FREQUENTLY ASKED QUESTIONS
(DESIGNED FOR GOOSE CREEK CONSOLIDATED INDEPENDENT SCHOOL DISTRICT)

What is NexStep®?

NexStep® is underwritten by Fidelity Security Life Insurance Company (Kansas City, Missouri) and is administered by Special Insurance Services, Inc. SIS is located in Plano, Texas and administers all aspects of the NexStep® product for FSL, including policy/certificate issuance, premium collection and claims administration.

The benefits provided by NexStep® will help you pay for out-of-pocket expenses you might be responsible for due to a hospital confinement or due to most out-patient procedures. For an expense to be eligible, it must meet three criteria:

1. First, it **must be medically necessary for the treatment of an injury or a sickness**. Expenses resulting from voluntary or elective surgeries, procedures or expenses due to wellness or preventive care, and those expenses designated as physician office visit expenses are not covered.
2. Second, the expense must be covered by your major medical plan and must have been applied towards your deductible or coinsurance provision under that plan. If an expense or procedure is not covered by your major medical plan, it will not be an eligible expense under NexStep®. If an expense or procedure is covered by your major medical plan, but the charges for such are not applied to your deductible or coinsurance provision, it will not be an eligible expense under NexStep®.
3. Third, the expense must be incurred while the NexStep® coverage is in force.

What constitutes a major medical plan?

A major medical plan must be a group medical plan (whether a fully insured plan or an employer sponsored self-funded plan) that provides benefits for hospital confinements and requires you to pay a deductible and/or portion of coinsurance. A major medical plan does not include Medicare, Medicaid or government sponsored programs not typically considered major medical coverage (such as, but not limited to, veterans benefits, etc.)

Who determines the benefit plan design that was made available to me?

Your employer has chosen the benefits and plan structure that have been made available to you. They, along with insurance professionals, have reviewed and analyzed your major medical plan coverage and its associated costs, to determine the most effective NexStep® plan(s) available.

How does the NexStep® Out-Patient 1 Benefit work?

Each covered family unit has a maximum of 4 out-patient benefits per occurrence per plan year. *This maximum applies to the entire family unit, regardless of the number of covered persons within the family unit.* If you have employee only coverage, you have 4 occurrences to use in a plan year. If you have dependent coverage, there are 4 occurrences to be used in the plan year for the entire family unit. It is NOT a "per person per occurrence" maximum.

An occurrence happens when you are treated on an out-patient basis for an eligible medical expense. It does not matter how many doctors you see or what period of time the treatments span; all expenses related to the treatment of the condition you are diagnosed with will accrue towards your out-patient maximum for one occurrence. If, however, at any time you go treatment-free for 90 consecutive days or more for that condition, then resume treatments, the new round of treatments will be considered a new occurrence.

The easiest example of this is a broken arm in January that requires insertion of plates & screws. You have out-patient surgery on your arm and are released from care by the doctor in March. You incur out-of-pocket expenses and your out-patient NexStep® coverage pays up to the benefit maximum. In November of that same plan year, you go back to the doctor to have the plates finally removed. You have another out-patient surgery resulting in out-of-pocket expenses. Even though this surgery was related to the broken arm injury in January, you have been treatment-free for 90+ days, therefore, it would be considered a new occurrence and NexStep® would respond up to its benefit maximum. Documentation of your treatment-free status may be required from your physician.

What if I am not 90 days treatment-free for a condition where I have already received my maximum NexStep® benefit, but a new plan year has begun?

While you have 4 occurrences per plan year, if you are not treatment-free for 90+ days going into a new plan year, the condition for which you are being treated does not qualify for a new "occurrence" by the simple fact that it is a new plan year. You need to realize that you may be out-of-pocket for expenses related to the treatment of that condition.

In fact, you should note, that some conditions may never qualify as a new occurrence, regardless of how many plan years are involved. For example, a cancer patient may be receiving chemotherapy or radiation therapy on an out-patient basis. The rounds of therapy may be such that they could be separated by 90 days or more, however, the patient would still be under the care and treatment of the physician during the time between therapy rounds, thus they would not be considered treatment-free.

I see that Physician Office Visit charges and expenses related to Wellness Visits are not covered under the Out-Patient 1 Benefit. Are these expenses ever eligible for coverage?

Most major medical plans offer reasonably low co-pays for physician office visits, as well as some type of benefit for wellness/preventive care. For this reason, and because the cost associated with including these types of charges is prohibitive, coverage for Physician Office Visit charges or Wellness expenses are not included in the NexStep® benefit package provided by your employer.

Will I receive an ID card or some other proof of insurance?

