MercyCare Health Plans™

MercyCare Health Plans
PO Box 550
Janesville, WI 53547
(608) 752-3431 • (800) 895-2421
MercyCareHealthPlans.com

HMO Individual Qualified Health Plan

The following information is provided as required to be communicated to a member for an individual health plan on the Federally-facilitated Marketplace.

Member Out of Network Liability and Balance Billing

LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a nonparticipating provider for a covered health service, benefit payments to such Nonparticipating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to the policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined in the policy. **YOU RISK PAYING MORE THAN THE COINSURANCE, DEDUCTIBLE AND COPAYMENT AMOUNT AFTER MERCYCARE HAS PAID ITS REQUIRED PORTION.** Nonparticipating providers may bill you for any amount up to the billed charge after MercyCare has paid its portion of the bill.

EXCEPTION

Emergency Care: Services required stabilizing or initiating treatment in an emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternative Facility. Emergency Care does not require prior authorization, and is covered for services provided by participating and non-participating providers. Services are covered at the in-network level of benefits.

Urgent Care: Covered Health Services received at an Urgent Care Center. Examples of urgent care situations are broken bones, sprains, non-severe bleeding, minor cuts and burns, and drug reactions.

- Outside the Service Area: If you require urgent care and you are outside the service area and cannot return home without medical harm, you should seek care by the nearest physician, hospital or clinic.
- To be covered, non-emergency or follow-up care must be provided by a participating provider.
- Members are entitled to these benefit provisions subject to the terms, conditions and exclusions of the policy and the Certificate. Coverage is subject to any coinsurance copayment, deductible and/or other limits shown in the Schedule of Benefits.

Member/Enrollee Claims Submission

To submit a claim, send an itemized bill from the physician, hospital, or other provider to the following address:

MercyCare Insurance Company
Claims Department
P.O. Box 550
Janesville, WI 53547-0550

Written proof of your claim includes: (1) the completed claim forms if required by us; (2) the actual itemized bill for each service; and (3) all other information that we need to determine our liability to pay benefits under the policy, including, but not limited to, medical records and reports. Be sure to include your name and identification card number. If the services were received outside the United States, please be sure to indicate the appropriate exchange rate at the time the services were received.

In accordance with Wisconsin law, if circumstances beyond your control prevent you from submitting such proof to us within this time period, we will accept a proof of claim, if provided as soon as possible and within one year following the 90-day period. If we do not receive the written proof of claim required by us within that one-year and 90-day period, no benefits are payable for that service.

An incomplete claim is a correctly filed claim that requires additional information, including but not limited to, medical information, coordination of benefits questionnaire, or a subrogation questionnaire. An incorrectly filed claim is one that lacks information which enables us to determine what, if any, benefits are payable under the

terms and conditions of the policy. Examples include, but are not limited to, claims filed that are missing procedure codes, diagnosis information or dates of service.

Grace Periods & Claims Pending Policies During the Grace Period

Grace period is a time period after the premium payment due date within which the premium can be paid without penalty.

Pended claim, for the purpose of this definition, means a timeframe in which a medical or pharmaceutical claim payment determination remains undecided due to a member has not paid their premium during the second and/or third month of their grace period.

During the grace period, we will:

- Pay all appropriate claims for services rendered to the member during the first month of the grace period, and
- Pend claims for services rendered to the member in the second and third months of the grace period and
- Notify providers of the possibility for denied claims when the member is in the second and third months of the grace period.
- If a member does not pay back all premiums, the last day of coverage will be the last day of the first month of the 3-month grace period.

Retroactive Denials

Right to Recovery: Payments made by MercyCare that exceed the amount that we should have paid may be recovered by MercyCare. MercyCare may recover the excess from any person or organization to whom, or on whose behalf, the payment was made.

You can help prevent retroactive denials by:

- paying premiums timely
- getting your care from participating providers

Member/Enrollee Recoupment of Overpayments

For overpayments of premiums, call customer service to request a refund at (800) 895-2421.

