Transparency Provisions for Website 2016

INTRODUCTION AND SCOPE

This document is meant to provide information to those New Hampshire members with certain key information about their health plan, as required by 45 CFR §155.1040(a) and §45 CFR 156.220. For more detailed information, please refer to your Explanation of Coverage (EOC).

Out-of-Network Liability and Balance Billing with Out-of-Plan Providers
It's important to know that Minuteman Health ("Minuteman" or "MHI") normally does not cover care received from an out-of-plan provider and members may have financial liability for services if received from an out-of-plan provider. Balance billing occurs when an out-of-network (what we refer to as "out-of-plan") provider bills a member for charges other than copayments, coinsurance, or any amounts that may remain on a deductible.

If a member decides to receive services from an out-of-plan provider, they must show their Minuteman ID card to the provider upon arrival. If an out-of-plan provider is planning to bill MHI directly, members should ask the out-of-plan provider to submit a standard medical claim form to MHI.

Payments to providers
Within 15 calendar days of receiving an electronic claim or 30 calendar days of receiving a non-electronic claim, MHI will:

- Pay the provider, OR
- If MHI does not pay the claim, MHI will tell the member and the provider the reason for non-payment, OR
- MHI will ask the provider to submit additional information in writing needed to evaluate the claim. MHI will then have 45 calendar days from the date the additional information is received to re-evaluate the claim.

Referrals to out-of-plan providers
In general, the providers in the MHI In-Plan Provider Network can provide most covered health care services. However, in some cases, there may not be an appropriate In-Plan Provider available for treatment. If this is the case, a member's treating In-Plan Provider can request approval from MHI for the member to be referred to an out-of-plan provider. In order to see an out-of-plan provider, members must first have the approval of MHI. (see Prior Authorization below)

If MHI determines that there is not an appropriate In-Plan Specialist for a member's treatment, MHI may approve treatment from an out-of-plan provider. MHI will work with the In-Plan Primary Care Provider ("PCP") or treating In-Plan Provider to identify an appropriate out-of-plan provider to treat you.

Prior Authorization
To start the Prior Authorization process, the member's In-Plan PCP or treating In-Plan Provider must submit a Prior Authorization Request Form to MHI. (The form can be obtained on MHI's website by visiting the "Forms and Documents" page on the provider tab or by clicking here http://minutemanhealth.org/resources/forms-and-documents and then selecting "for providers" and clicking "prior authorization form.").

The treating In-Plan Provider must fill out the form and also explain in detail why the member needs to be treated by an out-of-plan provider. Upon review, MHI will send a written notice with approval or denial to the member and the treating In-Plan Provider. Members should not make an appointment with the out-of-plan provider before receiving MHI's response.

For more details on the Prior Authorization process, see the "Claims and Utilization Management Procedures" section of you Explanation of Coverage (EOC).

Emergency services with out-of-plan providers
All Minuteman plans cover services for Emergency Medical Conditions, when rendered at out-of-plan emergency providers. MHI defined Emergency Medical Condition as follows: A medical condition of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the insured or another person (or, with respect to a pregnant woman, the health of the woman or her unborn could) in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part.

If the emergency treatment leads to hospitalization at an out-of-plan hospital, members have a benefit for care at that hospital until they are clinically stable for transportation to an In-Plan Facility. It's important to know that if a member chooses not go to an In-Plan Hospital once stabilized and wishes to receive additional services at the out-of-plan hospital, then those services may not be covered. Members only have a benefit for transfers to out-of-plan hospitals when necessary services are not available at an In-Plan Hospital.

Enrollee Claims Submission
For In-Plan Providers, you do not have to submit claims to MHI. In-Plan Providers do this for you. Most out-of-plan providers will bill MHI directly in which case the out-of-plan provider should submit a standard medical claim form to MHI.

In some cases, out-of-plan providers will not bill MHI directly. In these instances, the member is responsible for submitting a claim to MHI. In order to do this the member must submit an itemized bill which includes the diagnosis and the date of treatment. For foreign medical bills and for some out-of-plan providers in the U.S., a member may have to pay the provider directly.

In order to be reimbursed for a claim, members must submit a copy of the bill and proof of payment to 1 Monarch Place, Suite 1500, Springfield, MA 01144 with with the Member's name, current address and Minuteman Member ID number (shown on the Member's ID card).

