



**MERCY CARE
HEALTH PLANS**

**HMO
MEMBER
HANDBOOK**

Winter 2006

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WELCOME TO MERCYCARE HEALTH PLANS

MercyCare Health Plans (MCHP) welcomes you as a member of our health care plan. We encourage our members to remain proactive in their healthcare, because no one has a greater interest in your well being than you. MCHP makes every effort to provide you with information and services that help improve your quality of life.

If you have a question about how your health plan works, or you would like a paper copy of any document we describe as being available online please call the phone number on the back of your MCHP identification card, 1-800-895-2421. This will put you in touch with a customer service representative who can help. Our hours are Monday through Friday, 8:30 a.m. to 4:30 p.m. TTY users may call 1-800-947-3529 for assistance.

- Our quarterly member newsletter “Healthy Living” is published for the promotion of your health and to keep you well informed about your health plan
- MercyCare Health Line is a health advisory line available 24 hours a day, 7 days a week. This service will offer advice and answer health related questions regarding nutrition, wellness, first-aid, and accessing local agencies for support and self-help. If necessary, MercyCare Health Line will direct you to medical professionals, including physicians, for further assistance. This service can be accessed by calling **(608) 758-5770 or (888) 756-6060**.
- Our network provider listing and pharmacy formulary are available at www.mercycarehealthplans.com along with additional information regarding our health plan activities.

NATURE OF HANDBOOK

This handbook is a summary of your health plan. This handbook is not a contract. This handbook does not describe all the benefits or exclusions contained in your certificate of coverage, schedule of benefits or drug rider. If there is any discrepancy between the handbook and the certificate of coverage, schedule of benefits or drug rider, the certificate, schedule or rider, whichever is applicable, will govern. Read your certificate of coverage, schedule of benefits and drug rider carefully. For more information, or answers to specific questions, you may contact customer service at 1-800-895-2421.

MERCYCARE HEALTH PLANS HAS EARNED AN “EXCELLENT” ACCREDITATION

MCHP is proud to have been awarded an “Excellent” accreditation from the National Committee of Quality Assurance (NCQA) for our latest accreditations in 2002 and 2004 – the highest level of accreditation awarded. NCQA recognizes that MCHP meets or exceeds the rigorous performance measures for consumer protection and quality improvement. The “Excellent” accreditation is granted only to those Managed Care Organizations that deliver high quality care and service. More information regarding NCQA is available at www.ncqa.org.



MCHP and its Board of Directors are committed to using our health plan resources and information systems to help our network of physicians continually improve the healthcare services you receive. The Board of Directors annually reviews and approves our quality improvement program and associated work-plan. In addition, the Board receives an annual progress report from MCHP. These documents are available to the public at www.mercycarehealthplans.com.

We also publish an annual summary of our quality results in our “Healthy Living” member newsletter.

MEMBER RIGHTS AND RESPONSIBILITIES

MCHP is a partnership that consists of you, your doctor (s) and health plan personnel. The goal is to assure that you receive appropriate quality health care. Your rights and responsibilities as part of the MCHP partnership are described below:

As a member, you have the right to:

- Receive information about the MCHP organization, services, practitioners, hospitals, other providers, and member rights and responsibilities
- Be treated with respect and recognition of your dignity and right to privacy
- Take part in decisions regarding your treatment
- Discuss openly and freely all planned treatments, procedures, and services regardless of cost or benefit coverage
- Confidentiality of your personal health information as described in your HIPAA Notice of Privacy Practices
- Know how to obtain health care services
- Know what your benefits are
- Understand the purpose and probable results and risks of treatment
- Initiate a complaint by phoning customer service at 1-800-895-2421 about the care or services that you receive as a MCHP member and receive a timely response
- Make recommendations regarding the organization's member rights and responsibilities policies by contacting customer service at 1-800-895-2421

