Agenda item #

GLENBROOK HIGH SCHOOLS
Assistant Superintendent for Business/CSBO
Regular Meeting – Monday, February 22, 2016

TO: **Dr. Michael Riggle**

FROM: **Hillarie Siena**

DATE: **February 22, 2016**

RE: **Discussion/Action: Insurance Cost Containment Discussion**

AUGUST

- Board of Education information packet. March 1st through June 30th quarterly claims report will be placed in the information packet.

NOVEMBER

- Finance Committee regularly scheduled meeting. Review plan year actual claims for full plan year ending August 31st. Review plan enrollment data for new plan year beginning September 1st. Discuss topics for first Cost Containment Committee meeting in December.

- Board of Education regularly scheduled meeting. Discuss items from November Finance Committee meeting. Discuss topics for first Cost Containment Committee meeting in December.

FEBRUARY

- **Finance Committee regularly scheduled meeting. Review September 1st through November 30th quarterly claims report. Discuss items from December Cost Containment Committee meeting.**

- **Board of Education regularly scheduled meeting. Discuss items from February Finance Committee meeting.**

MARCH/APRIL

- Meet with HUB to review claims, trend data and plan design, and obtain recommendation for calculated premium increases. Review of SSCRMP pool performance.

APRIL

- Board of Education regularly scheduled meeting. Present renewal information (includes claims data through February) with recommendations for plan changes. Review SSCRMP pool performance.

- Present renewal information and recommended plan changes to the Cost Containment Committee.

MAY

- Present renewal information and recommended plan changes to all staff.

- Begin open enrollment period.

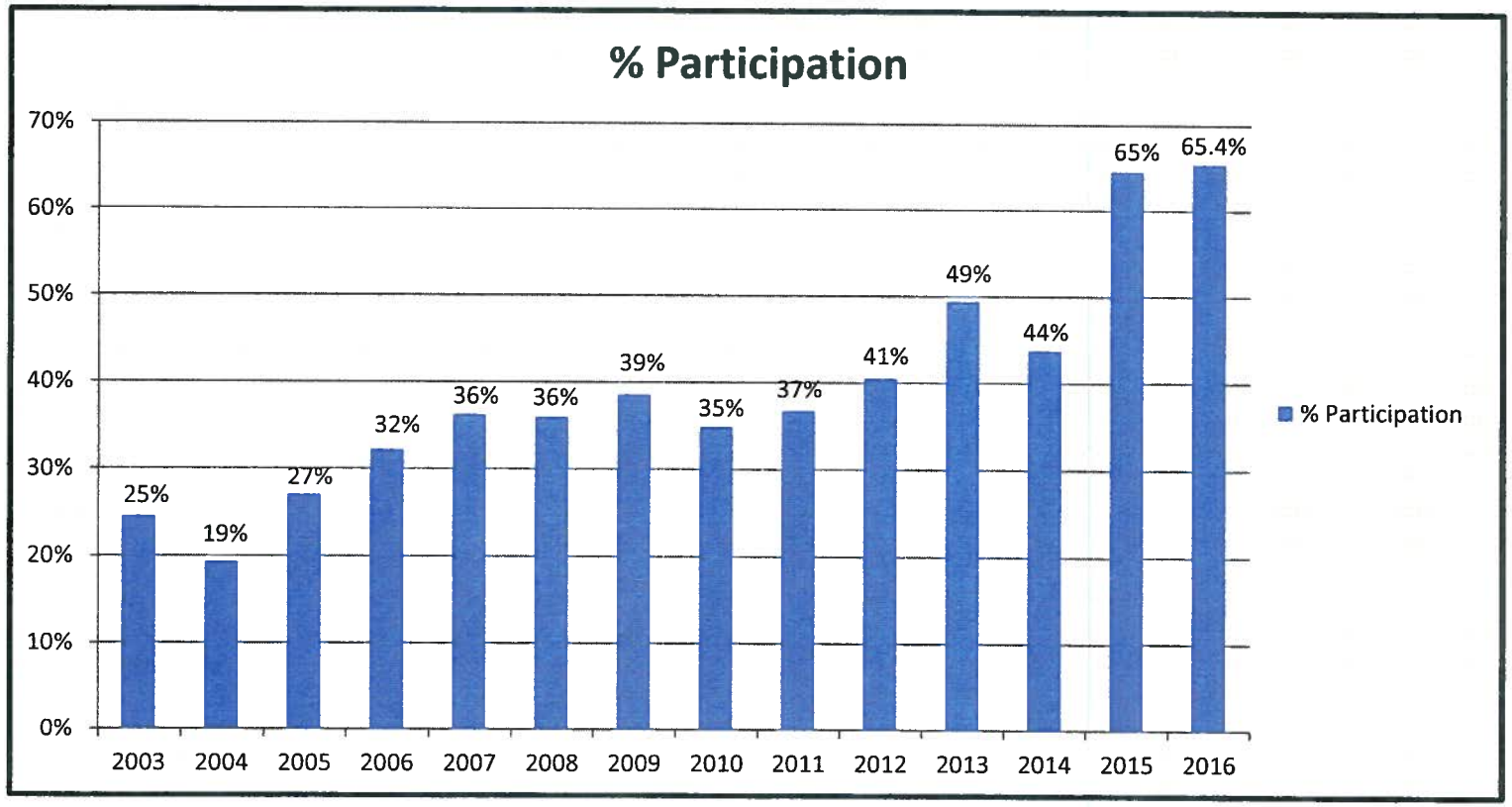
Cost Containment Committee Options
Plan Year 9/1/2015-8/31/2016

A	Initial Focus of Cost Containment Committee
	Spousal coverage survey - March 2016 Rx: Specialty Drug Tier (4th tier) Rx Discount card program - February 1, 2016

B	**Implemented 9/1/15 or 10/1/15**
	Rx: dropped co-pay for generic tier to zero **Rx: moved from National Formulary to Value Formulary category (10/1)** **Board contribution into Health Savings Accounts increased to $1,000/$1,600** **Wellness rebate eligibility expanded criteria** **Mandatory e-learning lesson on district insurance plans**

C	Deferred Items
	Expand from 2-tier to 4-tier PPO/HMOIL Plans Need projected shift in enrollment, impact on family premium and % of spouses potentially leaving plan Spousal carve-out/spousal surcharge Contribution Amounts in Proportion to Base Salary Explore compensation bands Greater Employee Participation in Premium Cost Sharing Establish cap on total claims, with shared cost on excess over cap Establish cap on % increase, with shared cost on excess over cap

Shape Your Life Wellness Program
Wellness Screening Participation History and Growth
FY2003 - 2016



Hillarie J Siena <hsiena@glenbrook225.org>

Glenbrook District #225 List of Individuals That Completed All 6 Required Activities and Earned $250 Rebate

1 message

Gorsky, Ben <bengorsky@hpn.com> Fri, Dec 18, 2015 at 3:39 PM
To: Hillarie J Siena <hsiena@glenbrook225.org>

Good afternoon Hillarie,

First off, I'm sorry for the long email! Whenever we're working with program incentives I always like to give a lot background info to paint as complete a picture as possible about participation. Hopefully I'm not over sharing.