Please note that the following payment requirements apply to claims submitted by both In-Plan and out-of-plan providers:

Within 15 calendar days of receiving an electronic claim or 30 calendar days of receiving a non-electronic claim, Minuteman will:

- Pay the In-Plan or out-of-plan provider, OR
- If MHI does not pay the claim, MHI will tell member and the In-Plan or out-of-plan provider the reason for non-payment, OR
- MHI will ask the In-Plan or out-of-plan provider to submit additional information in writing needed to evaluate the claim. MHI will then have 45 calendar days from the date the additional information is received to re-evaluate the claim.

Claims will be considered paid on the date a check was issued or electronically transferred. MHI will mail checks no later than 5 business days after a check is issued. If a claim is not paid within the state mandated timeframe, MHI will pay interest to the provider. This interest will be paid in addition to any reimbursement due for health care services provided. Interest will accrue beginning the date the payment was due. Interest will accrue at the rate of 1.5% per month, not to exceed 18% per year. Interest payments will not apply to a claim that MHI is investigating because of suspected fraud.

Submitting claims from a foreign provider
If a member receives health care services in a foreign country, provider bills must be translated into English and converted into U.S. dollar values before submitting to MHI.

Once this information is submitted, MHI will:

- Repay the member for Covered Services, less any Copay, Deductible, and Coinsurance amounts, OR
- If MHI does not pay the claim, MHI will tell member the reason for non-payment, OR
- MHI will ask the member to submit additional information in writing needed to evaluate the claim. MHI will then have 45 calendar days from the date the additional information is received to re-evaluate the claim.

If you receive services from an out-of-plan provider and are seeking reimbursement from MHI, you must send written notice of claim to MHI within 20 days after you visited the out-of-plan provider or as soon as reasonably possible. Notice of such services should be given by or on behalf of the member to MHI at: 1 Monarch Place, Suite 1500, Springfield, MA 01144 with information sufficient to identify the Member shall be deemed notice to MHI.

Upon receipt of a notice of claim, MHI will provide you with a claim reimbursement request form. If you have questions regarding the claim reimbursement request form, contact the Member Services Team at 855-644-1776.

Once received, MHI will review your reimbursement request form and determine whether your claims are reimbursable under the terms of this policy. Please refer to your EOC for additional details.

Grace Periods and Claims Pending Policies During the Grace Period
MHI provides a grace period of three consecutive months for subscribers receiving advance payments of the premium tax credit (APTC) and who have previously paid at least one full month's premium during the benefit year.

If you do not pay the full amount of the Premium to MHI by the premium due date, a grace period is triggered. A grace period is an additional period of time during which coverage remains in effect. The grace period is either 3-months for individuals receiving APTC or 31 days for individuals not receiving the APTC.

If the Subscriber does not pay the required Premium by the end of the grace period, the Policy is terminated. The application of the grace period to claims is based on the date of service and not on the date the claim was submitted. If you fail to reinstate your coverage before the end of the applicable grace period, and you received services during the grace period, those services you received during the grace period are not covered. If you fail to pay your first premium payment you do not receive the 3-month grace period and your policy is cancelled.

Claims Pending occurs when a provider who rendered health care services to you submitted a claim to MHI even though you have not yet paid your monthly premium. "Claims Pending" means that MHI has neither approved nor denied your claim. MHI will pay all appropriate claims for services rendered to the member during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period.

There are other circumstances apart from a member not paying his/her premium which may result in claims being pended. For example, MHI may have to conduct additional research into a claim and ensure that there is no fraudulent or accidental billing before approving or denying such a claim. The claim may be delayed due to a provider asking for medical record or the claim is in the process of being reviewed by our Medical Management team.

Retroactive Denials
A retroactive denial is the reversal of a previously paid claim leaving the member responsible for the payment of the claim. Claims may be denied retroactively, even after the member has obtained services from the provider.

In order to prevent a retroactive denial, you should always pay your monthly premium on time. MHI also encourages you to understand your specific plan's In-Plan and out-of-plan coverage as obtaining care from an out-of-plan provider may be the cause of a retroactive denial. You should also attempt to notify MHI of inpatient admissions in order to ensure that any necessary prior authorizations are obtained in advance of the service.

In addition, Minuteman may retroactively deny a previously paid claim in the event of fraud and/or intentional misrepresentation.

Please refer to the list of services requirement prior authorization at http://www.minutemanhealth.org/members/members-forms-documents (click on Prior Authorization Forms).

Enrollee Recoupment of Overpayments of Premium

Enrollee recoupment of overpayments is the refund of a premium overpayment by the member due to an inadvertent over-billing by MHI. In the event that it is determined that MHI has over-billed you for your monthly premium payment, MHI will credit your account for the amount paid in excess of the actual monthly premium payment. You may request a refund of your credit balance by contacting a billing specialist at 603-657-1027. You may also submit a request in writing to:

Minuteman Health, Inc.
P.O. Box 120025
Boston, MA 02112-0025

Refund requests will be evaluated upon receipt. All refunds require approximately two weeks for processing.