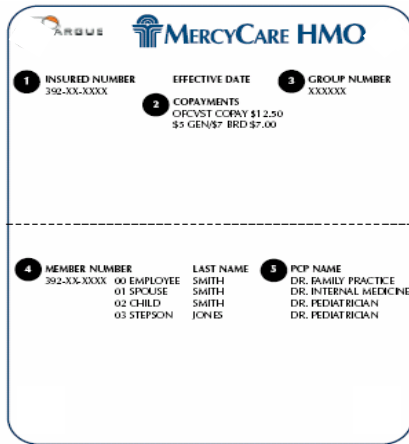
As a member, you are responsible to:

- Provide information about your past illnesses, hospitalizations, medications and other matters concerning your health that will help your practitioner understand your health care needs and provide appropriate care
- Participate in understanding any health problems you may be experiencing and develop mutually agreed upon treatment goals and plans with your practitioner
- Cooperate as much as possible with mutually agreed upon treatment goals and advice of your health care practitioner.
- Read your MCHP member handbook, certificate of coverage, schedule of benefits and provider directory so that you understand how to use the MCHP
- Choose a PCP with whom you will coordinate your care
- Identify yourself as a MCHP member by presenting your MCHP insurance card before receiving health care services
- Pay your co-payments at the time of your visit
- Keep your appointments
- Discuss any questions you have about your health with your practitioner
- Notify MCHP of address, telephone or other status changes within 30 days of the change

For more information about your Rights & Responsibilities, please contact MCHP by phone at 1-800-895-2421 or e-mail to mercycares@mhsvl.org.

MEMBERSHIP CARDS

A MCHP membership card is given to you once you enroll in the Plan. MCHP cards include:



1. **Insured Number**
 - Employee's identification number
2. **Co-payments**
 - Co-payments required to be paid at time of service
3. **Group Number**
 - This is how MCHP identifies your employer and benefit package
4. **Member Number**
 - Each family member will have a personal identification number
5. **PCP Name**

HOW TO CHOOSE A PRIMARY CARE PHYSICIAN (PCP)

A Primary Care Physician (PCP) is a doctor who is an Internist, Family Practitioner or Pediatrician.

- **Internists** usually care for adults and older adolescents.
- **Family Practitioners** care for adults, children, babies, and some follow women through pregnancy and delivery.
- **Pediatricians** care for babies and children usually up to age 18.

The process for selecting a PCP may include:

- Recommendations from family, friends or another physician.
- Using your MCHP provider directory to select physicians in your area.
- Contacting customer service for more information such as languages spoken.

It is important to choose a PCP in order to have one physician responsible for your total health care and help you coordinate and manage your health care needs. With the advice of your PCP, you can choose to consult another specialist if you should require more specialized care.

Women may select an Obstetrician/ Gynecologist for their routine women's health care, but must select a PCP for all other services.

CHOOSING A SPECIALIST

Although as a MCHP member you may self-refer to most specialists within MCHP's network of providers, we believe that all of your health care can best be directed through your primary care physician (PCP). Your PCP should be familiar with your medical problems, and together you can determine which specialist will best serve you and your medical needs.

The MCHP on-line provider directory lists PCP and specialized doctors, including their specialty, location, phone number and educational background.

PROVIDER NETWORK

A Provider Network is a group of practitioners and providers contracted with MCHP to provide services for members within a geographic location.

Should you require services not available in the network, it will be necessary for you to obtain a written referral approved by the plan.

For a listing of MCHP providers visit us at www.mercycarehealthplans.com. Or, call our customer service department at 800-895-2421 to request a printed copy of the current directory.

MCHP has mechanisms in place to monitor the access to care our members receive for primary care services and behavioral health services. The following standards have been established with MCHP practitioners.

ACCESS TO SERVICES

For access to primary care services the standards are as follows:

- Regular and Routine Care Visits - 10 Business Days
- Urgent Care Appointments – 48 Hours

For access to Behavioral Health Services the standards are as follows:

- Routine Office Visit – 10 business days
- Urgent Appointments – 48 Hours
- Non-Life-Threatening Emergency – 6 hours

MCHP monitors after hours care our provider offices offer to ensure that our members can reach a live person to help direct them with their care. If you or a family member believes you have a serious medical or psychiatric condition that requires immediate attention, you should seek care from the closest urgent or emergency care facility.