I just securely emailed you an excel file containing the names of all the individuals from District #225 that completed all 6 of the program requirements this year to earn the $250 medical premium rebate which included: 1-Verifying / Updating Contact Information, 2-Annual Wellness Screening, 3-Health Power Assessment, 4-Have a Main/Primary Care Physician, 5-Compelte District #225 Medical Benefits e-Learning Lesson, and 6-Complete 2 Additional e-Learning Lessons from Qualifying List. There are a total of 454 individuals that fully participated this year and met all of the requirements.

The excel file also includes Insurance Plan, Relationship Type (Employee or Retiree), Building, and Rebate (1 if they should technically qualify for the $250 OR blank if they aren't on a district medical benefit plan as designated on the eligibility list this year) for all of the participants. Please note I included everyone whether you listed them as qualifying for the rebate or not just in case anyone changed their benefits this year and should be eligible now - I figured it's better to have more data as opposed to less in case you needed to double check. If it would help your team to have this file contain additional information or be sorted a certain way please let me know. We're happy to help further.

Last year a total of 533 individuals met the program requirements for the rebate which only included the wellness screening and health power assessment questionnaire, so this year's figure of 454 is down by 79. I would attribute this decrease to the number of additional requirements we added to the program this year. If this year's requirements were the same as last year (screening and health power assessment only) then participation would have actually increased this year to 545 individuals. So technically program engagement is up this year, but the number of participants that earned the incentive is down.

In case you happened to be curious... I wanted to pass along some metrics about individuals that **DID NOT** meet all of the program requirements, specifically in regards to by how many requirements participant's missed out on the $250 rebate by:

- Missed $250 By 1 Requirement - 13 participants *
- Missed $250 By 2 Requirement - 22 participants *
- Missed $250 By 3 Requirement - 63 participants
- Missed $250 By 4 Requirement - 30 participants
- Missed $250 By 5 Requirement - 30 participants
- Missed $250 By 6 Requirement - 285 participants

* About 29 participants (between users that missed the $250 rebate by 1 or 2 requirements) missed completing the e-Learning Lesson requirements only but did completed everything else.

Please let me know if you need anything else in regards to this. I will be sending the post-screening billing information (screening, reflex, and flu shot) in a follow-up secure email.

Thanks,
Ben

--
Benjamin Gorsky
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Phone: 630.333.9020
Fax: 630.941.9064

Glenbrook Insurance Costs Actual vs Expected
September - December 2015

	Total Actual Costs	Total Expected Costs	
PPO	2,195,975	2,277,835	
HDPPO	382,142	304,009	
HMO	1,517,187	1,283,708	
HMOBA	173,708	154,724	
Total Medical	4,269,012	4,020,276	
		106.2%	Percentage of expected - Medical
Dental	214,232.00	241,729.00	
H S A Board Contributions	119,800.00	120,000.00	
Total Other Costs	334,032.00	361,729.00	
Total Insurance Costs	4,603,044	4,382,005	
		105.0%	Percentage of expected - All
Wellness Premium Rebate	114,000	133,250	
		85.6%	Percentage of expected

Glenbrook School District #225
Medical/Rx Reporting
PPO & Rx (Group # P21650)

	Medical and Rx								
	Lives	Members	Medical Claims	Rx Claims	Total Paid Claims	Total Fixed Costs	Total Actual Costs	Total Expected Costs	Actual / Expected
9/1/2015	418	989	$378,703	$207,137	$585,839	$35,716	$621,555	$570,482	109.0%
10/1/2015	418	989	$248,286	$186,123	$434,409	$29,195	$463,604	$570,482	81.3%
11/1/2015	417	985	$313,639	$161,783	$475,422	$32,416	$507,838	$569,117	89.2%
12/1/2015	416	982	$352,118	$216,562	$568,680	$34,298	$602,978	$567,753	106.2%
1/1/2016									
2/1/2016									
3/1/2016									
4/1/2016									
5/1/2016									
6/1/2016									
7/1/2016									
8/1/2016									
Total	1,669	3,945	$1,292,746	$771,604	$2,064,350	$131,625	$2,195,975	$2,277,835	96.4%
S/L Recoveries			$0		$0		$0		
Revised Total			$1,292,746	$771,604	$2,064,350	$131,625	$2,195,975	$2,277,835	96.4%
2016 PEPY	417		$8,972	$5,548	$14,520	$946	$15,466	$16,377	
2016 PMPY		986	$3,782	$2,347	$6,129	$400	$6,529	$6,929	

Glenbrook School District #225
Medical/Rx Fixed Costs
PPO & Rx (Group # P21650)

	Lives	Medical ASO Fee	Access Fee	RxRebates	Transitional Reinsurance Fee	Individual Stop Loss Premium	PCORI	Total
9/1/2015	418	$18,935	$1,965	($4,046)	$3,626	$15,065	$171	$35,716
10/1/2015	418	$12,414	$1,965	($4,046)	$3,626	$15,065	$171	$29,195
11/1/2015	417	$15,682	$1,960	($4,037)	$3,612	$15,029	$171	$32,416
12/1/2015	416	$17,606	$1,955	($4,027)	$3,601	$14,993	$170	$34,298
1/1/2016								
2/1/2016								
3/1/2016								
4/1/2016								
5/1/2016								
6/1/2016								
7/1/2016								
8/1/2016								
Total	1,669	$64,637	$7,844	($16,156)	$14,465	$60,151	$684	$131,625
2016 PEPM	417	$38.73	$4.70	($9.68)	$8.67	$36.04	$0.41	$78.86

Glenbrook School District #225
Medical/Rx Reporting
HSA & Rx (Group # P41885)

	Medical and Rx								
	Lives	Members	Medical Claims	Rx Claims	Total Paid Claims	Total Fixed Costs	Total Actual Costs	Total Expected Costs	Actual / Expected
9/1/2015	90	221	$77,770	$698	$78,467	$7,728	$86,195	$76,002	113.4%
10/1/2015	90	221	$62,604	$14,690	$77,293	$6,970	$84,263	$76,002	110.9%
11/1/2015	90	221	$47,394	$12,879	$60,273	$6,209	$66,482	$76,002	87.5%
12/1/2015	90	221	$119,459	$15,931	$135,390	$9,812	$145,203	$76,002	191.1%
1/1/2016									
2/1/2016									
3/1/2016									
4/1/2016									
5/1/2016									
6/1/2016									
7/1/2016									
8/1/2016									
Total	360	884	$307,227	$44,197	$351,424	$30,719	$382,142	$304,009	125.7%
S/L Recoveries			$0		$0		$0		
Revised Total			$307,227	$44,197	$351,424	$30,719	$382,142	$304,009	125.7%
2016 PEPY	90		$11,038	$1,473	$12,511	$1,024	$13,535	$10,134	
2016 PMPY		221	$4,580	$600	$5,180	$417	$5,597	$4,127	

