Table of Contents

Introduction .......................................................................................................................... 3
Protected Health Information Disclosure Authorization Form ............................................. 5
Frequently Asked Questions about Medicare Reference-Based Pricing Plans ................. 6
Helpful Hints on Discussing the Plan with Your Physician .............................................. 8
Dear Member:

ResourceOne Administrators is the claims administrator for the “Group Name Here” Employee Health Benefit Plan, (the “Plan”). Please review this member packet and contact us with any questions you may have regarding its content.

Claims that are submitted to the Plan are reviewed for accuracy and reasonableness of charges as part of the Plan’s adjudication process. Federal law mandates that the Plan process claims in strict accordance with the terms of its Plan Document, and charges that exceed certain reasonable and customary limits are excluded from coverage. Claim analysis reduces healthcare costs by identifying errors and ensuring that the Plan pays healthcare service providers only for services they actually provide. The Plan caps payment at a usual-and-customary maximum-payable amount, based on industry standards, set forth by the terms of the Plan Document. If left undetected, billing errors and excess charges can result in higher premiums for you and your employer.

TAKE NOTE! When a medical-services provider accepts an assignment of benefits from you, they limit their rights to those set forth within the Plan Document. In other words, a provider that accepts assignment of benefits is no different from any other plan member. The Plan Document, your ID card, and other correspondence advises providers that they may only accept assignment of benefits from you if they agree to treat that assignment of benefits as payment in full for services rendered. Despite accepting assignment of benefits as payment in full, however, some providers may attempt to collect funds from you—above and beyond the maximum amount payable by the Plan or any copay, coinsurance, or deductible you may owe. This is called balance billing. If a provider or provider representative contacts for payment, we ask that you contact us immediately.

IF A PROVIDER OR ANY AGENCY SEEKING PAYMENT CONTACTS YOU REGARDING THESE CLAIMS, CONTACT US WITHOUT DELAY!

Please be aware that you are responsible for any amount attributed to your deductible, copay, or co-insurance.

To help you with any billing issues you may encounter, the Plan has selected Innovative Medical Risk Management, Inc. to provide you with a patient-advocacy program. We provide our services to individuals who may require assistance with locating a physician or other medical providers that will accept your Plan’s reimbursement. Your Plan is a Medicare reference-based pricing plan that generally bases payments to healthcare providers on the prices that Medicare would pay plus some incremental percentage of Medicare payment.

As your patient advocates, we can assist you in several ways:

- Provide education to you about your health plan
- Assure that you have the needed information about your health plan to communicate effectively with your physician and other treating providers
- Advocate for you by being a liaison between you and your providers about your Medicare reference-based pricing plan
- Provide education to your providers about your health plan’s reimbursement methods
- Contact your current providers about acceptance of your health plan
We may use your protected health information to coordinate our Patient Advocacy services more effectively. On the next page, you will find a Private Health Information Disclosure Authorization Form. Providers may require this authorization to allow us to obtain payment information for medical services. For each person in your household that participates in this plan, please print this authorization form, fill it out, sign it (or have the applicable participant sign it), and return it to us at:

ResourceOne Administrators
1350 S. Boulder Ave.
Third Floor
Tulsa, OK 74119

Please keep one copy for your records.

This member packet also contains sections entitled "Frequently Asked Questions about Medicare Reference Based Pricing Plans" and "Helpful Hints on Discussing the Plan with Your Physician." We have provided you with this information to assist with understanding your new health plan.

Please feel free to contact us if you have any questions or concerns at our toll-free number 866-271-1852

Sincerely,
ResourceOne Administrators
Protected Health Information Disclosure Authorization Form

I hereby authorize my health plan, healthcare provider, and their applicable business associates to disclose my Protected Health Information (“PHI”) to ResourceOne Administrators (“ROA”). I authorize ROA to assist me in obtaining health care services or payment information for those services. IMRM will not use this information for any purposes other than eligibility, precertification and authorization, utilization management, case management, disease management, and patient advocacy services. PHI includes the following: enrollment, claims, payment, or managed-care information. Unless otherwise indicated, my authorization includes the release of the following (please strike through those you wish to exclude, if any):

- Diagnosis or treatment for alcoholism, drug abuse, or dependency
- Diagnosis or treatment regarding mental health issues
- HIV antibody test results or diagnosis and treatment
- Genetic test results or related treatment

Unless otherwise revoked, this authorization will commence on the date indicated below and will expire on the following date: ________________. If I fail to specify an end date, this authorization will expire twelve months from the date below:

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 C.F.R. Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 C.F.R. Part 164), and the Privacy Act of 1974 (5 U.S.C. § 552a).

I understand that I may revoke the authorization at any time by giving written notice of the revocation to IMRM at 270 First Avenue South, Suite 100, St. Petersburg, FL 33701.

I understand that revocation of this authorization will not affect any action IMRM or other authorized parties have taken reliance on this authorization before IMRM received my written notice of revocation.

I understand that IMRM provides administrative and informational services only and does not provide health insurance or medical services—nor does it recommend treatment. Consequently, independent health care practitioners, who are not employees or agents of IMRM, will provide all medical services.

Identification of person or persons authorizing releases: (please complete all items):

Subscriber Name: _________________________________________________ SSN: ______________________

Employer Name: _____________________________________________________________________________

Signature: _________________________________________________  Date:___________________________

Signature: _________________________________________________  Date:___________________________

Signature: _________________________________________________  Date:___________________________

| Name of Participant: | | SSN: | |
|----------------------|-----------------|
| Date of Birth (MM/DD/YYYY): | Relationship to Subscriber: | |
| Signature: | Date: |

| Name of Participant: | | SSN: | |
|----------------------|-----------------|
| Date of Birth (MM/DD/YYYY): | Relationship to Subscriber: | |
| Signature: | Date: |

| Name of Participant: | | SSN: | |
|----------------------|-----------------|
| Date of Birth (MM/DD/YYYY): | Relationship to Subscriber: | |
| Signature: | Date: |
**Q:** What is a Referenced-based Pricing Plan?