MCHP also monitors its telephone system records to ensure members receive adequate access to our customer service department. Our goal is for 95% of our customers to reach a representative within 30 seconds.

Please contact MCHP if you believe either of the above standards is not being met.

URGENT CARE

Urgent Care is care you need sooner than a routine doctor's office visit. URGENT CARE IS NOT EMERGENCY CARE. Some examples of urgent care cases are:

- Minor cuts
- Most broken bones
- Sprains
- Minor burns
- Sore throat
- Rash
- Bruises

In Service Area:

If you are in the Network Service Area, Urgent Care services are covered at any participating provider or participating Urgent Care Center. Network Urgent Care Centers are listed in your Online Provider Directory.

Out of Service Area:

If you are out of your Network Service Area and cannot return home without medical complications or harm, you should seek care from the nearest urgent care facility (physician, clinic, hospital). Follow up care is not covered when it is provided by a non-MercyCare provider.

EMERGENCY SERVICES

Emergency means a medical condition that manifests with symptoms of sufficient severity, including pain, to lead a prudent lay person to reasonably conclude that a lack of immediate medical attention will likely result in death or serious injury to your body, or if you are pregnant, serious jeopardy to your fetus.

Some examples of emergency care cases are: heart attacks, chest pain, strokes, loss of consciousness, significant blood loss, suffocation, attempted suicide, seizure or convulsions, acute allergic reactions, acute asthma attacks, acute appendicitis, coma, or drug overdose.

If, as a prudent lay person, you reasonably conclude that a lack of immediate medical attention will likely result in bodily injury or harm, **GO TO THE NEAREST EMERGENCY CARE PROVIDER OR CALL 911**. You or your family must notify MCHP as soon as reasonably possible or within 48 hours of an emergency or out of state emergency hospital admission. MCHP has the right to transfer you (at no expense to you) to the facility of their choice upon confirmation from your attending physician that you are able to travel. As an HMO member your initial visit to an emergency facility is covered. A participating network practitioner or provider must provide follow up care. Follow up care received from a non-participating provider is not a covered benefit.

Life threatening emergencies are covered anywhere in the world; however, providers outside the United States may not accept insurance payments and may require you to provide payment at the time of service. If you should find yourself in this situation, you should be sure to request a detailed billing and retain all of your receipts. Reimbursement for covered benefits can be arranged when you return to the service area.

HOW AND WHEN TO OBTAIN A REFERRAL

MCHP has an extensive network of participating providers and specialists. If the specialty care a participating MCHP PCP wants the member to receive is available within the member's MCHP provider network, the PCP will direct the member to an in-network specialist. MCHP does not require pre-approved referrals to specialists within the member's provider network. If medically necessary care is not available from a network provider, the PCP or another network practitioner may submit a referral for services from an out-of-network provider.

- A referral is a written form prepared by a participating Mercy Care practitioner requesting approval for the member to receive services from an out-of-network provider.
- Non-urgent referral requests must be submitted in writing to MCHP before the member can receive services from an out of network provider. Non-urgent requests for services that are received at MCHP 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.
- On Non urgent referral requests for services, MCHP will make a decision within 15 days of receiving the referral.
- Once MCHP makes a decision on the referral, MCHP 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, redirect the member to available network services and provide grievance 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 1-800-895-2421 if you have questions about a referral.

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

NEW TECHNOLOGY REVIEWS

MCHP evaluates new and existing technologies for possible inclusion in your benefit package. New technology can be a service, treatment, procedure, treatment facility, equipment, drug, device or supply. Health care determinations are based on expert opinion; however, your benefit package may have exclusions for certain types of services or procedures.

