

## SECTION 2

### Membership

#### Membership Overview

Employees choose MCIC during an initial or open enrollment period. Open enrollment periods are held once each contract year as determined by the employer group and MercyCare Insurance Co. The open enrollment period allows eligible employees to renew or change their health coverage. Employees may join MCIC at other times during the year upon life qualifying events such as:

- ◆ newly hired
- ◆ recently married
- ◆ recently widowed
- ◆ a birth or adoption occurring in the family
- ◆ loss of other coverage

#### Verification of Membership and Benefits

The MCIC Member Identification (ID) card helps the provider determine the member's eligibility and benefits. **Possession of the MCIC ID card does not guarantee coverage or benefit level, if member is ineligible on the date of service.** Services provided beyond limitations of the Employer Master Group Policy are not covered.

The member's ID card should be presented upon arrival to the provider office. Please request to see the member's ID card for **each** visit. Should they fail to present it, you can contact MCIC Customer Services to verify eligibility. The office should make a copy of the ID card for the member's file. The member should inform the provider office of any insurance changes that may have occurred since their last visit. Some changes that may affect the Member's insurance coverage are:

- ◆ An employer change.
- ◆ A change in insurance carriers.
- ◆ A change in benefit levels/co-pays

For assistance with member eligibility, the provider may contact MCIC **Customer Services** at **1-800-895-2421**, Monday - Friday, 8:30 am - 4:30 pm.

## **Member Rights and Responsibilities**

MCIC is committed to treating members in a manner that respects their rights and to inform members of MCIC's expectation of their responsibilities. A formal statement was developed in 1997 and continues to be published annually to members and MCIC Providers.

MCIC has provided a copy of the Member Rights and Responsibilities in Section 13. If you have any questions regarding this statement or want to obtain another copy for your office, please contact your Provider Relations Representative at 608-752-3431. MCIC's Member Rights and Responsibilities are also available on our website at [www.mercyhealthsystem.org](http://www.mercyhealthsystem.org)

## **HIPAA Privacy Rule**

As a covered entity under HIPAA (Health Insurance Portability and Accountability Act), MercyCare is required to have certain policies and procedures in place regarding the uses and disclosures of PHI (Personal Health Information). As a healthcare provider, you are also a covered entity under HIPAA, and are therefore, subject to these federal guidelines.

MercyCare distributes a Notice of Privacy practices to our members, which you will find in Section 13. It outlines the uses and disclosures of PHI, as well as rights of the member and the protections in place to safeguard PHI.

As a MercyCare contracted provider, we expect you to adhere to the HIPA Privacy regulations, as they apply to healthcare providers. Additionally, we expect you to be aware of the uses and disclosures of PHI made by MercyCare, and to help us ensure the protection of PHI that is shared between us. If you have questions about MercyCare's implementation of the HIPAA Privacy Rule, or you need to report a member complaint about a MercyCare breach of confidentiality, please contact the MercyCare Privacy Officer at 608-741-3345.