**A:** A Referenced-Based Pricing Plan is a simplified “Consumer (employee) Driven Health Care Plan” that has proven to be beneficial for employers and plan participants by reducing medical costs. This plan eliminates Preferred Provider Networks allowing plan participants to access any provider they choose. Reimbursements to all providers are based on Medicare referenced pricing plus an incentive bonus over and above allowable amounts.

**Q:** Why is my employer offering a Reference-Based Pricing Plan instead of our current PPO or HMO plan?

**A:** The Referenced-Based Pricing Plan allows your employer to continue to provide quality benefits while controlling costs for you and your family.

**Q:** Is there a network or list of providers that I can choose from?

**A:** With the Referenced-Based Pricing Plan, you can go to any provider you choose. There are no restrictions on which providers you can access therefore, there is no network or provider list to choose from.

**Q:** Can I still go to my current physician?

**A:** Yes. It is recommended that you contact your physician’s office prior to your next visit to confirm they will accept your plan’s reimbursement. A guide for discussing the plan with your physician is included with your member materials. Please remember that you can also call your Patient Advocate to contact your physician on your behalf.

**Q:** If my physician’s office tells me they will accept the plan reimbursement is there anything else I need to do?

**A:** There is nothing else you need to do with your physician however, please contact Patient Advocacy at #866-271-1852 to let them know that your provider will accept your plan.
Q: What if my physician won’t agree to accept the Referenced-Based Pricing reimbursement?

A: Contact Patient Advocacy at # 866-271-1852 for assistance. Patient Advocacy can help by reaching out to your physician or in locating another physician for you that will accept the plan. Please remember that under your plan you can continue to see your current physician or any physician you choose whether or not they accept your plan reimbursement.

Q: What does the Assignment of Benefits provision on my ID card mean?

A: Assignment of Benefits means that you give your right to receive payment of eligible Plan benefits to your provider, less your personal responsibility, in accordance with your plan benefits, for any deductible, co-pays and/or coinsurance. If your provider accepts the Assignment of Benefits, their rights to receive benefits from the plan are the same as yours, no more and no less. If your provider accepts Assignment of Benefits instead of billing you directly, they may not balance bill you for any amounts other than your co-pays, deductible or coinsurance.

Q: What is a balance bill?

A: When your provider bills you for any amount over the Plan’s allowance for the service rendered. 

*Example: Doctor’s charge is $100 and the plan allowance is $70.00. If the provider bills you for the $30 dollar difference, this is called balance billing. You will be able to see the amount that exceeds your plan allowable amount on the Explanation Of Benefits (EOB) received from ResourceOne Administrators*

Q: What should I do if I receive a balance bill?

A: Contact ResourceOne Administrators at #918-280-7797 and they will have you send them a copy of the balance bill from your provider. ResourceOne will then review the bill to ensure that it is a true balance bill and not co-pays, deductible or coinsurance that you may be your responsibility. ResourceOne will then coordinate with your Patient Advocate to contact the provider on your behalf. The Patient Advocate may send a letter to the provider and you will receive a copy of that letter. Your Patient Advocate will keep you informed on the status of your balance bill.

Please feel free to contact your Patient Advocate with any other questions you may have about your plan. Your Patient Advocate Phone number is 866-271-1852.
If you contact your physician directly to confirm if they will accept your Referenced-Based Pricing Plan, the following information will guide you in explaining how your Plan works:

- Contact your physician’s office and let them know that your benefit plan has changed and advise them of the changes.

- Let your physician know that your plan no longer contracts with a PPO Network or that you are no longer covered under an HMO.

- Advise your physician that your plan now reimburses all providers based on Medicare Fee Schedule allowable amounts, current version for their locale, plus an additional (percentage).

- Ask your physician if they will be willing to accept this reimbursement rate and only hold you responsible for any applicable copays, deductibles and coinsurance.

- Make your physician aware that there are no contracts to sign.

- Your physician’s staff may tell you to call your “insurance company” to find out if they are accepted by the plan or if they are “in-network”. If they do, explain that your plan does not use a PPO network and that you have the freedom to go to any provider you choose. YOUR PLAN ACCEPTS ANY PHYSICIAN AND ANY MEDICAL FACILITY.

- If you are asked for the name of your insurance company, respond that your plan is a self-funded plan through your employer (Employer Name) and administered by ResourceOne Administrators. If you have fax machine or email access, offer to send them a copy of your ID card.

Resource One Administrators
• You may be asked if you are a Medicare participant. Respond that you are not and that the Medicare fee schedule is just used as a benchmark to determine the allowable amounts under your plan. Remind your physician that an additional 50 percent will be added to the Medicare fee schedule allowable amount for their reimbursement.

• If the person you are speaking with doesn’t know if your physician will accept the plan, ask to speak with the billing manager or the office manager. They are typically the ones who can make these decisions or they will know who the decision maker is.

If your physician’s office agrees to accept your new plan, let them know that all the information about the plan is on your ID card which you will bring in to them at the time of your next appointment. Please let your Patient Advocate know your physician has agreed to accept your plan as they may be able to refer other plan members to this physician’s practice.

If your physician’s office will not agree to accept your plan or if they still have questions, please contact your Patient Advocate who will call them on your behalf.

Your Patient Advocate is available to assist you with speaking to your physician. Please feel free to contact them Monday – Friday from 8:00 AM to 5:00 PM (EST).

**Patient Advocate Phone Number – 866-271-1852**