Some of the criteria that may be used for evaluation of new technologies are:

- Whether it is commonly performed or used on a widespread geographic basis
- If the service is generally accepted by the medical profession in the United States of America to treat a specific bodily injury or sickness
- The failure rate or side effect of the technology is acceptable
- The technology is recognized for reimbursement by Medicare, Medicaid and other insurers and self-funded plans

The Hayes Medical Technology Directory is one of the sources used by MCHP as an aid in developing coverage determinations that are based on scientific evidence of safety and efficacy. MCHP notifies its network providers of the newest technologies available for coverage.

BEHAVIORAL HEALTH/ SUBSTANCE ABUSE SERVICES

Services provided by a participating network practitioner or provider are covered as described in your **Schedule of Benefits**. If you need assistance in locating a network practitioner or provider, please contact our customer service department at 1-800-895-2421.

A participating network practitioner or provider must provide all mental health and substance abuse services. **Please be advised that it is your responsibility to confirm that an out of network provider has an MCHP approved referral or you will be held financially responsible for that provider's charges.**

Benefit Limitations:

Mental health and substance abuse benefits are defined in your schedule of benefits. Once you reach your benefit maximum, you will be financially responsible for any further services and charges for the remainder of the contract year. It is beneficial to record the services that you have used. Please refer to your Certificate of Coverage and Schedule of Benefits to determine the coverage limits of your benefit plan.

DISEASE MANAGEMENT PROGRAMS

MCHP has a team of registered nurses dedicated to improving your health, preventing illness, and increasing the quality of care. Some of the ways that we do this are by:

- Helping members with specific problems or questions they might have about their illness or their benefits as they relate to their disease.
- Working with your physician to make sure that all MCHP practitioners have the most up-to-date, committee approved treatment guidelines. We can help coordinate care between you and your doctor.

If you have certain conditions such as diabetes, asthma or depression; you may be contacted by MCHP to participate in our Disease Management Programs.

Please contact customer service at 1-800-895-2421 if you have any questions about your specific condition or to discuss recommended scheduling of preventative services, and they will put you in touch with a nurse in the Quality Health Management Department (QHMD).

STAYING HEALTHY

It is the goal of MCHP to improve the health and well being of our members. Through the "Stay Healthy Benefit" that is included in most of our policies, you have the ability to be reimbursed up to \$50 per contract year for health education or physical fitness programs. Examples of covered programs:

- Adult Physical Fitness Programs
- Stop Smoking Classes
- Wellness Programs
- Weight Loss and Weight Management Programs
- Lamaze Classes
- Health Club Membership

For additional information, please refer to your Certificate of Coverage.

UTILIZATION MANAGEMENT PROCEDURES

MCHP and the Quality Health Management Department (QHMD) do not reward, financially or otherwise, practitioners or individuals conducting utilization review for issuing denials of coverage or services; nor do we encourage decisions that result in under-utilization. Utilization decisions are based only on appropriateness of care and the member’s benefit coverage.

Utilization management is the process of evaluating and determining the appropriateness of medical care services, as well as providing any needed assistance to clinician or patient, in cooperation with other parties, to ensure the appropriate use of resources. The QHMD at MCHP works in partnership with members and practitioners to promote the comprehensive delivery of health care services.

The Quality Health Management department consists of registered nurses, medical and behavioral health practitioners. The QHMD bases its decisions on appropriateness of care and services, nationally recognized criteria (Interqual® and Hayes Medical Technology®), 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, rehabilitation and home health services. **Medical and behavioral health requests are categorized by the following listings:**

Pre-service Requests:	Any care or service that must be approved in advance of the member obtaining services. Your certificate of coverage and schedule of benefits list services that must be prior authorized by MCHP. Your network practitioner has the list of surgical procedures that must be prior authorized by MCHP. Non-urgent requests for services will have a decision made as soon as possible but within 15 days of the request for services. The request date for non-urgent services will be the day it is received by MCHP. Non-urgent requests for services that are received at MCHP after the close of business will be marked as received on the next business day.
Pre-Service Urgent Requests:	Any request for medical care or treatment that if the decision was delayed more than 72 hours from the receipt of the request, the delay could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function. Pre-service requests may also include requests where a practitioner who knows the member’s medical condition can state that a delay of more than 72 hours in the decision process would subject the member to severe pain that could not be adequately managed without the care or treatment that is being requested. Decisions will be made within 72 hours of receiving the request. Pre-service urgent requests do not include services received at an urgent care center or emergency department. MCHP does not prior authorize or require pre-certification of services received in an urgent care facility or emergency department.
Concurrent Review	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:	A review of services when the treatment is ongoing and the hospital admission or services were not previously approved. MCHP will make a coverage decision within 24 hours of receiving the information.