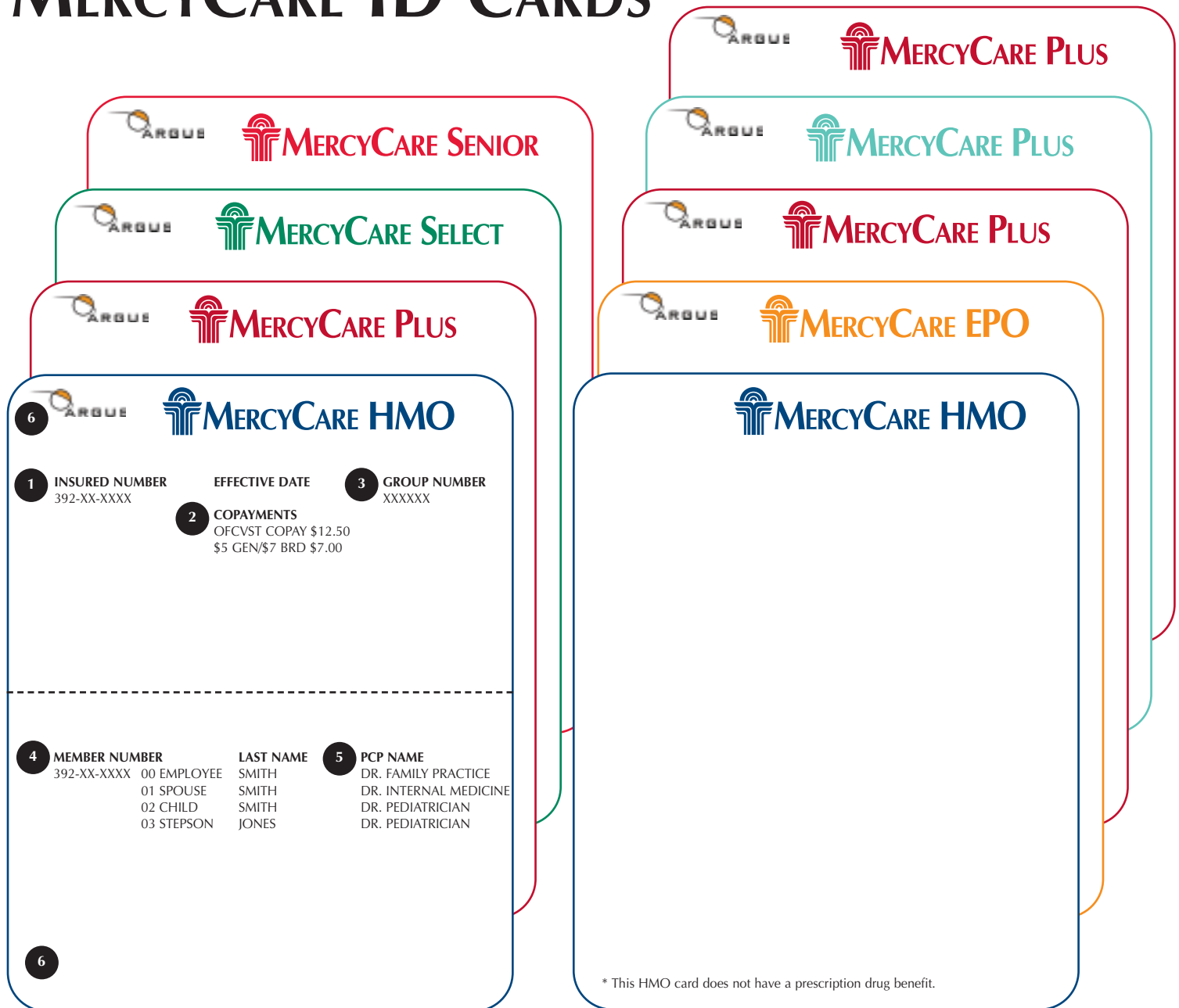
## **MercyCare Healthy Living Newsletter**

MercyCare Healthy Living Newsletter is a newsletter that is designed and distributed specifically for MCIC's member population and provider network. This publication contains at least annually information such as:

- ◆ Member Rights and Responsibilities
- ◆ Privacy and Confidentiality
- ◆ Provider Directory
- ◆ Participating Pharmacies
- ◆ Formulary Information
- ◆ Health Issues
- ◆ Community Education
- ◆ Customer Service Questions and Answers

The "Healthy Living" newsletter is mailed quarterly. If you have not received a copy of this newsletter, or if you have suggestions for any topics to be published, please contact your provider relations representative at 800-752-3431.

# MERCYCARE ID CARDS



## MERCYCARE CARDS INCLUDE:

- 1 INSURED NUMBER**  
Employee's identification number
- 2 COPAYMENTS**  
Copayments required to be paid at time of service
- 3 GROUP NUMBER**  
This is how MercyCare identifies your employer and benefit package
- 4 MEMBER NUMBER**  
Each family member will have a personal identification number
- 5 PCP NAME**  
Your primary care physician (family practice physician, internal medicine, pediatrician)
- 6 ARGUS**  
MercyCare Prescription Drug information.

**CUSTOMER SERVICE LINE 800•895•2421**

# COMPLAINT PROCEDURES

**MercyCare 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 Plan.**

## **VERBAL COMPLAINT**

If you have a complaint regarding a decision made by the Plan or with any other aspect of the Plan, you may contact our Customer Service Department via the telephone.