Upon receipt of your enrollment form, SIS will issue you a certificate of insurance, outlining the plan benefits, terms, conditions and limitations. An ID card that you can present to providers at the time of service is also issued.

If you need to see a doctor before you receive your ID card, you can contact the SIS Customer Service Department with your provider's name, address and phone number. Simply explain the situation to the SIS representative and he/she can contact the provider on your behalf to explain the NexStep® plan.

How do I file a claim?

When you enroll in the NexStep® plan, you will receive a certificate of insurance, an ID card, and a claim form, along with specific instructions on how to file a claim. This form outlines the procedures you should follow and where you should send your claim. Simply stated, you will need to submit a completed claim form, itemized bills (NOT balance due statements), and EOB's that correspond to the itemized bills.

You must file one claim form per year for each insured person for whom you are filing a request for claims reimbursement/payment on. The claim form has a section authorizing providers to release medical information to FSL/SIS if requested. We must have a current (no more than a year old) signature on file on this form in the event it is necessary to request medical records from your provider. Having this form already on file with SIS results in faster claim service.

Claims may be filed at any time, but must be filed no longer than 12 months from the date of service in order to be eligible for coverage.

<u>Upon receipt of all required documentation</u>, claims processing takes approximately 10 business days.

If you have any questions about this process, you can call the Customer Service Department at Special Insurance Services at (800) 767-6811, and representatives will be happy to assist you.

What is a diagnosis code?

A diagnosis code is also called an ICD-9 code. This is a standardized medical code that a physician or a provider assigns based on your condition/diagnosis. Most providers, except for hospitals, use a standard billing form called a HCFA. This form is usually not given to the patient, but is used to bill insurance carriers and would include the diagnosis code. Hospitals utilize a UB04 form to bill insurance companies, which will include the diagnosis code on it. A sample diagnosis code might be 465.9 (upper respiratory infection).

How do I get a diagnosis code when the provider will not submit it to me?

Due to HIPAA laws, physicians and providers normally will not print the diagnosis code on the billing form that is given to the patient unless the patient requests it. By law, the provider is required to provide this information to you if you ask for it. If you have asked your provider for a HCFA form and they indicated they can't give that to you, you simply need to explain that you need your diagnosis codes so you can file for insurance benefits, or ask the provider to file the bill with the insurance company on your behalf.

What is a CPT code?

A CPT code is a standardized code used by physicians and other providers to denote the type of service(s) performed. An example code might be 99212 which denotes an office visit charge. Hospitals do not use CPT codes.

What is the difference between an itemized provider bill and an EOB?

An itemized provider bill from the medical provider details the procedures performed and the dates of service of those procedures. This bill (unless it is the patient's copy, as explained above) should include the dates of service for each procedure performed, a CPT code for each procedure performed, a diagnosis code, and the charge for each procedure. Sometimes, a provider will send you a re-capped statement or a "balance due" statement. These types of bills do not contain the itemization the insurance company requires in order to process your claim.

An Explanation of Benefits, or EOB as it is commonly referred to, is a statement from your major medical insurance company outlining the charges they have processed, detailing what expenses were filed, the dates of service, how much was discounted due to PPO re-pricing, what expenses were not covered and why, what was applied to the deductible, how much was paid to the provider, and what the claimant's out-of-pocket responsibility is.

The EOB, along with the itemized bill, provides the insurance company with the information necessary to process your claim under the NexStep® program.

I paid the provider, but NexStep® paid them, too. Why?

When you go to a doctor or to the hospital, you are usually required to execute an Assignment of Benefits at the time of treatment. These assignments apply to any and all insurance coverage you might have. Provider bills indicate whether or not an Assignment of Benefits exists. NexStep® benefits are "assignable" and when the insurance company is aware that benefits have been assigned to the provider, we are legally obligated to make our payments to that provider, whether or not you paid the provider at the time of service.

If your provider will not accept your NexStep® ID card and requires you to make a payment at the time of service, you should ask them to stamp your bill "paid in full" or to provide you with a receipt indicating they have received a full or partial payment for the specific services rendered. Otherwise, benefit payment will go to the provider and you would need to contact them for a refund of any amounts paid by you up front that create an overpayment on your account.

Most providers, if they will file for insurance benefits from more than one carrier, should accept your NexStep® ID card reducing, if not eliminating, their requirement that you pay for services up front. If your provider accepts your ID card and is still requiring you pay up front, it may be they did not understand the NexStep® concept when they called in to verify insurance coverage. In this instance, you can ask your provider to call the SIS Customer Service department again, or you may contact SIS and request Customer Service call the provider to explain the benefits again. Ultimately, however, it is the provider's decision whether or not to require payment from the patient at the time of service.

