# Information About the Consumer Choice Option

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# Consumer Choice Option / Questions & Answers

## What is Consumer Choice?

Georgia law requires insurers to offer a "Consumer Choice" option to members enrolling in an insured HMO, POS or PPO plan. This option allows members to receive services from a non-network provider (physician, hospital or other provider) while still being covered at an in-network level.

Although you may "nominate" any non-network provider, the nominated doctor or hospital must first agree to the following in order for your services to be covered at the in-network rate:

1) accept Blue Cross and Blue Shield of Georgia's (BCBSGA) and Blue Cross Blue Shield Healthcare Plan of Georgia (BCBSHP) reimbursement as payment in full (in addition to the member's usual copayments, deductibles and/or coinsurance);
2) comply with BCBSGA and BCBSHP utilization management programs.

## Is there a charge to elect the Consumer Choice Option?

**Yes.** The law allows insurers to increase the monthly premium rate for employees who elect this offering. The amount of the monthly premium increase is 17.5% for Consumer Choice Option HMO and POS benefit plans, and 10% for Consumer Choice Option PPO plans. Because these amounts are billed to the employer, the amount an employer may charge its employees will differ from company to company. Please check with your employer to determine the exact amount you will contribute if you elect a Consumer Choice Option plan.

## How do I choose the Consumer Choice Option?

Selecting the Consumer Choice Option is just like selecting any other benefit option. You must do so either at open enrollment, if you are newly hired, or when your employer's eligibility rules allow you to do so. To select the Consumer Choice Option:

1) ***Newly applying members*** must complete BCBSGA/BCBSHP's Member Enrollment Application and select the Consumer Choice Option plan they desire. (You must still select a network Primary Care Physician for each person enrolled if you selected the HMO or POS Consumer Choice Option.)
2) ***Currently enrolled members*** must complete a Member Change Form and select the Consumer Choice Option plan they desire.

## How is Consumer Choice different from a PPO or POS plan?

A PPO or POS plan allows members access to out-of-network providers at an out-of-network benefit level. When a member utilizes the services of an out-of-network provider, the member usually pays more in the form of increased copayments, deductibles and/or coinsurance.

Under the Consumer Choice Option, members may utilize the services of an out-of-network provider at in-network benefit levels only when that provider has:

1) been nominated by the member;
2) signed a form accepting BCBSGA/BCBSHP's conditions; and
3) been approved by BCBSGA/BCBSHP.

After a provider has been approved, the member's benefits are paid as though the provider were part of the BCBSGA/BCBSHP network.

## Once I elect the Consumer Choice Option, can I go to any doctor and get benefits paid at in-network levels?

**No.** First, you must complete a Provider Nomination Form and receive notification from BCBSGA/BCBSHP that the nomination has been accepted before out-of-network providers can be reimbursed at in-network benefit levels.

For any nomination to be approved, the provider must sign the nomination form agreeing to BCBSGA or BCBSHP's terms and conditions before that provider's services will be covered at in-network levels. The provider has absolute discretion regarding whether he or she wishes to participate in the Consumer Choice Option.

## How do I nominate my physician?

Call customer service at 1-800-441-2273 to request a Consumer Choice Physician Nomination Kit. The kit includes a provider nomination form and pre-addressed return envelope. Members must complete the provider nomination form, which is a two-step process:

1) The provider must sign the nomination form and request details about BCBSGA/BCBSHP's reimbursement rates for the services he or she intends to provide.
2) The provider must sign the form again to indicate his or her acceptance of the rates and other terms and conditions, once he or she has reviewed them.

After you have completed these steps, please return the completed nomination form to BCBSGA/BCBSHP for approval by mail in the pre-addressed envelope or fax directly to 1-877-541-1162.

## How long will it take to get approval of a nominated provider?

Once BCBSGA/BCBSHP Georgia has received a completed nomination form – completed and signed by both the provider and the member – we will respond by mail or fax within three business days.

## What if I select the Consumer Choice Option and then decide I want to return to a non-Consumer Choice Option plan?

Under most employers' rules, you may make a plan election only once during each year. If your employer's rules allow you to switch plans other than during your open enrollment period, you may move from the Consumer Choice Option plan you elected back to the non-Consumer Choice version of that plan within 31 days of enrolling. Please check with your employer for details. Your employer must submit any such requests in writing to BCBSGA/BCBSHP.