If the Customer Service Department is unable to resolve your complaint initially, they will contact you by phone with the outcome within 10 working days of the receipt of the complaint.

If you are not satisfied with the resolution of the complaint, you may submit a written request for a grievance hearing.

## **GRIEVANCE**

You have the right to request a grievance hearing at any time you are dissatisfied with a decision made by the Plan, or with any other aspect of the Plan by submitting your concern to the Plan in writing.

The Customer Service Department will send notification, acknowledging the receipt of your grievance request within 5 days. You will then be contacted via the telephone (if available) by a Customer Service Representative who will explain the grievance process and advise you of the next available date for a grievance hearing. You will receive a written confirmation of your hearing date a minimum of 7 days before the hearing is scheduled.

The Grievance Committee will review the substance of your concern and review all relevant documents pertaining to the grievance. The Grievance Committee will not include the person who made the initial determination. There will be at least one member of the committee who is a MercyCare insured and who is not employed by MercyCare, if possible.

At your grievance hearing, you and/or a representative you have chosen to act on your behalf have the right to be present and/or a representative you have chosen to act on your behalf may present information relevant to the grievance. If you choose

not to be present, you may also participate in the hearing through a conference call.

The Grievance Committee will then make a decision on the resolution of the grievance.

Within five (5) working days of the grievance hearing, the Customer Service Department will send a letter to you with the resolution of the grievance and if applicable any corrective action that will be taken.

All grievances will be decided within thirty calendar days after receipt of the grievance, unless there are extenuating circumstances. In such cases, Customer Service will notify the member in writing before the 30<sup>th</sup> day that the grievance has not been decided, the reason for the delay, and when a decision on the grievance may be expected. MercyCare will resolve the case within thirty calendar days after giving this notice.

An expedited review may be obtained if a delay of service could seriously jeopardize your life or health or your ability to regain maximum function, or if a reviewing physician advises us that you would subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance, or that the grievance should be expedited. You will be notified by phone of the outcome as quickly as your health condition requires, but not more than 72 hours after receipt of the grievance.

You will also be notified of any additional rights you have in case the results are not to your satisfaction.

## **INDEPENDENT REVIEW**

You have the right to request and obtain an independent review. An "independent review" is a review of an adverse determination or an experimental treatment determination, as defined below, by an independent review organization. An "independent review organization" is a neutral expert certified by the Commissioner of Insurance.

- a. "Adverse Determination" means a determination by MercyCare, in which all of the following apply:
  1. An admission to a health care facility, the availability of care, the continued stay or other treatment that is a covered benefit has been reviewed by the Plan.

2. Based on the information provided, the treatment in #1 above does not meet MercyCare's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.
3. Based on the information provided, MercyCare reduced, denied or terminated the treatment under #1 above, or payment for the treatment was denied.
4. The amount of the reduction or the cost or expected cost of the denied or terminated treatment or payment exceeds, or will exceed during the course of the treatment, \$250.

This definition includes the denial of a request for a referral for out-of-plan services when you request health care services from a provider that does not participate in MercyCare's provider network because the clinical expertise of the provider may be medically necessary for the treatment of your medical condition and that expertise is not available in MercyCare's provider network.

- a. "Experimental treatment determination" means a determination by MercyCare in which all of the following apply:
  1. A proposed treatment has been reviewed.
  2. Based on the information provided, the proposed treatment is determined to be experimental under the terms of the Plan.
  3. Based on the information provided, MercyCare denied the treatment or payment for the treatment.
  4. The cost or expected cost of the denied treatment or payment exceeds, or will exceed during the course of the treatment, \$250.

After MercyCare makes an adverse determination or an experimental treatment determination, you will receive a notice explaining your right to request an independent review, and how to go about obtaining an independent review. Your request for independent review must be made within 4 months from the date of the adverse determination or experimental treatment determination, or from the date of receipt of notice of the grievance panel decision, whichever is later. The request for independent review must be made in writing and sent to MercyCare, Customer Service Department, Independent Review, P.O. Box 2770, Janesville, Wisconsin 53547-2770. The request should contain the following:

- a. Your name, address, and phone number.

