

**NATIONAL HEALTH ADMINISTRATORS, INC.™**



**NHAI PROVIDER MANUAL**

**FOR**

**PREFERRED PROVIDERS**



## National Health Administrators Inc.

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1200 Brown Street, Suite 12 . Peekskill, NY 10566  
(914) 739-6100 . Fax (914) 739-8341

Dear Participating Physicians and other Providers:

Enclosed is the new National Health Administrators (NHA) Provider Manual. This manual will provide you with important information you will need to conduct business with NHA, such as benefits, procedures and policies that govern the "Plan" and its members.

It is our desire to make your interaction with NHA and our membership less stressful and time consuming to both you and your office staff. The manual was designed for easy reference to all areas pertaining to NHA and the Plan. It outlines what we expect from you, and what you should expect from NHA, always keeping in mind what is best for the membership.

We look forward to working with you and building responsible and reasonable reimbursements that benefit payers, providers and patients alike. If you should have additional questions, please visit our web-site at [www.nhai.net](http://www.nhai.net) or call our PPO coordinator at 1-800-679-2400, Ext.4.

National Health Administrators, Inc.

## TABLE OF CONTENTS

<b>IMPORTANT CONTACT INFORMATION .....</b>	<b>4</b>
<b>PROVIDER RESPONSIBILITIES .....</b>	<b>5</b>
Member Verification .....	5
Medicare .....	5
Dependent Coverage .....	5
Retirees .....	6
COBRA .....	6
Timely Submission of Claims Required .....	6
Penalties for Failure to Timely File Claims .....	6
Reimbursement Limited on Untimely Filed Claims .....	6
Assignment of Benefits .....	6
PPO Discounts and/or Medicare Discounts .....	7
<b>PRE-CERTIFICATION RULES .....</b>	<b>7</b>
General Pre-Certification Rules .....	7
Pre-Certification and Utilization Review Required for Certain Procedures .....	7
Enrollment is Required for “Special” Benefit Programs That Requires Pre-Enrollment .....	8
Pre-Certification Is Not a Guarantee of Payment .....	8
Penalties for Failure to Pre-Certify Benefits .....	9
<b>PENALTY CHART FOR LATE FILED CLAIMS AND/OR FAILURE TO PRE-CERTIFY BENEFITS .....</b>	<b>9</b>
<b>GENERAL APPEALS RULES .....</b>	<b>10</b>
Rights of Review and Appeal .....	10
Pre-Certification and Medical Necessity Appeals .....	10
Claims Payment/Benefit Appeals .....	10
Authorized Representative .....	11
<b>CLAIMS PAYMENT .....</b>	<b>11</b>
<b>CLAIM DENIAL AND APPEAL RULES .....</b>	<b>12</b>
Level 1: Initial Investigation of Payment .....	12
Level 2: Appeal of Pre-certification or Medical Necessity .....	12
Level 3: ERISA Complaints and Appeals after Level 1 and 2 Have been Exhausted .....	12
Level 4: A Second Appeal of a Previously Denied Claim .....	12
Level 5: In the event of a second or subsequent appeal, or a complex, unique claim .....	13
Level 6: The Plan Administrator/Board of Trustees, at its sole discretion, may submit any unresolved claim or issue to binding arbitration .....	13
<b>BINDING ARBITRATION .....</b>	<b>13</b>
<b>COMPLIANCE OFFICE .....</b>	<b>13</b>
<b>COMPLIANCE GUIDELINES .....</b>	<b>14</b>
Rule #1 Timely Submission of Claims .....	14
Rule #2 Current Group Health ID Cards .....	14
Rule #3 Assignment of Benefits .....	15
Rule #4 Duty to Notify Patient .....	15
Rule #5 Patients Responsible for Timely Filing of Claims Paid Directly .....	15
Rule #6 Accurate Completion of Claims Forms .....	15
Rule #7 Provider Adjustments Due to Provider Error .....	15
Rule #8 Patient Responsibility .....	15
Rule #9 Enrollment in Special Benefit Programs .....	16
Rule #10 Non-PPO Providers .....	16
Rule #11 Electronic Filing of Claims .....	16

<b>CASE MANAGEMENT .....</b>	<b>16</b>
Case Management .....	16
Urgent Care Claims .....	17
Pre and Post-Service Claims .....	17
Filing Extensions .....	17
Concurrent Care Decisions .....	17
Adverse Benefit Determination .....	18
<b>MEDICAL NECESSITY .....</b>	<b>18</b>
<b>PRIVACY AND CONFIDENTIALITY .....</b>	<b>18</b>
Person in Charge of Privacy Policies and Complaints .....	19
Where to File Complaints .....	19
Medical Release and Authorization .....	19
Authorized Individuals .....	19
<b>COORDINATION OF BENEFITS (COB) .....</b>	<b>19</b>
Allowable Expense .....	20
Closed Panel Plan .....	20
Order of Benefit Determination Rules for COB .....	20
Non-Dependent or Dependent Rule .....	21
Exception to the Non-Dependent/Dependent Rule .....	21
Active Employee, Retired, or Laid-off Employee .....	21
Dependent Child Covered Under More Than One Plan .....	21
COBRA or State Continuation Coverage .....	22
Longest or Shortest Length of Coverage .....	22
Effect of COB on the Benefits of the Plan .....	22
Right to Receive and Release Needed COB Information .....	22
Facility of Payment/Right of Recovery .....	22
Right of Recovery By The Plan .....	22
Special Rules for Medicare Coordination .....	23
Services Provided by a Provider Who Accepts Medicare Assignment of Benefits .....	23
Medicare Providers Who Do Not Accept Assignment of Benefits .....	23
Contract Providers Not Covered by Medicare .....	23
Benefits Not Covered by Medicare .....	23
Reduced Benefits .....	23
<b>COORDINATION OF BENEFITS (COB) CHART .....</b>	<b>24</b>
<b>CREDENTIALING .....</b>	<b>25</b>
<b>ADDITIONAL INFORMATION .....</b>	<b>25</b>

## IMPORTANT CONTACT INFORMATION

For information on other providers and the NHAJ organization, please visit our web site at [www.nhai.net](http://www.nhai.net).