Glenbrook School District #225
Medical/Rx Fixed Costs
HSA & Rx (Group # P41885)

	Lives	Medical ASO Fee	Access Fee	RxRebates	Transitional Reinsurance Fee	Individual Stop Loss Premium	PCORI	Total
9/1/2015	90	$3,888	$518	($771)	$810	$3,244	$38	$7,728
10/1/2015	90	$3,130	$518	($771)	$810	$3,244	$38	$6,970
11/1/2015	90	$2,370	$518	($771)	$810	$3,244	$38	$6,209
12/1/2015	90	$5,973	$518	($771)	$810	$3,244	$38	$9,812
1/1/2016								
2/1/2016								
3/1/2016								
4/1/2016								
5/1/2016								
6/1/2016								
7/1/2016								
8/1/2016								
Total	360	$15,361	$2,074	($3,085)	$3,241	$12,974	$153	$30,719
2016 PEPM	90	$42.67	$5.76	($8.57)	$9.00	$36.04	$0.43	$85.33

Glenbrook School District #225
Medical/Rx Reporting
HMO-I & Rx (Group #H21650)

	Medical and Rx									
	Lives	Members	Medical Claims	Rx Claims	Total Paid Claims	Physician Service Fee (PSF)	Total Fixed Costs	Total Actual Costs	Expected Costs	Actual / Expected
9/1/2015	268	752	$82,583	$48,461	$131,044	$111,761	$31,776	$274,582	$323,036	85.0%
10/1/2015	267	751	$223,693	$42,805	$266,499	$111,344	$31,664	$409,508	$321,831	127.2%
11/1/2015	266	752	$248,947	$44,646	$293,593	$110,927	$31,560	$436,080	$320,626	136.0%
12/1/2015	264	747	$204,776	$50,824	$255,600	$110,093	$31,325	$397,018	$318,215	124.8%
1/1/2016										
2/1/2016										
3/1/2016										
4/1/2016										
5/1/2016										
6/1/2016										
7/1/2016										
8/1/2016										
Total	1,065	3,002	$759,999	$186,736	$946,736	$444,126	$126,326	$1,517,187	$1,283,708	118.2%
S/L Recoveries			$0		$0			$0		
Revised Total			$759,999	$186,736	$946,736	$444,126	$126,326	$1,517,187	$1,283,708	118.2%
2016 PEPY	266		$8,507	$2,104	$10,612	$5,004	$1,423	$17,039	$14,464	
2016 PMPY		751	$3,016	$746	$3,762	$1,775	$505	$6,043	$5,131	

Glenbrook School District #225
Medical/Rx Fixed Costs
HMO-I & Rx (Group #H21650)

	Lives	Medical Admin Fee	RxRebates	Transitional Reinsurance Fee	Individual Stop Loss Premium	Managed Care	ACA Taxes & Fees	Total
9/1/2015	268	$11,406	($2,069)	$2,757	$13,931	$2,870	$2,881	$31,776
10/1/2015	267	$11,364	($2,061)	$2,754	$13,879	$2,860	$2,870	$31,664
11/1/2015	266	$11,321	($2,054)	$2,757	$13,827	$2,849	$2,860	$31,560
12/1/2015	264	$11,236	($2,038)	$2,739	$13,723	$2,827	$2,838	$31,325
1/1/2016								
2/1/2016								
3/1/2016								
4/1/2016								
5/1/2016								
6/1/2016								
7/1/2016								
8/1/2016								
Total	1,065	$45,326	($8,222)	$11,007	$55,359	$11,406	$11,449	$126,326
2016 PEPM	266	$42.56	($7.72)	$10.34	$51.98	$10.71	$10.75	$118.62

Glenbrook School District #225
Medical/Rx Reporting
HMO-BA & Rx (Group #B21650)

	Medical and Rx									
	Lives	Members	Medical Claims	Rx Claims	Total Paid Claims	Physician Service Fee (PSF)	Total Fixed Costs	Total Actual Costs	Expected Costs	Actual / Expected
9/1/2015	47	113	$5,280	$4,747	$10,026	$18,718	$5,503	$34,247	$38,681	88.5%
10/1/2015	48	116	$9,450	$6,730	$16,179	$19,116	$5,623	$40,918	$39,504	103.6%
11/1/2015	47	115	$3,673	$7,682	$11,355	$18,718	$5,511	$35,584	$38,681	92.0%
12/1/2015	46	114	$34,500	$4,740	$39,240	$18,320	$5,399	$62,958	$37,858	166.3%
1/1/2016										
2/1/2016										
3/1/2016										
4/1/2016										
5/1/2016										
6/1/2016										
7/1/2016										
8/1/2016										
Total	188	458	$52,902	$23,899	$76,801	$74,871	$22,036	$173,708	$154,724	112.3%
S/L Recoveries			$0		$0			$0		
Revised Total			$52,902	$23,899	$76,801	$74,871	$22,036	$173,708	$154,724	112.3%
2016 PEPY	47		$3,450	$1,525	$4,976	$4,779	$1,407	$11,161	$9,876	
2016 PMPY		115	$1,423	$626	$2,050	$1,962	$577	$4,589	$4,054	

Glenbrook School District #225
Medical/Rx Fixed Costs
HMO-BA & Rx (Group #B21650)

	Lives	Medical Admin Fee	RxRebates	Transitional Reinsurance Fee	Individual Stop Loss Premium	Managed Care	ACA Taxes & Fees	Total
9/1/2015	47	$2,000	($363)	$414	$2,443	$503	$505	$5,503
10/1/2015	48	$2,043	($371)	$425	$2,495	$514	$516	$5,623
11/1/2015	47	$2,000	($363)	$422	$2,443	$503	$505	$5,511
12/1/2015	46	$1,958	($355)	$418	$2,391	$493	$495	$5,399
1/1/2016								
2/1/2016								
3/1/2016								
4/1/2016								
5/1/2016								
6/1/2016								
7/1/2016								
8/1/2016								
Total	188	$8,001	($1,451)	$1,679	$9,772	$2,013	$2,021	$22,036
2016 PEPM	47	$42.56	($7.72)	$8.93	$51.98	$10.71	$10.75	$117.21

