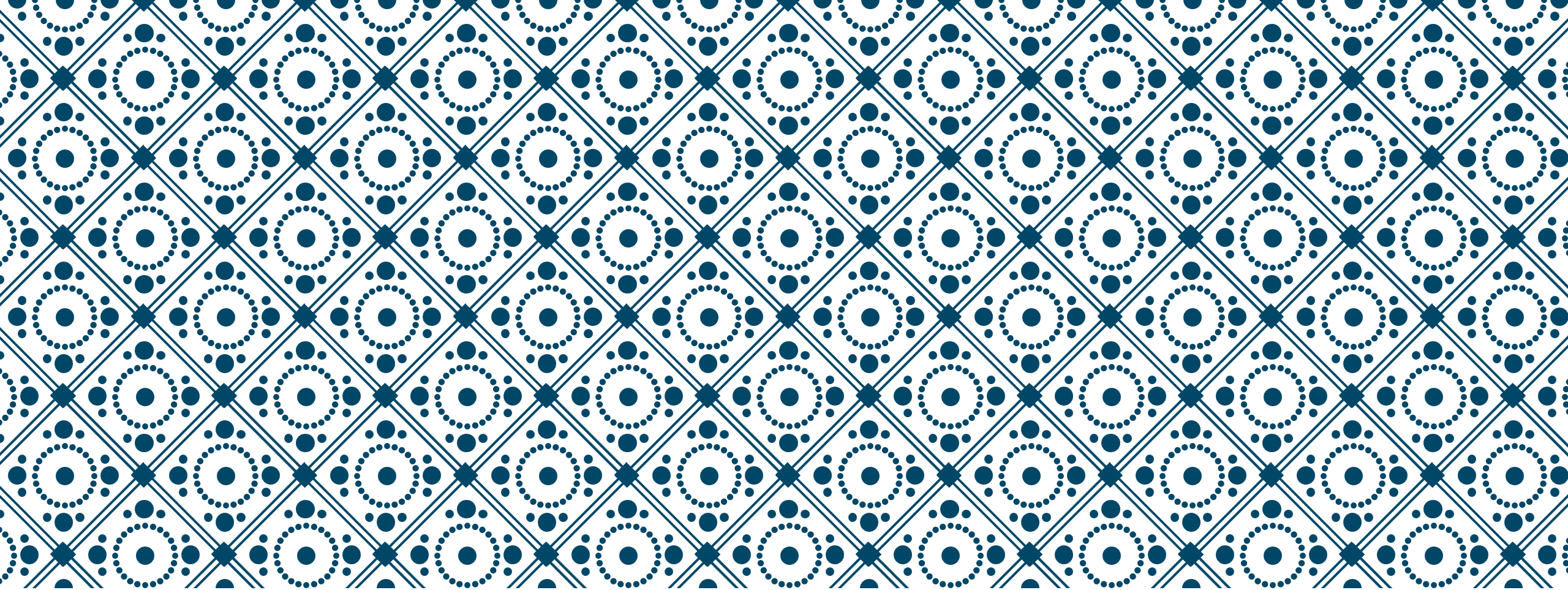


EXCEPTIONS

Waivers and Exemptions

EXCEPTIONS

- Pre-Billing Waivers
- Post Billing Waivers
- Exemptions

PRE-BILLING WAIVERS

- Provider not Enrolled
- Provider Unavailable
- Extra 15 miles/ 30 minutes
- DHS approved
- 45 Day Transition

PROVIDER NOT ENROLLED

EI provider is not included in the list of in network providers for the family's insurance carrier

- *Issued by CBO staff at the completion of a benefit verification check.*

PROVIDER UNAVAILABLE

Insurance covered provider is not immediately available to begin services within 15 business days.

- Requested by Service Coordinator after attempting to find availability with an EI enrolled provider that is also in network with the family's insurance carrier.

EXTRA 15 MILES/ 30 MINUTES

Family must travel more than 15 miles or 30 minutes for to receive services from an in-network provider.

- This waiver allows the family to see a provider in the clinic that is out of network but is closer to their home

DHS APPROVED

BCBS LAR Policy

DHS Request

45 DAY TRANSITION

Issued when there is a change in insurance.

- No insurance coverage to insurance coverage
- Change in insurance carriers
- Change in policy type (PPO to EPO)

✓Allows providers to make adjustment to new insurance.

- Safety net, expected to bill insurance during this time.

✓Allows Service Coordinator (SC) time to apply for long term waivers if needed

- Pre-billing waivers

POST-BILLING WAIVERS

Service Not Covered

Benefits Maximum has been Met

Issued after the provider had billed the family's insurance.

SERVICE IS NOT COVERED

Issued when the CBO receives an explanation of benefits or letter (that references a date of service) from the insurance company along with a claim form that states that the service billed is not a covered benefit.

EOB may state:

- Service is not a Covered Benefit
- Benefits for services were not approved during pre-certification
- Services do not meet coverage requirements.
- In home therapy not covered
- Charges are ineligible under your plan
- Developmental delay not covered
- Not medically necessary
- Medical group did not approve

MAX MET

Issued when the CBO receives an explanation of benefits from the insurance company along with a claim form that states that the maximum benefits for the service billed has been met for that benefit year.

EOB may state:

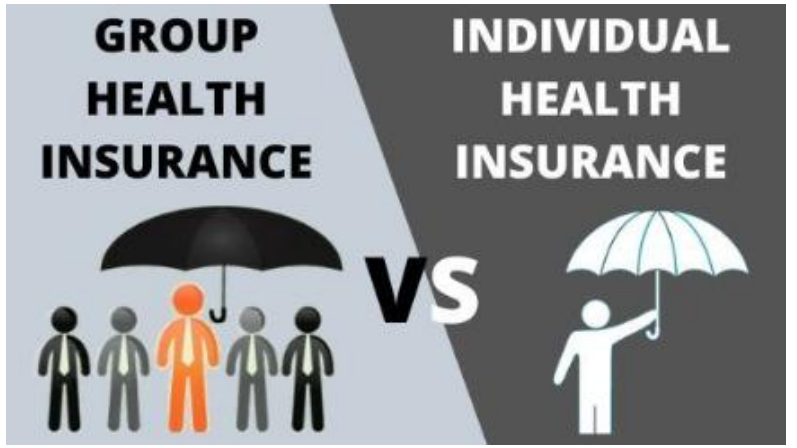
- Maximum benefits have been paid
  - 30 visits per year and all 30 visits have been paid to the provider they are now billing the 31st visit.

EXEMPTIONS

- Individual Plan*
- Pending Exemption*
- Caps on All Services
- Caps on Some Service
- HSA/HRA*

INDIVIDUAL PLAN

Issued when the family's plan has been purchased privately and is <u>not part of a group plan.</u>



PENDING EXEMPTION

Issued by the CBO when a request for an exemption is received.

CAP ON ALL SERVICES

Issued when there is a lifetime cap for the plan that could be endangered by billing the insurance for EI services.

- EI services must use at least 20% of the cap to be approved

CAP ON SOME SERVICES

Issued when there is a lifetime cap for a specific service that could be endangered by billing the insurance for EI services.

- EI services must use at least 20% of the cap to be approved

HSA/HRA

Issued when funds are automatically deducted from the account to pay EI providers when insurance is billed.

- Automatically withdrawn means the family does not have an option of how funds are spent. Payments made to providers from these accounts is beyond the family's financial obligation.
- Money paid out of these accounts cover co-pays and deductible. Parents in the EI program are not financially responsible for co-pays and deductibles.