I have already met my deductible and out-of-pocket maximum for the plan year. If I elect to participate in the NexStep® plan will I be paying for coverage I won't be able to use?

Enrollment in the NexStep® plan follows those guidelines established for enrollment in your group major medical plan. The plan is lining up with your TRS BCBS plan year.

If you do not elect to enroll in the NexStep® plan when it is first made available to you, you will not be able to enroll in it until the next allowable period of open enrollment, unless you qualify by law as a "special enrollee" due to certain qualifying events. Whether or not, or for how long, you might be paying for coverage that might not be available in this situation, is dependent upon what point in the plan year you met your deductible and coinsurance maximum and when the next period of open enrollment comes around.

What is excluded under NexStep®?

For an expense to be eligible under NexStep®, it has to be covered by your major medical plan. If an expense is denied by your major medical plan, but would otherwise have been an eligible expense under NexStep®, it will not be covered by NexStep®. A couple of simple examples to illustrate this are:

1. Your major medical plan limits diagnostic testing to a maximum of $500 and does not cover testing in excess of this amount. If you incur diagnostic testing expenses in the amount of $750 due to an illness or injury, and your major medical plan pays $500, the remaining $250 would not be reimbursable or payable by NexStep® because it would be denied under the major medical insurance plan.
2. Your major medical plan has a pre-existing limitation provision and denies benefits because you were not able to show proof of creditable coverage. Those expenses that were denied would be ineligible under NexStep®.

In addition to the above, NexStep® does not cover:

1. Expenses that are not medically necessary and do not result from the treatment of an illness or an injury;
2. Physician office visit charges
3. Expenses related to wellness
4. Charges for well newborn care after birth;
5. Durable medical equipment, unless it was dispensed to the insured person in the hospital or at the provider's office;
6. Pregnancy for a dependent, other than a covered dependent spouse;
7. Confinement or other covered treatment for Dental or Vision care that is not related to an accidental injury;
8. Expenses related to the treatment of mental or nervous disorders;
9. Expenses related to treatment of alcoholism, drug addiction, or complications thereof;

This is not a complete list of exclusions under the NexStep® plan. For a full list of exclusions, terms and conditions, you should refer to your certificate of insurance.

The NexStep® enrollment form asks for social security numbers for me and my dependents. Do I have to give this information out?

SIS is a professional third party administrator operating within the guidelines for privacy as established by HIPAA and required by law. All personal information provided to SIS is held in the strictest confidence and is used internally only for identification of an insured person. This information is NOT printed on any materials that are sent out of SIS's offices.

Each insured person is entered in the SIS database and assigned a unique master claim number that is in no way related to the person's social security number. This unique master number appears on all correspondence and EOB's issued by SIS for the NexStep® plan.

SIS requires social security numbers on all employees and their covered dependents for two reasons:

1. First and foremost, SIS is <u>required by federal law</u> to report to the Center for Medicare Services on a quarterly basis certain data on individuals who may or may not be eligible for Medicare. The data SIS has to provide to CMS includes social security numbers, therefore we must obtain these in order to enter you and your dependents into our databases; and
2. Secondly, on occasion, a provider might call to check on payment status and may not have the master number to refer to. When this occurs, and the insured person is someone with a very common name (John Smith for instance), the provider will often give the SIS Customer Service representative the person's social security number so they can determine which John Smith in our database they are calling in regard to. SIS prides itself on being able to provide fast, quality customer service. Having the proper information on hand enables SIS to handle all inquiries quickly and efficiently.

When can I file for and get reimbursement for expenses related to my pregnancy?

An ob/gyn assesses a global fee for the pre-natal care and delivery costs associated with a pregnancy. This cost is not considered to be an "earned" cost to the ob/gyn until the time of delivery, even though your doctor may require you to pre-pay your estimated portion of the global delivery charge prior to actual delivery. It would not be uncommon for an ob/gyn to require that the patient's portion of the cost be paid in full by the 7th month of the pregnancy term.

The global fee includes all pre-natal check-ups and routine office visits associated with the pregnancy, as well as the physician's delivery fee. Expenses such as sonogram charges, non-routine lab work, and other non-routine diagnostic testing are usually not considered to be a part of the global delivery fee and are charged by the doctor independently of such fee.

You are eligible to file for and receive benefits for your covered pregnancy as follows:

1. Global fee – at the time of delivery;
2. Expenses outside the global fee – at the time the expense is incurred

Deposits or pre-payment arrangement terms that you may have made with your physician do not alter the above.

Expenses for the physician's global fee are applied to your in-patient hospital confinement benefit along with expenses charged by the hospital for labor & delivery, room & board, etc. Those expenses outside the global fee (such as those listed above) are applied to your out-patient expense benefit.