Glenbrook School District #225
Dental Reporting
Group #21651

	Dental					
	Lives	Dental Claims	Total Fixed Costs	Total Actual Costs	Total Expected Costs	Actual / Expected
9/1/2015	678	$52,772	$2,339	$55,111	$60,634	90.9%
10/1/2015	678	$50,738	$2,339	$53,077	$60,634	87.5%
11/1/2015	675	$39,890	$2,329	$42,218	$60,365	69.9%
12/1/2015	672	$61,507	$2,318	$63,825	$60,097	106.2%
1/1/2016						
2/1/2016						
3/1/2016						
4/1/2016						
5/1/2016						
6/1/2016						
7/1/2016						
8/1/2016						
Total	2,703	$204,907	$9,325	$214,232	$241,729	88.6%
2016 PEPY	676	$900	$41	$941	$1,073	

Glenbrook School District #225
Dental Fixed Costs
Group #21651

	Lives	Dental ASO Fee	Total
9/1/2015	678	$2,339	$2,339
10/1/2015	678	$2,339	$2,339
11/1/2015	675	$2,329	$2,329
12/1/2015	672	$2,318	$2,318
1/1/2016			
2/1/2016			
3/1/2016			
4/1/2016			
5/1/2016			
6/1/2016			
7/1/2016			
8/1/2016			
Total	2,703	$9,325	$9,325
2016 PEPM	676	$3.45	$3.45

Glenbrook School District # 225

Aggregate Report -PPO & Rx (Group # P21650)

ASO

9/1/2014 - 8/31/2015

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
		GROSS CLAIMS		C+D				E+F+H	FIXED COSTS					I+J+K+L+M+N
Month	Employee Enrollment	Blue Cross	Blue Shield	Total Gross Medical	Access Fee	Amounts over ISL $250k	ISL Credits	Adj. Gross = Gross Claims + Access Fees + ISL Credits	Admin. Fee	Individual Stop-Loss Premium	Rx	Rx Rebates	Adjustments	Total Cost
Sept.	483	$ 287,173	$ 189,204	$ 476,376	$ 2,808	$ -	$ -	$ 479,184	$ 23,342	$ 15,828	$ 158,717	$ (14,206)	$ 87	$ 662,950
Oct.	467	$ 84,501	$ 187,236	$ 271,737	$ 825	$ -	$ -	$ 272,562	$ 13,315	$ 15,304	$ 180,811	$ -	$ -	$ 481,992
Nov.	472	$ 189,475	$ 156,798	$ 346,273	$ 1,753	$ -	$ -	$ 348,026	$ 16,967	$ 15,467	$ 157,523	$ -	$ -	$ 537,984
Dec.	471	$ 202,476	$ 209,704	$ 412,180	$ 1,886	$ -	$ -	$ 414,065	$ 20,197	$ 15,435	$ 218,409	$ (12,175.88)	$ -	$ 655,929
Jan.														
Feb.														
Mar.														
Apr.														
May														
June														
July														
Aug.														
TOTAL	1,893	$ 763,624	$ 742,941	$ 1,506,565	$ 7,272	$ -	$ -	$ 1,513,837	$ 73,822	$ 62,034	$ 715,460	$ (26,384)	$ 87	$ 2,338,855
AVG	473	$ 190,906	$ 185,735	$ 376,641	$ 1,818	$ -	$ -	$ 378,459	$ 18,455	$ 15,508	$ 178,865	$ (6,596)	$ 22	$ 584,714

Notes: Sept. Adjustment is for August Manual Claim of ($231.76) and $319.09 in vendor fees

Premium Equivalency Rates - 9/1/2013			
Active Single	Active Family	Medicare Single	Medicare Family
$ 724	$ 1,450	$ 254	$ 490

	SSCRMP Renewal 7/1	
Monthly Factors & Rates	7/01/14 to 6/3/15	7/01/15 to 8/31/15
Individual Stop Loss	$250,000	
Expected Claims Factor	N/A	
Aggregate Claims Factor	N/A	
Access Fee	0.63%	
Administrative Rate	4.90%	
Individual Stop-Loss Rate	$32.77	
Aggregate Stop-Loss (Annual)	N/A	

Month	Single	Family	Medicare Single	Medicare Family	Total Enrollment	Premium Equivalency	% of Total Cost to Premium Equivalency
Sept.	199	279	4	1	483	$ 550,132	120.51%
Oct.	194	269	4	0	467	$ 531,522	90.68%
Nov.	192	276	4	0	472	$ 540,224	99.59%
Dec.	192	275	4	0	471	$ 538,774	121.74%
Jan.							
Feb.							
Mar.							
Apr.							
May							
June							
July							
Aug.							
Total	777	1099	16	1	1893	$ 2,160,652	108.25%

Total Cost/Total Enrollment	Total Cost PEPM
Sept.	$ 1,373
Oct.	$ 1,032
Nov.	$ 1,140
Dec.	$ 1,393
Jan.	
Feb.	
Mar.	
Apr.	
May	
June	
July	
Aug.	
Total	$ 1,234

NOTE: All data presented has been transcribed directly from the BCBSIL BARS bills.
To guarantee financial accuracy, please use the data directly from your BCBSIL BARS bill.

Printed: 2/3/2015

Aggregate Report - H S A & Rx (Group # P41885)
ASO
9/1/2013 - 8/31/2014

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
		GROSS CLAIMS			C+D+E				F+G+I	FIXED COSTS				J+K+L+M+N+O
Month	Employee Enrollment	Blue Cross	Blue Shield	Rx	Total Gross Medical	Access Fee	Amounts over ISL $250k	ISL Credits	Adj. Gross = Gross Claims + Access Fees + ISL Credits	Admin. Fee	Individual Stop-Loss Premium	Rx Rebates	Adjustments	Total Cost
Sept.	50	$ 38,617	$ 15,349	$ 5,804	$ 59,771	$ 512	$ -	$ -	$ 60,283	$ 2,644	$ 1,639	$ (764)	$ -	$ 63,802
Oct.	46	$ 27,703	$ 15,811	$ 1,919	$ 45,433	$ 515	$ -	$ -	$ 45,948	$ 2,226	$ 1,507	$ (702)	$ 811	$ 49,790
Nov.	49	$ 30,346	$ 16,030	$ 3,194	$ 49,571	$ 614	$ -	$ -	$ 50,185	$ 2,429	$ 1,606	$ (748)	$ -	$ 53,471
Dec.	49	$ 17,019	$ 18,812	$ 8,036	$ 43,867	$ 377	$ -	$ -	$ 44,244	$ 2,149	$ 1,606	$ (748)	$ -	$ 47,251
Jan.														
Feb.														
Mar.														
Apr.														
May														
June														
July														
Aug.														
TOTAL	194	$ 113,686	$ 66,002		$ 198,642	$ 2,017	$ -	$ -	$ 200,659	$ 9,449	$ 6,357	$ (2,962)	$ 811	$ 214,314
AVG	49	$ 28,421	$ 16,501		$ 49,660	$ 504	$ -	$ -	$ 50,165	$ 2,362	$ 1,589	$ (741)	$ 203	$ 53,579