Post-Service Requests:	Any request for care or services after the service has already been provided. This may include 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 MCHP being notified of the admission.
Case Management:	This program assists our members who have long term or high cost medical conditions. Our goal is to help manage health care benefits and promote quality healthcare with cost effective outcomes. Our case management team follows the Case Management Society of America standard of practice. This includes assessment, planning, implementation, coordination, monitoring and evaluation to develop and execute an individual's comprehensive case management plan.

Written notification will be sent to the member and the requesting practitioner for approved referral requests for out of network services. This notification will state what services are approved. If you do not receive a written approval from MCHP, then the services have not been approved.

If any request for service that is reviewed by the QHMD is denied, both the member and requesting provider or practitioner will receive a written notification of the services denied and the reason for the denial. This letter will also contain grievance and independent review organization information.

Verbal denial and approval notification will also be given to the requesting practitioner or provider in urgent or concurrent requests.

MCHP business hours are Monday through Friday, 8:00 am to 4:30 pm CST. Confidential voice mail and fax receiving services are available 24 hours a day, seven days a week. Requests for services that are received after scheduled business hours will be responded to on the next business day. Non urgent requests for services that are received after normal business hours will be marked as received on the next business day.

Phone Number: 1-800-895-2421

Fax Number: 1-608-758-7726

COMPLAINT PROCEDURES

MCHP is committed to ensuring that all member concerns are handled in an appropriate and timely manner. We ensure that every member has the opportunity to express dissatisfaction with any aspect of the MercyCare HMO products.

Every MCHP member has the right to contact our customer service department to address a concern. If you contact MCHP by telephone our customer service representatives will research your concern and advise you of the outcome.

A grievance hearing must be offered to any member or member's representative who writes to MCHP about an adverse determination, or any other concern with the health plan. The grievance hearing is your opportunity to present your issue to a panel of your peers, consisting of people who are also covered by MCHP. The panel will hear your case, and then make a determination based on all of the information gathered and presented. Examples of grievance requests include referral denials and claim denials. Again, any written concern will be considered a grievance.

MCHP must follow guidelines created by the State of Wisconsin Office of the Commissioner of Insurance (OCI). In addition, as an accredited health plan, we follow the guidelines of NCQA. When the guidelines of these two organizations differ, we adopt the standards that favor members' rights. For example, the OCI allows 45 days to complete a hearing, and NCQA allows 30 days. Therefore, MCHP employs the 30 day standard to complete a grievance.

When MCHP receives your grievance, you may expect the following to occur: A written acknowledgement of the receipt of your grievance will be sent to you within 5 days of the receipt of your grievance. Your concern will be reviewed by multiple departments prior to your hearing to determine if an error was made at the original determination. Upon completion of the internal investigation, you will be contacted to be advised of one of the following:

- The initial denial was overturned and your request is now being approved. You will also be advised you have the right to continue with your grievance or cancel it as this time, or
- Your grievance is ready to be scheduled. You will be advised of the tentative date and time. All grievances are scheduled for Thursdays. If the tentative date is not convenient for you, you will be able to choose from other dates available. You will be given a general overview of what to anticipate at your hearing. You will be given the opportunity to ask any questions in order to assure you are prepared for your hearing.

You will receive a letter confirming the date of your hearing at least 7 days prior to your hearing. At this time, we will inform you of additional rights, including attendance and possible alternate representatives.