## What if my doctor doesn't want to accept reimbursement terms or comply with utilization management guidelines required by BCBSGA/BCBSHP?

The law does not obligate a provider to accept our terms and conditions or our reimbursement rates. If a provider elects not to sign the Consumer Choice Option Provider Nomination Form, he or she is under no obligation to do so.

If you are seeking services from a specific provider, we recommend that you check with that provider BEFORE completing the Consumer Choice Option application and making a final plan election. Once you have selected a Consumer Choice Option plan, you cannot switch plans until the following open enrollment, except within the 31-day grace period described above.

## Once a doctor has agreed to your terms, can I receive services from that doctor or hospital for the remainder of the time I'm enrolled in a BCBSGA or BCBSHP health plan?

Once the provider has signed the form agreeing to BCBSGA's or BCBSHP's reimbursement and other terms and conditions, you may utilize the services of the provider until your plan's anniversary the following year. You will need to repeat the nomination/approval process each year for the out-of-network provider's services to be covered at in-network benefit levels.

## Will prescriptions written by a non-network doctor be covered?

If you nominate a provider and that provider is ultimately approved under the Consumer Choice Option, he or she may write prescriptions that will be covered at in-network benefit levels. Remember, if your plan restricts you to having prescriptions filled at network pharmacies, you must either use only network pharmacies *or* have a completed and approved Provider Nomination Form for any non-network pharmacy. (Note: This requirement does not apply to PPO plans.)

### If my doctor admits me to a non-network hospital, will the hospital charges be covered?

Any services must be provided by either a network hospital or a hospital for which a Provider Nomination Form has been completed and approved by BCBSGA/BCBSHP. This form must also be completed and approved for any other providers rendering services – for example, radiology, anesthesia services, physical therapy or lab work. To be subjected to in-network benefit levels, all services must be provided by either in-network providers or providers approved under the Consumer Choice Option.

**For additional information about the Consumer Choice Option, please call Customer Service at 1-800-441-2273.**

BlueCross BlueShield of Georgia

*Blue Cross and Blue Shield of Georgia*
*3350 Peachtree Road, N.E.*
*Atlanta, Georgia 30326*
*1-800-441-2273*

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# Provider Nomination Form For Consumer Choice Option

## I. To be Completed by Member

| Member's (Patient) Name | Member's (Patient) ID Number | Group Number |
|---|---|---|
| Subscriber's Address (City, State, Zip) | Member's (Patient) Date of Birth | |
| | Member's (Patient) Telephone Number | Member's (Patient) Fax Number |

Narrative description of reason for provider nomination:

______________________________________________________________________

______________________________________________________________________

By signing below, the Subscriber acknowledges that the nominated provider is not a plan In-Network provider and that the provider, therefore, has not been credentialed by the plan credentialing body. Subscriber further acknowledges that he or she alone is responsible for the selection of the nominated provider and that the plan has not undertaken any credentialing or quality assurance measures regarding said provider. The nominated provider will not be credentialed by the plan, nor will the plan undertake to conduct routine quality assurance measures which are used for In-Network providers. The member understands that any and all physicians, hospitals and any others who are not in-network providers must be nominated by the member (patient) and approved by the plan prior to any services being performed by the provider in order for the services to become eligible for reimbursement at in-network benefit levels.

**Subscriber's Signature:** | **Date:** **Month** ______________ **Day** _____________ **Year** _____________

**When this form is completed, please return to:**

**Blue Cross and Blue Shield of Georgia**
**P.O. Box 84053, Columbus, GA 31908**

**Toll free fax:**
**(877) 541-1162**

## II. To be Completed by Provider

If you have any questions, please call (800) 441-2273.

| Name of Nominated Provider | | Name of Provider Group (if applicable) | |
|---|---|---|---|
| Provider Georgia License Number | Provider Tax ID Number | Provider's Telephone Number | Provider Fax Number |
| Provider Address (City, State, Zip) | | | |

By signing below, the provider, or authorized representative, attests that said provider is fully licensed in the state of Georgia to provide the services described above by the patient. Said representative also further states that he/she/it is not a plan network provider and has not been credentialed by the plan. Furthermore, the nominated provider agrees to accept or consider accepting the reimbursement rate established by the plan for specified procedures, agrees not to balance bill the Member designated above, agrees to adhere to the plan's utilization management requirements and other reasonable criteria.