Notes: September admin fee does not include the Rx claims
Oct. Adjustment is an Rx adjustment from September

Premium Equivalency Rates - 9/1/2013			
Active Single	Active Family	Medicare Single	Medicare Family
$ 482	$ 966	$ -	$ -

	SSCRMP Renewal 7/1	
Monthly Factors & Rates	7/01/14 to 6/3/15	7/01/15 to 8/31/15
Individual Stop Loss	$250,000	
Expected Claims Factor	N/A	
Aggregate Claims Factor	N/A	
Access Fee	0.63%	
Administrative Rate	4.90%	
Individual Stop-Loss Rate	$32.77	
Aggregate Stop-Loss (Annual)	N/A	
Rx Rebate	($15.27)	

Month	Single	Family	Medicare Single	Medicare Family	Total Enrollment	Premium Equivalency	% of Total Cost to Premium Equivalency
Sept.	22	28	0	0	50	$ 37,652	169.45%
Oct.	18	28	0	0	46	$ 35,724	139.37%
Nov.	21	28	0	0	49	$ 37,170	143.86%
Dec.	21	28	0	0	49	$ 37,170	127.12%
Jan.							
Feb.							
Mar.							
Apr.							
May							
June							
July							
Aug.							
Total	82	112	0	0	194	$ 147,716	145.09%

Total Cost/Total Enrollment Total Cost PEPM	
Sept.	$ 1,276
Oct.	$ 1,082
Nov.	$ 1,091
Dec.	$ 964
Jan.	
Feb.	
Mar.	
Apr.	
May	
June	
July	
Aug.	
Total	$ 1,103

NOTE: All data presented has been transcribed directly from the BCBSIL BARS bills.
To guarantee financial accuracy, please use the data directly from your BCBSIL BARS bill.

Printed: 2/3/2015

Glenbrook School District # 225

Aggregate Report - HMO-I & Rx (Group #H21650)

Cost Plus

9/1/2014 - 8/31/2015

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
		GROSS CLAIMS			C+D+E			F+H	FIXED COSTS							I+J+K+L+M+N+O+P
Month	Enrollment	Blue Cross	Blue Shield	Rx	Total Gross Medical & Rx Claims	Amounts over ISL $125k	ISL Credits	Gross Claims + ISL Credits	Admin. Fee	HMO Managed Care Fee	Physician Service Fee (PSF)	Rx Rebates	Individual Stop-Loss Premium	ACA Taxes & Fees	Adjustments	Total Cost
Sept.	263	$ 82,403	$ 16,614	$ 37,409	$ 136,426	$ 9,486	$ (328)	$ 136,098	$ 10,617	$ 2,522	$ 109,710	$ (2,351)	$ 10,909	$ 6,081	$ -	$ 273,585
Oct.	260	$ 69,386	$ 8,430	$ 43,343	$ 121,158	$ 1,824	$ (32)	$ 121,127	$ 10,496	$ 2,493	$ 108,830	$ (2,324)	$ 10,785	$ 6,011	$ (2,511)	$ 254,906
Nov.	261	$ 133,929	$ 16,603	$ 50,980	$ 201,512	$ 48,869	$ (48,740)	$ 104,032	$ 10,537	$ 2,503	$ 109,005	$ (2,333)	$ 10,826	$ 2,158	$ -	$ 236,728
Dec.	262	$ 132,900	$ 26,531	$ 39,680	$ 199,111	$ 1,447	$ (767)	$ 198,344	$ 10,577	$ 2,513	$ 109,534	$ (2,342)	$ 10,868	$ 2,167	$ (43,971)	$ 287,689
Jan.																
Feb.																
Mar.																
Apr.																
May																
June																
July																
Aug.																
Stop Loss Settlement							($48,740)									
TOTAL	1,046	$ 418,617	$ 68,179	$ 171,411	$ 658,207	$ 61,626	$ (98,607)	$ 559,600	$ 42,227	$ 10,031	$ 437,078	$ (9,351)	$ 43,388	$ 16,417	$ (46,482)	$ 1,052,909
AVERAGE	262	$ 104,654	$ 17,045	$ 42,853	$ 164,552	$ 15,407	$ (12,467)	$ 139,900	$ 10,557	$ 2,508	$ 109,270	$ (2,338)	$ 10,847	$ 4,104	$ (11,620)	$ 263,227
						$	(36,981)									

*Note: October Adjustment - 3rd Qtr PDC Adjustment

November ISL credits = ($48,739.59) & ($48,740.20) in Settlement from 2013 - 2014 plan year

December Adjustment ($43,970.64) is the reimbursement of Transitional Reinsurance ACA fee that was collected

	SSCRMP Renewal 7/1	
Monthly Factors & Rates	7/01/14 to 6/3/15	7/01/15 to 8/31/15
Individual Stop Loss	$125,000	
Expected Claims Factor	N/A	
Aggregate Claims Factor	N/A	
Managed Care Fee	$9.59	
Physician Service Fee		
Single	$175.70	
Family	$528.48	
Administrative Rate	$40.37	
ACA Taxes 9/1/14 - 10/31/2014	$23.12	
11/1/2014 - 8/31/2014	$8.27	
Individual Stop-Loss Rate	$41.48	
Aggregate Stop-Loss (Annual)	N/A	
Rx Credit	($8.94)	

Premium Equivalency Rates			
Single	Family	Medicare Single	Medicare Family
$532	$1,440		

Month	Single	Family	Medicare Single	Medicare Family	Total Enrollment	Premium Equivalency	% of Total Cost to Premium Equivalency
Sept.	83	180	0	0	263	$303,356	90.19%
Oct.	81	179	0	0	260	$300,852	84.73%
Nov.	82	179	0	0	261	$301,384	78.65%
Dec.	82	180	0	0	262	$302,824	95.00%
Jan.							
Feb.							
Mar.							
Apr.							
May							
June							
July							
Aug.							
Total	328	718	0	0	1046	$1,208,416	87.13%

Total Cost/Total Enrollment Total Cost PEPM	
Sept.	$1,040
Oct.	$980
Nov.	$907
Dec.	$1,098
Jan.	
Feb.	
Mar.	
Apr.	
May	
June	
July	
Aug.	
Total	$1,006

NOTE: All data presented has been transcribed directly from the BCBSIL BARS bills.
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Printed: 2/3/2015

Glenbrook School District # 225

Aggregate Report - HMO-BA & Rx (Group #B21650)

