of coverage. In order for a procedure or treatment to be determined medically necessary, it must be: recommended or approved by a physician; consistent with the patient's condition; accepted as a standard of good medical practice; be medically proven to be an effective treatment of the condition; not performed mainly for the convenience of the patient; not conducted for research purposes; and deemed as the most appropriate level of service that can be safely provided to the patient. All of these criteria must be met in order for a service to be considered medically necessary.

Q: What if payment is never received?
A: If you or your providers do not receive payment for your claim, please call our friendly Client Service Department to let us know. As long as it is 30 days past the date the check was printed, we can place a request for the check to be canceled and a new check reissued.

Q: How long do I have to submit a claim?
A: Every plan has different submission deadlines for a claim. The "how to submit a claim" section of your Plan Document will provide this information.

Q: What is an appeal?
A: An appeal is a written request for review of a processed claim that resulted in a different-than-expected outcome (Adverse Benefit Determination). To appeal a claim, you must include the following: name of member, ID number, group health plan name, and a statement of why the Claimant disagrees with the Adverse Benefit Determination. You may include any additional supporting information, even if it was not initially submitted with the claim. Once received, the plan will provide a new review by an individual who has not previously been connected to the claim in any way. For more information on appeals and how to submit them, please refer to your Plan Document.

Q: What is a pre-existing condition?
A: A pre-existing condition is a condition for which the patient was treated within a specified time period prior to becoming enrolled under the insurance plan (the look-back period). What that means is that when we receive a claim, we will request medical records from that provider and any other providers seen. This process verifies whether what you are being seen for is considered a pre-existing condition. If it is not, your plan will pay according to the coverage outlined in your Benefits Booklet.

If you were seen or treated for something that is indicated in your medical records within the six-month look-back period, your current plan will not initially make payment, and will extend our investigation by reviewing any Certificates of Creditable Coverage (CCC) from previous health insurance carriers. This review will verify if there was a break in coverage, as well as how long you were covered under the former insurance policy. EBMS may be able to waive some or all of the items denied for pre-existing status. If you did not have previous coverage, or if the break in coverage was longer than 63 days, you will be subject to the pre-existing time frame. EBMS will need to receive all the medical records from all providers seen in order to complete a pre-existing investigation.

Q: What is an EOB?

A: EOB stands for Explanation of Benefits. It provides a breakdown of what services were billed, the provider billing them, the amount applied to your deductible (or the amount paid), and how much you have applied to your deductible during the current plan year. If, for some reason, you need to be reimbursed for any up-front costs, a check will be attached to the bottom of the EOB. Log in to your personal miBenefits account at **www.ebms.com** to go paperless!

For every service provided, you will receive a separate EOB. If there are any charges identified in the "ineligible" column, there will be a message code located beside the charges. Each of these codes will mean something different to the outcome of the claim. Some you will need to follow up on, some are the provider's responsibility, and others are related to the way the provider billed. If you see a message code on your EOB that is not listed below, please feel free to contact EBMS client services at your group's dedicated toll free number for additional clarification.

Here is a list of the most frequently-used message codes you will see that require action on you or your provider's part in order to process the claim:

- **MED:** The plan has a provision relating to Medical Necessity. To apply the provision to your claim, we need medical records. The provider should have received a letter indicating the information needed. For further consideration, please provide the requested information within 45 days of this notice. If not provided within 45 days, this notice constitutes formal determination of the claim.

  This message indicates that the services provided must be reviewed to make sure they are medically necessary. This is accomplished through a review of the medical records. EBMS uses standards of care and medical reviews to determine medical necessity. Your provider typically will respond with the needed information. However, if you choose, you may expedite the needed information by contacting your provider. The provider may then send the information to EBMS for proper processing of the claim.

- **PEX:** The plan has a provision relating to Pre-Existing Conditions. To apply this provision to your claim, we need medical records. The provider should have received a letter indicating the information needed. For further consideration, please provide the requested information within 45 days of this notice. If not provided within 45 days, this notice constitutes formal determination of claim. This message indicates that you have not yet submitted proof of coverage, or have a break in coverage that requires EBMS to investigate the claim. You will receive a letter asking you to state the physicians you have seen and the medication you have taken during the specified time frame. If you or your dependents have had continuous coverage, please submit your proof of coverage to complete the investigation. The pre-existing condition investigation is very time intensive and requires medical records from every provider seen during the pre-ex time frame. Please make sure that you return all requested documents timely to assist with the processing of the claim.

- **OIC:** We are in receipt of correspondence that indicates there may be other insurance coverage in place. In order to correctly apply this plan's coordination of benefits provision, an immediate update is required. A letter has been sent requesting specific information. Please see that this information is provided within 45 days of this notice. If the requested information is not provided within 45 days, this constitutes formal determination of the claim. This code will appear on your Explanation of Benefits when we have received information with a claim (such as an EOB from another carrier) that indicates the possibility of other insurance.

- **COB:** The plan has a provision relating to Coordination of Benefits. To correctly apply this provision to your claim, we need a copy of your primary insurance plan's Explanation of Benefits. For further consideration, please provide the requested information within 45 days of this notice. If not provided within 45 days, this notice constitutes formal determination of the claim.

This message indicates that EBMS has a record of another insurance available that should be paying on this claim first. If that is not the case, please contact EBMS to update your other insurance record. There will be additional information necessary to process that claim, which may include the date the other insurance coverage terminated, reason for termination, and other pertinent information. If you do have other insurance, please submit the EOB provided by the other insurance. Your provider also may have a copy of this information. You or the provider then should send the information to EBMS for proper processing of the claim.

- **ITM:** The plan has a provision relating to how to submit a claim. In order to correctly apply this provision to your claim, we need an itemized bill for the services. For further consideration, please provide the requested information within 45 days of this notice. If not provided within 45 days, this notice constitutes formal determination of the claim. This message indicates that an itemization of the charges is needed to properly process the claim. Typically, this is only necessary for claims that have billed charges over $25,000. Your provider usually will respond with the needed information. However, if you choose, you may expedite the needed information by contacting your provider. The provider then may send the information to EBMS for proper processing of the claim.

ENSURING PRIVACY AND SECURITY FOR YOUR PERSONAL HEALTH INFORMATION

Q: What is HIPAA and how does that affect me?

A: HIPAA - Health Insurance Portability and Accountability Act – is legislation passed by Congress that had a profound impact on group health plan coverage with respect to confidentiality and other issues. Federal regulations require that we protect the health information of any person we administer benefits for. Information regarding covered minor children may be given over the phone to a covered parent but once a child reaches the age of 18, the parents are no longer entitled to any information unless a HIPAA authorization has been received.

The same rules apply for husband and wife or partners on the policy. If there is no HIPAA authorization on file, no protected health information (claims, doctors seen, and diagnosis, etc.) can be shared with anyone other than the individual.

Members complete the required authorization two ways: by paper copy sent by email, mail, or fax OR through their miBenefits account (see steps below).

- Log into your miBenefits account (Not registered? Click on "New User" and follow the simple instructions)
- Hover over Policy Updates
- Click on submit/update HIPAA authorizations
- Fill this form out completely
- Click on submit

The HIPAA Authorization form must be completed if a covered parent wishes to allow the other parent access to their covered, minor children's health information. The form will also allow access on the miBenefits account. The easiest way to provide this information to EBMS is through miBenefits. If you want to connect with our Client Service Center, please access your organization's dedicated toll-free number (available on the front of your health plan ID card).

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