



Provider Portal

Checking Member Eligibility and Benefits Guide

Welcome!

This little guide walks you through the essential steps you'll need to complete for common tasks on the portal. Let's go!

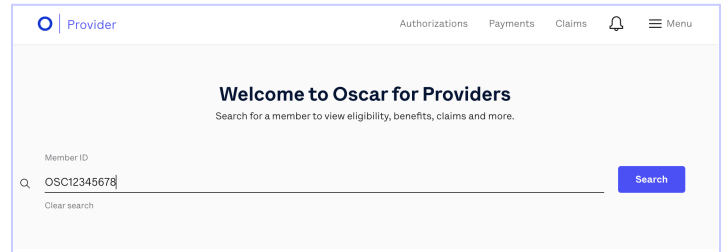
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Step 1: Login and search for the member profile

To confirm a member's eligibility and provider network status, simply:

1. Login to our portal at provider.hioscar.com
2. Search for the member by using their OSC ID, or by entering the patient's first name, last name, and date of birth.



Step 2: Checking member eligibility

On a member's profile, you'll have access to their demographic details, coverage status, and the start and end dates of their plan coverage.

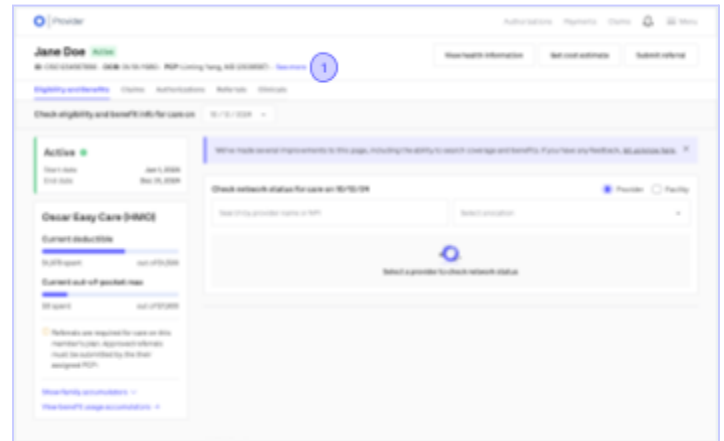
1 Demographic information

"See more" tool tip:

- OSC ID
- Carrier
- Gender
- Gender identity
- Language
- DOB
- Phone
- Address
- Family Members
- Assigned PCP

2 Coverage period

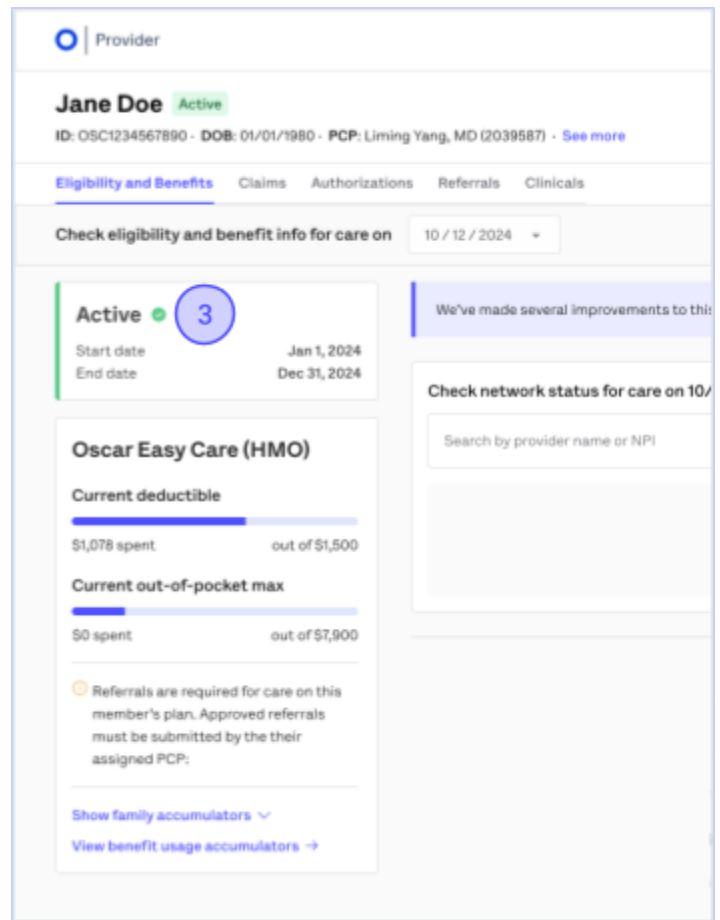
Use the calendar to easily check member eligibility for past or future dates by clicking forward or backward.