On the date of your hearing, a facilitator will greet you. This person acts as your advocate and will again explain what to anticipate at your hearing. The facilitator will take you to the meeting. He/she will introduce you to the committee, and then the committee members will introduce themselves to you. We always attempt to have committee members who do not work for MCHP, and all committee members will have MCHP insurance coverage of some type. If your original claim determination was based on a medical decision, the medical director will be at the hearing to answer any questions you may have, and will also answer questions the committee may have. Usually, a grievance committee is made up of one voting member from MCHP, two voting members from outside of MCHP, the medical director, two note takers, a quality assurance observer, and a utilization review nurse.

Once you have presented your case and discussed it with the committee, you will be excused from the meeting. The 3 voting members, a note taker (s) and quality assurance person will be present during deliberations. Upon conclusion of all hearings for the day, you will receive a phone call from the facilitator, advising you of the outcome. Within 5 days of the completion of the hearing, you will receive the written outcome of the hearing. If the grievance was not decided in your favor, you will be advised of all the additional rights you have after the grievance level appeal.

Your concerns are important to us. In order for us to improve the service that we provide for you, it is essential that you voice your concerns so that we may identify areas for improvement.

If you have any questions regarding your rights or the grievance process, please contact our customer service department at **1-800-895-2421**.

PRESCRIPTION DRUG BENEFIT

MCHP has two drug plans. You may be eligible to participate in only one of these programs based on employer benefit selection. If you have questions about which drug benefit is available to you, please call our customer service representatives and they will assist you.

Two-Tiered Drug Plan (closed): This drug plan has an extensive list of prescription medications. All medications listed in the formulary have been reviewed for safety and effectiveness and were chosen by a committee of your Physicians and Pharmacists.

Three-Tiered Drug Plan (open): This drug plan is an open formulary, which means that all drugs are available to our members unless otherwise determined to be excluded. All medications listed in the formulary have been reviewed for safety and effectiveness and were chosen by a committee of your physicians and pharmacists, and they also determine the placement of drugs within each tier of this open formulary. Other changes may occur to this formulary as determined by MCHP.

Formulary Exceptions: An extra feature of your prescription drug benefit is the ability to receive medications that are not listed on the MCHP formulary. In order to obtain a medication that is not listed on the formulary, your physician must contact MCHP.

Prior Authorization: Some medications listed in the MCHP formulary require prior authorization. If your physician prescribes one of these medications, he/she will need to submit documentation that meets criteria for coverage. A committee of physicians and pharmacists establishes the criteria for approval. These criteria are in place to help ensure safe medication usage and that the medications are used according to the most current treatment guidelines.

Generic Medications: MCHP covers and encourages the use of generic medications. Generic medications have the same active ingredient as the brand name and have undergone vigorous scientific comparison studies that are approved by the Federal Food and Drug Administration (FDA). If you receive a generic medication, you will be charged the generic co-pay. If a brand name medication is not available in a generic form, you must pay the brand name co-pay as outlined in your policy. Co-pay amounts are printed on your MCHP membership card.

Prescription Limits: Your MCHP pharmacy benefit only includes prescription medications. Generally, the maximum quantity of medication you may receive in a single prescription is a 30-day supply. You may receive a prescription of most covered drugs for up to 90 days if prescribed by your physician; however, you will be required to pay three co-pays at the time of purchase.

Filling Your Prescription: Your prescription may be filled at any participating pharmacy across the country. Please contact MCHP customer service if you have questions about participating pharmacies.

Mail Order: MCHP offers a prescription mail-order service. The service will help reduce your co-pay/coinsurance and make it more convenient to receive your prescriptions. If your prescription drug benefit allows you to receive a 90-day supply, you may be able to participate in the mail order services. The advantage of doing so is that your prescription will be mailed to your home and you will receive a 90 day supply for only 2 co-pays.