Medical Necessity and Prior Authorization Timeframes and Member Responsibilities

Medical necessity is used to describe care that is reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care. MHI covers non-preventive services only if they are medically necessary and appropriate. The member's In-Plan PCP will provide or arrange most of the member's health care in accordance with MHI policies and the member's EOC.

Some treatments and services require Prior Authorization. Prior authorization is a process through which MHI approves a member's access to a covered benefit. Prior authorization must be approved by MHI before the member can access the benefit. One example is MRIs and other types of diagnostic imaging services.

Please refer to the "Claims and Utilization Management Procedures" section of your EOC for more information including a list of services that require Prior Authorization. A list of services which require Prior Authorization is also available online at http://minutemanhealth.org/resources/forms-and-documents (click on Prior Authorization Forms). Members are notified of changes to the Prior Authorization list at least 60 days in advance before the change takes effect.

If any Non-Covered service or treatment, such as a cosmetic procedure, is performed at the same time as the authorized services, MHI may deny the Non-Covered service or treatment. MHI covers Medically Necessary treatment due to complications from the non-covered services.

MHI must provide Prior Authorization for treatment by an out-of-plan provider. Emergency situations are the only exception where you do not need a prior authorization to go to an out-of-plan provider. You do not need Prior Authorization for diagnostic imaging services provided in the Emergency Room or during an inpatient admission.

To get Prior Authorization, your treating In-Plan Provider must contact MHI to request a Prior Authorization Request Form. MHI's Health Services Department sends Prior Authorization Request Forms to your provider. The provider can either send us a Prior Authorization Request Form or contact MHI by phone.

MHI will decide whether the service is:

- A Covered Service
- Medically Necessary
- To be provided in the appropriate setting
- In keeping with generally accepted medical practice
- Available within the MHI network
- Consistent with MHI's medical necessity criteria

Your provider may also contact MHI by phone. The provider should contact MHI at least seven days before your procedure. MHI will make a pre-service decision within two working days after we get all needed information. This information includes the results of any face-to-face clinical evaluation or second opinion required. If MHI approves coverage, we will inform the provider by phone by phone within 24 hours. MHI will send written or electronic Prior Authorization to you and your doctor within two working days thereafter.

If MHI denies coverage for the services MHI will:

- Tell your doctor by phone within 24 hours
- Send a written or electronic denial of coverage to you and your provider within one working day thereafter

For urgent pre-service requests, MHI will notify you and your provider in writing within two business days of receiving all information, or within 72 hours of receipt of your request, whichever is earlier. MHI will also inform the provider within 24 hours of making the decision.

For post-service requests, MHI will notify you and your provider in writing within 30 calendar days of the request.

If your provider has asked for Prior Authorization, you may call the Member Services Team at 855-644-1776 to get its status or outcome. You may call MHI's Health Services Department at <phone number> if you want a copy of the clinical criteria MHI uses to make its medical necessity decision.

The "Covered Benefits" section of your EOC tells you if a particular Durable Medical Equipment (DME) item needs Prior Authorization.

If MHI reviews a procedure or hospital stay, it does not mean that MHI will cover all charges. MHI makes decisions about benefits according to all the terms of this EOC. Whether or not you obtain Prior Authorization, items that are not covered under this EOC may be denied.

Even when we do not require Prior Authorization for coverage of a particular benefit, you or your provider may ask MHI to make a determination whether a proposed admission, procedure, or service is Medically Necessary. We will do so within seven working days of obtaining all necessary information, expect that we may choose not to perform such a review if we determine that the admission, procedure or service will be covered.

It is important to emphasize that you must get a Prior Authorization from MHI for services provided by an Out-of-Plan provider, including Out-of-Plan mental health and substance abuse providers, before you get the services. As stated above, your In-Plan PCP or treating In-Plan Provider must submit a Prior Authorization Request Form to MHI. The form should explain why services are not available from an In-Plan Provider. MHI will notify you and your doctor in writing of our decision to authorize or not authorize the service. You should not make an appointment with the out-of-plan provider before you receive MHI's response. For more details on the Prior Authorization process, see the "Claims and Utilization Management Procedures" section of your EOC. You will be responsible for Copays, Deductibles and Coinsurance at the In-Plan level.