3 Coverage status

Simply hover over the status icon to view details. The status may include:

- Active:** The member is eligible for covered benefits.
- Inactive:** The member's plan is not active. Benefits are not eligible for coverage.
- Plan not started:** Coverage period has not started.
- Out of network:** The plan is not in-network with this provider and organization and benefits are not eligible for coverage.
- Grace period:** The plan is currently active but not up-to-date on premium payment.
Reference: [Provider Manual](#) for specific plan details on claim coverage.
- Delinquent:** The plan is currently active but not up-to-date on premium payment.
Reference: [Provider Manual](#) for specific plan details on claim coverage.



4 Referral requirement notice

This message appears for members enrolled in an HMO plan that requires referrals for specialist care.



Step 3: Checking member plan and benefits

Explore the member's plan details in the "Benefits & Coverage" tab:

1 Plan name

2 Plan accumulators

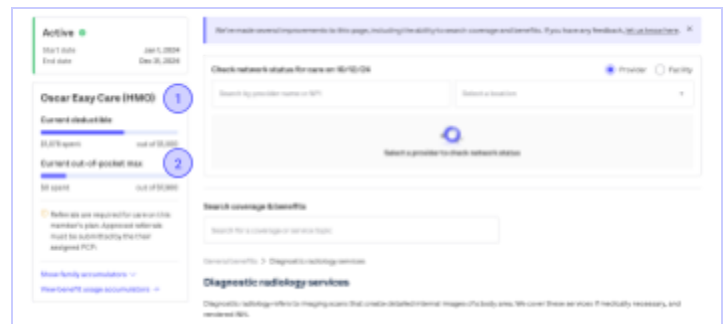
- **Deductible:** shows how much the member has paid toward their annual deductible.
- **Maximum out-of-pocket:** Displays the total amount the member may need to pay before the plan covers 100% of eligible cost.

3 Benefit usage accumulator

Specific benefit limits for the member's plan, click to expand:

- **Limits:** How many uses are allowed. (e.g., 0 of uses)
- **Resets:** When the limit resets. (e.g., at the end of plan year)

Note: Benefit details update based on the member's eligibility dates you select in the calendar.



Step 4: Searching for member benefits

Scroll down to the “[Search coverage & benefits](#)” section to explore member plan benefits.

Use the search bar to find specific benefits

1. Enter a keyword related to the service or benefit you’re looking for (e.g., “therapy”, “preventative”, “emergency”).
2. A dropdown menu with related benefits will appear.
3. Select the most relevant option to view detailed information, including:
 - Coverage by location
 - Pre/post deductible
 - Referral requirement, if applicable

Note: Use broad terms if you’re unsure of the exact benefit name (e.g., type “labs” instead of “freestanding labs”).

Search coverage & benefits

Simply enter one keyword (e.g., “therapy”), and a dropdown with related benefits will appear. Choose the best match to see detailed information, including coverage by location, pre- and post-deductible coverage.

Search by keyword (e.g. “therapy” or “MRI”)
therapy]

- Radiation therapy**
Found in: Cancer
- Mental health therapy**
Found in: Mental health & substance use disorder services
- Infusion therapy**
Found in: Professional services and outpatient care
- Intensive behavioral therapy (IBT)**
Found in: Mental health & substance use disorder services

Generics (Tier 1)	Full price / 20%
Preferred Brands (Tier 2)	Full price / 20%
Non-Preferred Brands (Tier 3)	Full price / 20%
Specialty (Tier 4)	Full price / 20%

Out-of-network care

Services at out-of-network providers are not covered except for some cases of emergency or urgent care (based on state requirements and plan’s conditions).

Step 5: Viewing member benefit details

Once you've selected a specific benefit, the benefits details page will display detailed coverage information.

Review the benefit breakdown

1. **Location/tier:** Identifies where the service is provided.
2. **Pre-deductible cost:** Shows the members responsibility for cost before meeting their deductible.
3. **Post-deductible cost:** Displays the member's cost after meeting their deductible.

General benefits > Mental health & substance use disorder services

Mental health & substance use disorder services

Related benefits

Mental health therapy

Location / Tier	Pre-deductible	Post-deductible
At specialist	20% coinsurance	20% coinsurance
Inpatient Facility Physician	Allowed amount Allowed amount	20% coinsurance 20% coinsurance
Outpatient Facility Physician	Allowed amount 20% coinsurance	20% coinsurance 20% coinsurance

Understand cost terms

Cost-sharing terms can vary depending on the service and the member's specific health plan. Below are the most common terms you'll encounter.

1. **Allowed amount:** The maximum payment the plan will cover for a specific service. Check the provider contract for rate specifics.
2. **Coinsurance:** The percentage of the allowed amount that the member pays for covered services.
3. **Copay:** A fixed dollar amount that the member must pay for a specific service, typically at the time of the visit.

Note: *The member is responsible for their share costs according to the details of their plan. In-network providers should not bill members beyond these amounts.*

General benefits > Mental health & substance use disorder services

Mental health & substance use disorder services

Related benefits

Mental health therapy

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