Pill Split Program: MCHP offers a pill split program for a selected group of medications. By participating in this program you will save on your medication costs. When you receive a prescription for 15 tablets with directions of ½ tablet daily (a 30 day supply) or 30 tablets with directions of ½ tablet daily (a 60 day supply) there will be a reduction of your normal co-pay or coinsurance amount for targeted medications. (Co-pay/coinsurance amounts vary but you should save between 40-50% in co-pays or coinsurance.) To find out if your medications qualify, please contact customer service.

The MCHP drug formulary is available on our website, or, a printed copy may be requested from customer service at **1-800-895-2421**.

PROTECTION OF PERSONAL HEALTH INFORMATION

MCHP is committed to ensuring that your personal health information remains confidential. Personal health information, or PHI, means any information about you that we receive or use in our business operations to make decisions. PHI includes demographic, claims and medical information. MCHP is bound by federal and state law to protect your personal information from inappropriate use or disclosure. A federal law, known as HIPAA, gives you several rights regarding the privacy of your personal information. As a member or potential member, you should have received a Notice of Privacy Practices, which explains your rights as well as the ways in which MCHP may use and disclose your personal information. You have the right to request a copy of the privacy notice at any time. The privacy notice is also available on our website.

HOW TO CHANGE YOUR PERSONAL INFORMATION

It is important that you notify your employer prior to informing MCHP of any changes. Your employer has the appropriate "Change of Status" form that requires your and your employer's signatures. Some examples of changes that MCHP requires notification of:

- New address, phone number, adding or deleting dependent, divorce or death.
- **Adding a new spouse:** A new spouse may be added to your coverage if you notify your employer and the appropriate paperwork is received **within 30 days after the date of marriage.**
- **Adding a newborn:** A newborn may be added to your coverage if the appropriate paperwork is received by MCHP **within 60 days of the date of birth.**

General Motors employees must contact the National Benefits Center at (800) 489-4646.

CHANGING YOUR PRIMARY CARE PHYSICIAN (PCP)

At any time, you may change your PCP by simply calling our customer service department at **1-800-895-2421**. The change will be made as long as the new provider you have selected is accepting additional patients. If your PCP no longer participates with the plan, we will make every attempt to notify you and assist you in selecting another PCP. MCHP reserves the right to modify the list of participating providers at any time.

COORDINATION OF BENEFITS

If you have other insurance in addition to your MCHP plan, it is important that you inform your provider of that information prior to, or upon arrival to an appointment. With your cooperation, MCHP is better able to appropriately coordinate your benefits. Your certificate of coverage describes the order of benefit determination rules that will apply.

COMMONLY ASKED QUESTIONS

Question: Why have I received a bill from Mercy Health System Physician Billing or Mercy Hospital?

Answer: If you receive a bill from Mercy Health System, you should call the phone number on the statement. You should ask for an explanation of the balance. The charges may be, but are not limited to, your co-pay, deductible, coinsurance, or non-covered charges. If you feel that MCHP has denied a charge in error, please call MCHP customer service at **1-800-895-2421**.

Question: May I continue my coverage if I lose my eligibility?

Answer: Yes, MCHP has conversion or continuation privileges available. Please contact your employer or refer to your Certificate of Coverage for a detailed description of these rights.

Question: I am on the 3-tier plan, why does my cost change from month to month?

Answer: The 3-tier drug plan is based on you paying a percentage of the total cost. The cost of the drug is based on the “average wholesale price” which can vary month to month.

Question: Why is the drug my practitioner ordered for me not on your formulary?

Answer: If your practitioner or physician orders you a non-formulary drug, he or she should be requesting a medication override. The MCHP managed care pharmacist will review the request and will either approve it or direct your physician to consider a comparable formulary plan drug.

Question: I do not agree with MCHP’s decision to deny my referral request to an out-of-plan provider. What are my options?

Answer: You should first contact your physician or practitioner who submitted the referral to MCHP and discuss covered alternatives. If your physician or practitioner disagrees with our decision, he or she should contact our Medical Director. In any event, you have the right to file a grievance by contacting customer service, who will in turn advise you how to proceed with the grievance process.



Toll Free: (800) 752-3431