**Signature of Provider or Authorized Representative:** | **Date:** **Month** ______________ **Day** _____________ **Year** _____________

Diagnosis or Nature of Illness or Injury

1. _________ 3. _________
2. _________ 4. _________

To ensure prompt and accurate response, including reimbursement rates for provider-listed codes, specific diagnosis codes and procedure codes must be listed for each service. Use attachment if necessary for additional procedures.

| Expected Dates of Service | | Place of Service | Procedures, Services or Supplies | | Diag. Code | Provider's Estimated Charges | Days or Units |
|---|---|---|---|---|---|---|---|
| From | To | | CPT/HCPCS | Modifier | | | |
| 1. | | | | | | $ | |
| 2. | | | | | | $ | |
| 3. | | | | | | $ | |
| 4, | | | | | | $ | |
| 5. | | | | | | $ | |

**Hospitals: For an estimate of allowable fees, please submit details as an attachment to this document.**

By signing below, the provider acknowledges that the Plan's payment estimate is based solely on the information provided above by the provider and that final payment will be subject to the normal payment rules of the plan. These may include, without limitation, (i) pre-certification or prior approval of services; (ii) member eligibility at the time services are rendered; (iii) the services rendered qualifying as covered services under the member's benefit plan; and (iv) any cost sharing provisions included in the member's benefit plan. This form is not to be construed as a guarantee of payment.

**Provider's Signature Verifying Acceptance of Fees Specified by Plan** ______________________

**(You may sign this before or after the plan has responded payment rates)**

**Date of Provider Acceptance** ______________

## This Section to be Completed by Plan

| Allowable Amount | Allowed Days / Units | Covered Benefit? | | Prior Authoriz. Required? | |
|---|---|---|---|---|---|
| | | Yes | No | Yes | No |
| $ | | | | | |
| $ | | | | | |
| $ | | | | | |
| $ | | | | | |
| $ | | | | | |
| $ | | | | | |

**The provision of allowable amounts by the Plan assumes the provider renders services according to the requested procedure codes. It also assumes administration according to the Plan's administrative policies and in accordance with the member's benefits. NOTE: Fees are subject to change. Please verify fees at the time you call for prior authorization of services.**

**Signature of Plan Representative** ______________________ **Date** __________

**(see back of form for additional instructions)**

## Instructions to the Subscriber

- Complete Section 1 of the form—the section entitled *"To Be Completed By Subscriber".*
- Take the form to the provider you wish to participate as your Consumer Choice Option provider.
- The provider will return the completed form to Blue Cross and Blue Shield of Georgia/HMO Georgia, Inc. Note: Forms submitted without complete provider information will be returned to the member.
- Blue Cross and Blue Shield of Georgia/HMO Georgia will not "credential" any providers you may nominate. You may nominate any qualified provider in the State of Georgia. What this means is that the quality of the provider you nominate has not been screened and that it is solely your responsibility.
- Blue Cross and Blue Shield of Georgia/HMO Georgia will not provide in-network coverage for the provider you are nominating until you have been notified that the application has been approved. This written notice constitutes formal approval of the provider. **We will notify you of approval within 3 days of receiving a *complete* application**.

## Instructions to the Provider:

- This form must be completed in its entirety with all required fields complete.
- Fax the form to Blue Cross and Blue Shield of Georgia/HMO Georgia at (877) 541-1162.
- Blue Cross and Blue Shield of Georgia will notify you of approval to treat the patient within **3 business days of receipt** of the completed form.
- Treatment may not begin until you have received formal notification/authorization from the Plan.
- Contact Customer Service to verify benefits and to receive prior authorization of services **before** beginning treatment.

**Listed below is additional information to assist you in obtaining information on how to administer this Blue Cross and Blue Shield of Georgia or HMO Georgia Benefit Plan.**

**Customer Service: (800) 441-2273**

- Eligibility and benefit verification
- Claim status

**Medical Management: (800) 441-2273**

- Referral authorization (must be initiated by the member's Primary Care Physician)
- Pre-authorization of medical services, including hospitalizations and outpatient surgeries (contact Medical Management to determine whether services require prior authorization)
- Pre-admission certification
- Emergency hospitalization
- Case management

**Provider Relations**

- Explanation of plan policies and procedures
- Provider education
- Contractual claim issues
- Provider demographic changes

**Claims Department:**

Submit claims to: Blue Cross and Blue Shield of Georgia<br>P.O. Box 84053<br>Columbus, GA 31908