Medical Necessity and Prior Authorization Timeframes and Enrollee Responsibilities

MercyCare's Quality Health Management Department (QHMD) bases its decisions on appropriateness of care and services, nationally recognized criteria (Interqual® and Hayes Medical Technology®), MercyCare Policies, CMS Criteria for durable medical equipment and supplies, NCCN Guidelines, Federal Drug Administration Guidelines, and the member's benefit package and certificate of coverage. Utilization management decisions may include inpatient hospital admissions, outpatient procedures, behavioral health transitional and inpatient services, skilled nursing facility admissions, out-of-network referral requests, and rehabilitation and home health services.

Medical, behavioral health and pharmacy requests are categorized by the following listings:

Pre-service requests	14 Days Any care or service that must be approved in advance of the member obtaining services. Your certificate of coverage, schedule of benefits, and formulary list services that must be prior authorized by MercyCare. Your network practitioner has the list of surgical procedures that must be prior authorized by MercyCare. Non-urgent requests for services will have a decision made as soon as possible but within 14 days of the request for services. *Pharmacy Requests*: 72 Hours
Pre-service urgent requests	72 Hours A request for services where routine preservice time frames could seriously jeopardize the life, health of the member or others due to the member's psychological state OR in the opinion of a practitioner with knowledge of the member's medical or behavioral condition would subject the member to adverse health consequences without the care or treatment that is subject of the request. Pre-service urgent requests do not include services received at an

	urgent care center or emergency department. MercyCare does not prior authorize or require pre-certification of services received in an urgent care facility or emergency department.
Concurrent review	24 Hours A review for services that have been previously approved and the course of treatment is ongoing. Concurrent review is typically associated with inpatient hospitalizations, skilled nursing care or ongoing ambulatory care. It will include an ongoing assessment of your care to ensure appropriate care, treatment, length of stay, and discharge planning.
Urgent concurrent review	24 Hours A review of services when the treatment is ongoing and the hospital admission or services were not previously approved.
Post-service requests	14 Days *Any request for care or services after the service has already been provided.* This may include by not limited to a request for an out-of-network appointment that a member has already attended or a hospital inpatient stay from which the member has been discharged prior to MercyCare being notified of the admission.

Referrals and Standing Referrals

A referral is a written form prepared by a participating MercyCare practitioner requesting approval for the member to receive services from an out-of-network provider.

Your primary care physician is responsible for your care. You can visit any participating provider without a referral, but your primary care physician is available to assist you in finding the appropriate participating provider. You do not need a referral from your primary care physician to receive covered services from any participating provider, including without limitation obstetrical and gynecological care.

If your primary care physician or another participating provider feels that you need specialty care beyond that available from participating providers, he or she must complete a referral form

- Non-urgent referral requests must be submitted in writing to MercyCare before the member can receive services from an out-of-network provider. Non-urgent requests for services received at MercyCare after business hours will be marked as received on the next business day.
- If non-emergent care is obtained without an approved referral, the member will be responsible for the charges.
- MercyCare will make a decision within 14 days of receiving the referral.
- MercyCare will make a decision within Urgent and Concurrent referral requests
- Once MercyCare makes a decision on the referral, MercyCare will notify in writing the requesting practitioner, the member, and the out-of-plan provider.
- Approved notices will state the type or extent of services authorized and the time period that the referral is valid.
- Denial notices will state the reason for the denial, or redirect the member to available network services and provide information regarding how to obtain the criteria the determination was based upon, Appeals and independent review information.
- A referral is not required for emergency care when the member is out of their network service area.
- Call customer service at (800) 895-2421 if you have questions about a referral.

Please be advised that it is your responsibility to confirm that MercyCare has authorized a referral before you receive non urgent or elective services. If you receive non urgent or elective care from an out-of-network provider without a MercyCare approved referral, you may be held financially responsible for that provider's charges.