Cost Plus

9/1/2014 - 8/31/2015

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
		GROSS CLAIMS			C+D+E			F+H	FIXED COSTS							I+M+N+O+P+Q +R
Month	Enrollment	Blue Cross	Blue Shield	Rx	Total Gross Medical & Rx Claims	Amounts over ISL $125k	ISL Credits	Gross Claims + ISL Credits	Admin. Fee	HMO Managed Care Fee	Physician Service Fee (PSF)	Rx Rebates	Individual Stop Loss Premium	ACA Taxes & Fees	Adjustments	Total Cost
Sept.	38	$ 7,170	$ 161	$ 3,841	$ 11,172	$ -	$ -	$ 11,172	$ 1,534	$ 364	$ 12,856	$ (340)	$ 1,576	$ 879	$ -	$ 28,041
Oct.	37	$ 2,253	$ 1,046	$ 5,725	$ 9,023	$ -	$ -	$ 9,023	$ 1,494	$ 355	$ 12,699	$ (331)	$ 1,535	$ 855	$ -	$ 25,631
Nov.	37	$ 312	$ 133	$ 2,659	$ 3,105	$ -	$ -	$ 3,105	$ 1,494	$ 355	$ 12,699	$ (331)	$ 1,535	$ 306	$ -	$ 19,163
Dec.	37	$ 48,732	$ 121	$ 5,811	$ 54,664	$ -	$ -	$ 54,664	$ 1,494	$ 355	$ 12,699	$ (331)	$ 1,535	$ 306	$ -	$ 70,722
Jan.																
Feb.																
Mar.																
Apr.																
May																
June																
July																
Aug.																
TOTAL	149	$ 58,467	$ 1,461	$ 18,036	$ 77,964	$ -	$ -	$ 77,964	$ 6,015	$ 1,429	$ 50,954	$ (1,332)	$ 6,181	$ 2,346	$ -	$ 143,556
AVERAGE	37	$ 14,617	$ 365	$ 4,509	$ 19,491	$ -	$ -	$ 19,491	$ 1,504	$ 357	$ 12,738	$ (333)	$ 1,545	$ 586	$ -	$ 35,889

*Note:

Monthly Factors & Rates		SSCRMP Renewal 7/1 7/01/14 to 6/3/15	7/01/15 to 8/31/15
Individual Stop Loss		$125,000	
Expected Claims Factor		N/A	
Aggregate Claims Factor		N/A	
Managed Care Fee		$9.59	
Physician Service Fee			
	Single	$156.45	
	Family	$470.57	
Administrative Rate		$40.37	
ACA Taxes	9/1/2014 - 10/31/2014	$23.12	
	11/1/2014 - 8/31/2015	$8.27	
Individual Stop-Loss Rate		$41.48	
Aggregate Stop-Loss (Annual)		N/A	
Rx Credit		($8.94)	

Premium Equivalency Rates				
Active Single	+Spouse	Family	Medicare Single	Medicare Family
$426	$826	$1,084	$426.00	$826.00

Month	Single	+Spouse	Family	Medicare Single	Medicare Family	Total Enrollment	Premium Equivalency	% of Total Cost to Premium Equivalency
Sept.	15	5	17	1	0	38	$29,374	95.46%
Oct.	14	5	17	1	0	37	$28,948	88.54%
Nov.	14	5	17	1	0	37	$28,948	66.20%
Dec.	14	5	17	1	0	37	$28,948	244.31%
Jan.								
Feb.								
Mar.								
Apr.								
May								
June								
July								
Aug.								
Total	57	20	68	4	0	149	$116,218	123.52%

Total Cost/Total Enrollment Total Cost PEPM	
Sept.	$738
Oct.	$693
Nov.	$518
Dec.	$1,911
Jan.	
Feb.	
Mar.	
Apr.	
May	
June	
July	
Aug.	
Total	$965

NOTE: All data presented has been transcribed directly from the BCBSIL BARS bills.

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Printed: 2/3/2015

Glenbrook School District # 225

Aggregate Report - Dental (Group # 21651)

9/1/2014 - 8/31/2015

A	B	C	D	E	F	G	H
							E+F+G
Month	Single	Family	Total Enrollment	Dental Claims	Dental Admin	Adjustments	Total Cost
Sept.	296	394	690	$64,834	$2,381	$0	$67,214
Oct.	286	382	668	$55,209	$2,305	$0	$57,514
Nov.	286	388	674	$52,414	$2,305	$0	$54,718
Dec.	286	389	675	$59,470	$2,329	$0	$61,799
Jan.							
Feb.							
March							
April							
May							
June							
July							
Aug.							
TOTAL	1,154	1,553	2,707	$231,926	$9,318	$0	$241,245
AVERAGE	289	388	677	$57,982	$2,330	$0	$60,311

Dental Admin. 9/1/2014	
$3.45	PEPM
Dental Admin. 7/1/2015	
	PEPM

Premium Equivalency Rates	
Single	$50
Family	$120

Month	Single	Family	Total Enrollment	Premium Equivalency	% of Total Cost to PE
September	296	394	690	$62,080	108.27%
October	286	382	668	$60,140	95.63%
November	286	388	674	$60,860	89.91%
December					
January					
February					
March					
April					
May					
June					
July					
August					
Total	868	1,164	2,032	$183,080	131.77%

NOTE: Dental Admin Fee was Changed to $3.35 PEPM retro to 7/1/2012 - Correction has not been made to system - Credit will be applied on the next possible statement

Printed: 2/3/2015

text_0 (5)

Mike:
I am working with a TPA out of Fort Wayne IN.
They employ a proactive approach to claims management by looking at pre-certifications of covered individuals so they can have a heads up on evolving large hospital claims. This proactive approach is similar to what we practice on our workers comp claims.
We need to avail ourselves of as many tools to manage our risks .
Something to ask our current broker to review for feasibility.
Joel

UTILIZATION REVIEW PROGRAM

The Claim Administrator has established the Utilization Review Program to assist you in determining the course of treatment that will maximize your benefits under this Health Care Plan. The Utilization Review Program requires a review of the following Covered Services **before** such services are rendered:

- Inpatient Hospital services
- Skilled Nursing Facility services
- Services received in a Coordinated Home Care Program
- Private Duty Nursing Services

You are responsible for satisfying Preadmission/Admission Review requirements. This means that you must ensure that you, your family member, or Provider of services must comply with the guidelines below. Failure to obtain Preadmission/Admission Review for services will require additional steps and/or benefit reductions as described in the provision entitled FAILURE TO NOTIFY. The toll-free telephone number for Preadmission/Admission Review is on your ID card. Please read the provisions below very carefully.

PREADMISSION REVIEW

- **Inpatient Hospital Preadmission Review**

  Preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  Whenever a nonemergency or nonmaternity Inpatient Hospital admission is recommended by your Physician, in order to receive maximum benefits under this benefit booklet, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the Hospital admission.