Drug Exceptions Timeframes and Enrollee Responsibilities
A formulary is a list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits (it can also be referred to as a "drug list"). In some cases, your provider may prescribe a prescription drug that is not part of your plan's formulary. MHI may ask your doctor to provide more information so that we can decide if the drug is Medically Necessary. This is called the Prescription Exception Process.

MHI has two exception processes depending on the nature of your request:

1) *Expedited Exception Process for Exigent Circumstances*

You may request an expedited exception for exigent circumstances. An exigent circumstance exists when an individual is suffering from a health condition that may seriously jeopardize the enrollee's life, health or ability to regain maximum function, or when an enrollee is undergoing a current course of treatment using a non-formulary drug. MHI will make a decision to either cover or not cover an expedited request within 24 hours of receiving this additional information from your Provider. If MHI decides to cover a non-Formulary drug, it may still be subject to Prior Authorization, Step Therapy and other utilization reviews. Note that an excepted prescription drug will be provided for the duration of your prescription and any cost-sharing associated will count towards your maximum out of pocket amount. You will pay the highest cost-share on our Formulary. A request for exception of a non-covered drug will be considered approved if MHI fails to provide a determination within 24 hours.

2) *Standard Exception Process*

You may also request a standard exception. MHI will make a decision to either cover or not cover an expedited request within 48 hours of receiving this additional information from your

Provider. If MHI decides to cover a non-Formulary drug, it may still be subject to Prior Authorization, Step Therapy and other utilization reviews. Note that an excepted prescription drug will be provided for the duration of your prescription and any cost-sharing associated will count towards your maximum out of pocket amount. You will pay the highest cost-share on our Formulary. A request for exception of a non-covered drug will be considered approved if MHI fails to provide a determination within 48 hours.

If MHI denies your exception request, you may request that MHI's decision be reviewed by an independent review organization. For more information on this right, please contact the Member Services Team at 855-644-1776

Information on Explanations of Benefits (EOBs)
An Explanation of Benefits (EOB) is a statement MHI will send a member to explain what medical treatments and/or services it paid for on member's behalf, MHI's payment, and the member's financial in accordance with the member's plan. More specifically, you will receive an EOB from MHI when we get a claim for services from your provider and we have adjudicated the claim(s). This EOB will show your payment responsibilities for Deductible and Copays/Coinsurance. The EOB will show what your Copay or Coinsurance is for a particular service. The EOB will not show whether you have paid the Copay to the provider.

Please click <INSERT LINK TO THE SAMPLE EOB ATTACHED> for a sample EOB which explains how you should read and understand this document.

Coordination of Benefits (COB)
The Coordination of benefits is a process that exists when a member is covered by more than one health plan. A coordination of benefit document shows which health plan pays first. If a member has double coverage, one plan is the primary payer and pays benefits first. The other plan is secondary and pays benefits second.

When a member or any dependents are covered by more than one health plan it is known as "double coverage." In this instance MHI may request to review plan documents from the other insurance carrier. If MHI is the secondary payer, we may be entitled to receive payment from your primary plan. MHI decides which insurance is primary based on rules used throughout the insurance industry, or as required by law. A copy of these rules is available upon request.

We will always provide you with the benefits described in your EOC. However, MHI will only provide coverage under MHI policies and rules. For example, if you see an out-of-plan provider without MHI's Authorization, except for Emergency Services, MHI will not cover the services you receive, even if your other plan covers them.

MHI is required to provide the Centers for Medicare & Medicaid Services (CMS) with information about your Group health plan and its covered Members. CMS is requiring this information to coordinate Medicare benefits and payments. To comply with the CMS requirements, you must provide Social Security Numbers (SSNs) for yourself and your covered Dependents upon request.

Medicare Part A or B:

You must tell us if you or a family member is enrolled in Medicare Part A or B. Medicare rules determine whether MHI or Medicare pays first for care. MHI follows these Medicare "order of payment" rules.

Medical Payment:

In some cases, Members who are injured have benefits under a "medical payment" clause of an insurance policy, such as a homeowner or auto insurance policy. If so, that "med payment" coverage will be primary to coverage under this EOC. If so, MHI will work with the other carrier. If the other carrier allows you to be repaid directly for medical expenses, you agree to allow the payment to be made to MHI.

Worker's Compensation (and similar programs):

In some cases, MHI has information showing that that a Member's care is covered under Workers' Compensation, or similar programs, or by a government agency. If so, MHI may suspend payment for such services until we determine if payment will be made by such program or agency. If MHI provides or pays for services covered under such programs or agencies, MHI will be entitled to recover its expenses from the provider or the party obligated to pay.