Prior Authorization

To assure proper medical management, the following services require prior authorization from MercyCare before they will be covered services, regardless of whether they are rendered by a participating or non-participating provider. Failure to get prior authorization means the procedure will be denied upon claim submission, unless

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the service is for a state mandated benefit or an Essential Health Benefit. State mandated and essential health benefit services will be reviewed for medical necessity prior to claim payment.
Categories of services and supplies requiring prior authorization are:

Autism Treatment	Maternity services received out of the service area in the last 30 days of pregnancy
Biofeedback services	Medical supplies
Cardiac rehabilitation	Non-participating provider services and supplies
Congenital Heart Disease Surgeries	Pharmaceuticals administered in provider's office
Dental/Anesthesia Services – Hospital or Ambulatory	Prosthesis
Dental Surgery - Accident Only	Psychological disorder and chemical dependency, inpatient and transitional treatment
Durable medical equipment	Reproductive services, inpatient
Genetic testing and counseling	Surgical services, inpatient, outpatient, and at a freestanding surgical facility
Hearing Exams and Hearing Aids	Skilled nursing facility services
Home health care	Temporomandibular disorders (TMJ)
Hospice care	Transplants

The method for filing a request for prior authorization, also known as a pre-service claim, is set out in the Claims Provisions section of this policy.

Drug Exceptions Timeframes and Member/Enrollee Responsibilities

Standard Request: Certain formulary drugs and clinically-appropriate drugs that are not shown in the Drug Formulary require prior approval from MercyCare before coverage is provided. This ensures that these drugs are used in a manner consistent with all of the criteria cited in the Drug Rider section marked COVERED DRUGS.

- Your network physician will need to send a prior approval form https://mercycarehealthplans.com/pharmacy-programs/ and documentation to MercyCare for our review. We will notify you (and your designee or prescriber) of our decision no later than 72 hours after we receive your request for prior approval.
    - Your physician should submit information such as you name, date of birth, your number, Requested Drug: name, dosage form, schedule, and duration of therapy as necessary, Indication for treatment and other pertinent diagnoses Current and past treatment of medical condition including alternative medications failed and reason of failure, or contraindications to formulary alternatives.

Expedited Request: In exigent circumstances, you (or your designee or prescriber) may request an expedited review of your request for prior approval. An exigent circumstance exists if you are suffering from a health condition that may seriously jeopardize your life, health or ability to regain maximum function, or when you are undergoing a current course of treatment using a non-formulary drug. We will notify you (and your designee or prescriber) of our decision no later than 24 hours after we receive your request for prior approval.

Independent Review: If we deny your request for prior approval of a clinically appropriate formulary or non-formulary drug, you may request an Independent External Review (IER) of our decision.

If a request for approval of a clinically appropriate formulary or non-formulary drug is granted, either through the standard or expedited process or through the Independent External Review (IER) process, the drug will be covered for the length of the prescription, including refills. In addition, the approved drug coverage will be treated as an essential health benefit. Please refer to the External Review section of your medical policy to see instructions and definitions regarding the IER process.

Information on Explanation of Benefits (EOBs)

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Every time a claim is submitted to us by your provider or yourself, we provide an explanation as to how we processed it in the form of an Explanation of Benefits (EOB). The EOB is *not* a bill. It merely explains how your benefits were applied to that specific claim.

The EOB will provide you the following information:

- the date you received the service
- the amount billed
- the amount allowed to be charged by your provider
- the amount we paid
- the amount you owe the provider will be shown as a copay, deductible, coinsurance or non-covered

The Coordination of Benefits (COB)

The Coordination of Benefits provision applies when you have health care coverage with more than one health plan.

Primary Plan/Secondary Plan is determined by the Order of Benefit Determination rules. When MercyCare is considered *Primary*, benefits will be paid for covered services as if no other coverage were involved. When MercyCare is considered *Secondary*, benefits will be paid based on what was already paid by the primary plan.