  If the proposed Hospital admission or health care services are determined to be not Medically Necessary, some days, services or the entire hospitalization will be denied. The Hospital and your Physician will be advised verbally of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. These letters may not be received prior to your scheduled date of admission.

- **Emergency Admission Review**

  Emergency admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  In the event of an emergency admission, in order to receive maximum benefits under this benefit booklet, you or someone who calls on your

behalf must notify the Claim Administrator no later than two business days or as soon as reasonably possible after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

- **Pregnancy/Maternity Admission Review**

  Pregnancy/Maternity admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Health Care Plan.

  In the event of a maternity admission, in order to receive maximum benefits under this benefit booklet, you or someone who calls on your behalf must notify the Claim Administrator no later than two business days after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

  Even though you are not required to call the Claim Administrator prior to your maternity admission, if you call the medical pre-notification number as soon as you find out you are pregnant, the Claim Administrator will provide you information on support programs to assist you during pregnancy.

- **Skilled Nursing Facility Preadmission Review**

  Skilled Nursing Facility preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  Whenever an admission to a Skilled Nursing Facility is recommended by your Physician, in order to receive maximum benefits under this benefit booklet, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

- **Coordinated Home Care Program Preadmission Review**

  Coordinated Home Care Program preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  Whenever an admission to a Coordinated Home Care Program is recommended by your Physician, in order to receive maximum benefits under this benefit booklet, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

- **Private Duty Nursing Service Review**

  Private Duty Nursing Service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  Whenever Private Duty Nursing Service is recommended by your Physician, in order to receive maximum benefits under this benefit booklet, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to receiving services.

CASE MANAGEMENT

Case management is a collaborative process that assists you with the coordination of complex care services. A Claim Administrator case manager is available to you as an advocate for cost-effective interventions.

Case managers are also available to you to provide assistance when you need alternative benefits. Alternative benefits will be provided only so long as the Claim Administrator determines that the alternative services are Medically Necessary and cost-effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations, and exclusions of the Health Care Plan.

LENGTH OF STAY/SERVICE REVIEW

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Upon completion of the preadmission or emergency review, the Claim Administrator will send a letter to your Physician and/or the Hospital confirming that you or your representative called the Claim Administrator and that an approved length of service or length of stay was assigned.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary. In the event that the extension is determined not to be Medically Necessary, the authorization will not be extended. Additional notification will be provided to your Physician and/or the Hospital regarding the denial of payment for the extension.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient care or other health care services or supplies are not Medically Necessary will be determined by the Claim Administrator. The Claim Administrator will provide notification of a decision to not authorize

payment for Inpatient care or other health care services or supplies to you, your Physician, and/or the Hospital or other Provider. The notification will specify the dates, services and/or supplies that are not considered Covered Services. For further details regarding Medically Necessary care and other exclusions from coverage, see the EXCLUSIONS—WHAT IS NOT COVERED section in this benefit booklet.

The Claim Administrator does not determine your course of treatment or whether you receive particular health care services. Decisions regarding the course of treatment and receipt of particular health care services are a matter entirely between you and your Physician. The Claim Administrator's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization or other health care service is a Covered Service under the Health Care Plan.

In the event that the Claim Administrator determines that all or any portion of an Inpatient hospitalization or other health care service is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service charge incurred.

Remember that the Claim Administrator's Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not determined to be Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as medically necessary, the Claim Administrator will not pay for the hospitalization, services or supplies unless the Claim Administrator determines it to be Medically Necessary and a Covered Service under the Health Care Plan.

NOTE: Keep in mind that a Medically Necessary determination does not guarantee that benefits are available. For example, it might be determined that a service is Medically Necessary, however, the Health Care Plan may limit or exclude that service. In that case, the Medically Necessary determination does not override the benefit provision in the benefit booklet.

UTILIZATION REVIEW PROCEDURE

The following information is required when you contact the Claim Administrator:

1. The name of the attending and/or admitting Physician;
2. The name of the Hospital where the admission has been scheduled and/or the location where the service has been scheduled;
3. The scheduled admission and/or service date; and
4. A preliminary diagnosis or reason for the admission and/or service.

Upon receipt of the required information, the Claim Administrator:

1. will review the information provided and seek additional information as necessary.
2. will issue a determination that the services are either Medically Necessary or are not Medically Necessary.
3. will provide notification of the determination.

APPEAL PROCEDURE

If you or your Physician disagree with the determination of the Claim Administrator prior to or while receiving services, you may appeal that decision. You should call the Claim Administrator's customer service number on your identification card. Your Physician should use the contact information in the notification letter.

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter, you may appeal that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

Medical Director
Health Care Service Corporation
P. O. Box A3957
Chicago, Illinois 60601

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

FAILURE TO NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Claim Administrator will not interfere with your relationship with any Provider. However, the Claim Administrator has established the Utilization Review Program for the specific purpose of assisting you in determining the course of treatment which will maximize your benefits provided under this benefit booklet.

Should you fail to notify the Claim Administrator as required in the Preadmission Review provision of this section, you will then be responsible for the first 20% of the Hospital or facility charges for an eligible stay or 20% of the charges for eligible Covered Services for Private Duty Nursing in addition to any deductibles, Copayments and/or Coinsurance applicable to this benefit booklet. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this benefit booklet nor can it be applied to your out-of-pocket expense limit, if applicable, as described in this benefit booklet.

MEDICARE ELIGIBLE MEMBERS

The preadmission review provisions of this Utilization Review Program do not apply to you if you are Medicare eligible and have secondary coverage provided under the Health Care Plan.

CLAIM ADMINISTRATOR'S MENTAL HEALTH UNIT

The Claim Administrator's Mental Health Unit has been established to assist in the administration of Mental Illness and Substance Use Disorder Rehabilitation Treatment benefits, including Preauthorization review, Emergency Mental Illness or Substance Use Disorder Admission Review and length of stay/service review for your Inpatient Hospital admissions and/or Outpatient services for the treatment of Mental Illness and Substance Use Disorders. The Mental Health Unit has staff which includes Physicians, Psychologists, Clinical Social Workers and registered nurses.

Failure to contact the Mental Health Unit or to comply with the determinations of the Mental Health Unit may result in a reduction of benefits. The Mental Health Unit may be reached twenty-four (24) hours a day, 7 days a week at the toll-free telephone number 1-800-851-7498. Please read the provisions below very carefully.

You are responsible for satisfying Preauthorization requirements. This means that you must ensure that you, your family member, your Behavioral Health Practitioner or Provider of services must comply with the guidelines below. Failure to Preauthorize services will require additional steps and/or benefit reductions as described in the provision entitled FAILURE TO PREAUTHORIZE OR NOTIFY.