- b. An explanation of your disagreement with MercyCare's determination, including any documentation that supports your position.
- c. A statement authorizing your representative to pursue independent review on your behalf if you are using such a representative to pursue independent review.
- d. The name of the independent review organization you select. You can obtain a list of certified independent review organizations from the Customer Service Department at [1-800-895-2421] or from the web site of the Office of the Commissioner of Insurance noted at the end of this Complaint Procedures section.
- e. The \$25 fee, payable to the independent review organization you select. The \$25 fee is refundable by MercyCare if the independent review decision is made in your favor in whole or in part.

In order to be eligible for independent review, you must exhaust MercyCare's internal grievance procedure. You need not exhaust the internal grievance procedure if either of the following conditions are met:

- a. Both MercyCare and you, or your authorized representative, agree that the appeal should proceed directly to independent review.
- b. The independent review organization determines that bypassing the grievance procedure is appropriate upon receiving a request from you or your authorized representative that is simultaneously sent to MercyCare. Bypassing the grievance procedure is appropriate if your health condition is such that requiring you to use the internal grievance procedure before proceeding to independent review would jeopardize your life or health or your ability to regain maximum function

MercyCare will acknowledge your request for independent review within 2 days of receipt of the request and immediately notify the independent review organization you selected. If the independent review organization determines that your case should be expedited (because following the normal procedure would jeopardize your life or health or your ability to regain maximum function), MercyCare will forward the case to the independent review organization within 1 day after receiving the request for review. Otherwise, MercyCare will forward the case to the independent review organization within 5 business days after receiving the request for independent review.

In addition to the information provided by you and MercyCare, the independent review organization

may consider any typed or printed, verifiable medical or scientific evidence that the independent review organization determines is relevant, regardless of whether the evidence has been submitted for consideration at any time previously. Any information you or MercyCare submit to the independent review organization must also be submitted to the other

party. If, on the basis of any additional information, MercyCare reconsiders your case and determines that the treatment should be covered, the independent review is terminated. An independent review does not include appearances by you or your authorized representative, any person representing MercyCare, or any witness on behalf of either you or MercyCare.

A decision of an independent review organization regarding an adverse determination must be consistent with the terms of the plan. A decision of an independent review organization regarding an experimental treatment determination is limited to a determination of whether the proposed treatment is experimental. The independent review organization will determine that the treatment is not experimental and find in your favor only if the independent review organization finds all of the following:

- a. The treatment has been approved by the Food and Drug Administration (FDA), if the treatment is subject to the approval of the FDA.
- b. Medically and scientifically accepted evidence clearly demonstrates that the treatment is proven safe, can be expected to produce greater benefits than the standard treatment without posing a greater adverse risk to you, and meets the coverage terms of the plan and is not specifically excluded under the terms of the plan.

The independent review organization will make a decision within 30 business days after receiving all pertinent information required to make the decision. If the independent review organization is working with an expedited case, it will make its decision as quickly as your health condition requires, but not more than 72 hours after receipt of all pertinent information required to make the decision. In the case of an expedited review, the independent review organization will notify you and MercyCare of its decision within 1 hour of making the decision, or as soon as possible.

The independent review organization decision will be in writing, signed on behalf of the independent review organization, and served by personal delivery or by mailing a copy to you or your authorized

representative and to MercyCare. The decision is binding on you and MercyCare.

## **OFFICE OF THE COMMISSIONER OF INSURANCE**

You may resolve your problem by taking the steps outlined above. You may also contact the Office of the Commissioner of Insurance to file a complaint. The Office of the Commissioner of Insurance is a state agency that enforces Wisconsin's insurance laws. To request a complaint form, you can contact the Office of the Commissioner of Insurance by one of the following:

**Office of the Commissioner of Insurance**  
**P.O. Box 7873**  
**Madison, WI 53707-7873**  
**(800) 236-8517**  
**(608) 266-3585**  
**Fax: (608) 264-8115**  
**Email: [marketreg@oci.state.wi.us](mailto:marketreg@oci.state.wi.us)**  
**Website: [www.oci.wi.gov](http://www.oci.wi.gov)**