PREAUTHORIZATION REVIEW

- **Inpatient Hospital Preauthorization Review**

  Preauthorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  In order to receive maximum benefits under this Health Care Plan, you must Preauthorize your nonemergency Inpatient Hospital admission for the treatment of Mental Illness or Substance Use Disorder by calling the Mental Health Unit. Participating and Non-Participating Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied. This call must be made at least one day prior to the Inpatient Hospital admission.

- **Emergency Mental Illness or Substance Use Disorder Admission Review**

  Emergency Mental Illness or Substance Use Disorder Admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  In order to receive maximum benefits under this Health Care Plan, you or someone who calls on your behalf must notify the Mental Health Unit no later than two business days or as soon as reasonably possible after the admission for the treatment of Mental Illness or Substance Use Disorder

has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits. Participating and Non-Participating Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

- **Partial Hospitalization Treatment Program Review**

  Partial Hospitalization Treatment Program review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  In order to receive maximum benefits under this Health Care Plan, you must notify the Mental Health Unit no later then 48 hours after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. Participating and Non-Participating Providers may call for you, when required, but it is your responsibility to ensure these requirements are satisfied. This call must be made at least 48 hours after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. The Mental Health Unit will obtain information regarding the service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.

  If an Inpatient Emergency Mental Illness or Substance Use Disorder Admission occurs after a service(s), in order to receive maximum benefits under this Health Care Plan, an additional call must be made to the Mental Health Unit for an Emergency Mental Illness or Substance Use Disorder Admission Review.

- **Length of Stay/Service Review**

  Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  Upon completion of the Preauthorization or Emergency Mental Illness or Substance Use Disorder Review, the Mental Health Unit will send you a letter confirming that you or your representative called the Mental Health Unit. A letter assigning a length of service or length of stay will be sent to your Behavioral Health Practitioner and/or the Hospital.

  An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary as determined by the Mental Health Unit. In the event that the extension is determined not to be Medically Necessary, the length of stay/service will not be extended, and the case will be referred to a Mental Health Unit Physician for review.

OUTPATIENT SERVICE PREAUTHORIZATION REVIEW

- **Outpatient Service Preauthorization Review**

  Outpatient service Preauthorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  In order to receive maximum benefits under this Health Care Plan for Outpatient services for the treatment of Mental Illness or Substance Use Disorder, you must Preauthorize the following Outpatient service(s) by calling the Mental Health Unit:

  - Psychological testing
  - Neuropsychological testing
  - Electroconvulsive therapy
  - Intensive Outpatient Programs

  Participating and Non-Participating Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied. This call must be made at least one day prior to the scheduling of the planned Outpatient services(s). The Mental Health Unit will obtain information regarding the Outpatient service(s). The Mental Health Unit will obtain information regarding the Outpatient service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient Hospital admission, Outpatient service, or other health care services or supplies are not Medically Necessary, as such term is defined in this benefit booklet, will be determined by the Mental Health Unit. If the Mental Health Unit Physician concurs that the Inpatient Hospital admission, Outpatient service, or other health care service or supply does not meet the criteria for Medically Necessary care, some days, services or the entire hospitalization will be denied. Your Behavioral Health Practitioner and in the case of an Inpatient Hospital admissions, the Hospital will be advised by telephone of this determinations, with a follow-up notification letter sent to you, your Behavioral Health Practitioner and the Hospital, and will specify the dates, services or supplies that are not considered Medically Necessary. The Mental Health Unit will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission or service. For further details regarding Medically Necessary care and other exclusions described in this benefit booklet, see the provision entitled, "EXCLUSIONS—WHAT IS NOT COVERED."

The Mental Health Unit does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is

a matter entirely between you and your Behavioral Health Practitioner. The Mental Health Unit's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization, Outpatient service or other health care service is Medically Necessary under the Health Care Plan.

In the event that the Mental Health Unit determines that all or any portion of an Inpatient Hospital admission, Outpatient service, or other health care service or supply is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service or supply charge incurred.

Remember that your Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Behavioral Health Practitioner or another health care Provider may prescribe, order, recommend or approve an Inpatient Hospital admission , Outpatient service or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Behavioral Health Practitioner prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, the Claim Administrator will not pay for the hospitalization, services or supplies if the Mental Health Unit Physician decides they were not Medically Necessary.

MENTAL HEALTH UNIT PROCEDURE

When you contact the Mental Health Unit to Preauthorize your Inpatient Hospital admission, Outpatient service, and/or other service/supply, provide notification of your Emergency Mental Illness or Substance Use Disorder Admission, or request a length of stay/service review you should be prepared to provide the following information:

1. the name of the attending and/or admitting Behavioral Health Practitioner;
2. the name of the Hospital or facility where the admission and/or service has been scheduled, when applicable;
3. the scheduled admission and/or service date; and
4. a preliminary diagnosis or reason for the admission and/or service.

When you contact the Mental Health Unit to Preauthorize your Inpatient Hospital admission, Outpatient service, and /or other service/supply, provide notification of your Emergency Mental Illness or Substance Use Disorder Admission, or request a length of stay/service review, the Mental Health Unit:

1. will review the medical information provided and follow-up with the Behavioral Health Practitioner;
2. upon request, will advise you of Participating Providers in the area who may be able to provide the admission and/or services that are the subject of the Preauthorization Review;

3. may determine that the admission and/or services to be rendered are not Medically Necessary.

APPEAL PROCEDURE

Expedited Appeal

If you or your Behavioral Health Practitioner disagrees with the determinations of the Mental Health Unit prior to or while receiving services, you or the Behavioral Health Practitioner may appeal that determination by contacting the Mental Health Unit and requesting an expedited appeal. The Mental Health Unit Physician will review your case and determine whether the service was Medically Necessary. You and/or your Behavioral Health Practitioner will be notified of the Mental Health Unit Physician's determination within twenty-four (24) hours or no later than the last authorized day. If you or your Behavioral Health Practitioner still disagree with the Mental Health Unit Physician, you may request an appeal in writing as outlined below.

Written Appeal

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after Claim processing has taken place or upon receipt of the notification letter from the Mental Health Unit, you may appeal that decision by having your Behavioral Health Practitioner call the contact person indicated in the notification letter or by submitting a written request to:

Blue Cross and Blue Shield of Illinois
Appeals Coordinator
Blue Cross and Blue Shield BH Unit
P. O. Box 660240
Dallas, Texas 75266-0240
Fax Number: 1-877-361-7656

You must exercise the right to this appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity.

Once you have requested this review, you may submit additional information and comments on your Claim to the Claim Administrator as long as you do so within 30 days of the date you asked for a review. Also, during this 30 day period, you may review any relevant documents held by the Claim Administrator, if you request an appointment in writing.

Within 30 days of receiving your request for review, the Claim Administrator will send you its decision on the Claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30 day period.

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.