CLAIMS SUPERVISOR	RESPONSIBILITIES	CONTACT NUMBERS
<b>CLAIMS OFFICE:</b>  National Health Administrators, Inc.™ P.O. Box 5000 Endicott, NY 13761-5000	Questions on Benefits, Claims, Membership, or Provider verification of benefits. See Compliance Office for Claims Appeals below.  <b>ALL MEDICAL CLAIMS MUST BE MAILED TO THIS OFFICE FOR PAYMENT.</b>	Hotline: (888) 679-2400, Ext. 1 Phone: (888) 335-0133 FAX: (607) 786-3437
<b>BEHAVIORAL HEALTH AND ADDICTIVE TREATMENT</b>		
NHAJ Behavioral ( <b>NHAJB</b> ) Claims (Mental Health/Substance Abuse) 246 Highway 34 South Matawah, NJ 07747	<b>NHAJB must authorize all mental health/substance abuse providers and services. Benefits must also be pre-certified by NHAJ Pre-Certification Department.</b>  <b>IN CASE OF EMERGENCY, GO TO THE NEAREST HOSPITAL.</b>	Hotline: (888) 679-2400, Ext. 3 Care Line: (888) 838-8874 Emergency Pager: (732) 207-5690 FAX: (732) 441-9866 E-Mail: Behavioral@nhai.net
<b>NHAJ EXECUTIVE OFFICE - NHAJ PPO</b>		
<b>EXECUTIVE OFFICE:</b>  National Health Administrators, Inc.™ 1200 Brown Street Suite 12 Peekskill, NY 10566  Normal Business Hours, except for Holidays: 9:00 A.M. - 5:00 P.M.	PPO Provider Relations, PPO Negotiations, PPO Contracting and pricing.	Hotline: (888) 679-2400, Ext. 4 FAX: (914) 739-8341
<b>For Benefit Information</b>		<b>Call NHAJ Hotline: 1-888-679-2400, Ext. 9</b>
<b>For Plan and/or Provider Information</b>		<b>NHAJ Website: <a href="http://www.nhai.net">www.nhai.net</a></b>
PRE-CERTIFICATION	RESPONSIBILITIES	CONTACT NUMBERS
<b>NHAJ Pre-Certification Department</b>  (Medical and Mental Health or Substance Abuse)	For Pre-certification, Utilization Review, Case Management for Medical, Mental Health Treatment.  <b>Pre-certification decisions are independent from payment or benefit decisions.</b>	Hotline: (888) 679-2400, Ext. 2 Phone: (866) 844-8244 FAX: (785) 233-3149 E-Mail: <a href="mailto:precertl@nhai.net">precertl@nhai.net</a>

PRESCRIPTIONS - Rx	RESPONSIBILITIES	CONTACT NUMBERS
<p><b>Medco Solutions Prescription Benefit Manager</b></p>	<p>For Prescription and Mail Order program or finding a local network pharmacy.</p> <p>For special Rx requests contact the Compliance Office or the Executive Offices of NHAI, Extension 6 then Extension 5.</p>	<p><b>Rx:</b> (800) 818-0093 Member Services</p> <p><b>Mail Order:</b> (800) 474-3455</p> <p><b>FAX:</b> (414) 784-4935</p>
CLAIMS APPEALS, COMPLAINTS, HIPAA COMPLIANCE	RESPONSIBILITIES	CONTACT NUMBERS
<p>Submit any requests concerning the following to the Compliance Office:</p> <ul style="list-style-type: none"> <li>■ HIPAA Certificate of Coverage</li> <li>■ COBRA information/questions</li> <li>■ Appeals on claims payments</li> <li>■ Complaints</li> </ul>	<p>All claims appeals must be filed in writing according to Plan rules. Appeals concerning benefit payments and/or Plan interpretation by the provider must be filed with the Compliance Office. Please allow 10 -30 days to review the claim once all information is submitted.</p> <p>For claims appeals concerning pre-certification and/or medical necessity, call the Pre-certification Office immediately. Emergencies will be processed within 24 hours, during normal business hours.</p>	<p><b>Compliance Office:</b> Attn: Gloria Gillespie 416 Creekstone Ridge Woodstock, Ga. 30188-1753</p> <p>Phone: (800) 645-1195 Fax: (770) 874-1097 Hotline: (888) 679-2400 EXT 5 E-Mail: <a href="mailto:compliance@nhai.net">compliance@nhai.net</a></p>
OUT-OF-STATE PROVIDERS	RESPONSIBILITIES	CONTACT NUMBERS
<p>NHAI PPO has a number of providers across the country. Please check the provider listing on our website.</p> <p>Out-of-State or traveling members may also call Three Rivers Provider Network (TRPN) or MultiPlan for referrals.</p>	<p>For emergencies, patients should go to the nearest hospital.</p> <p>PPO directories are available on line at <a href="http://www.nhai.net">www.nhai.net</a>.</p>	<p><u>Contact PPO office for information:</u> Hotline: (888)679-2400, ext. 4 E-Mail: <a href="mailto:info@nhai.net">info@nhai.net</a></p> <p><u>Out-of-State referrals:</u></p> <p>TRPN: (866) 393-0966 Online: <a href="http://www.trpnppo.net">www.trpnppo.net</a></p> <p>MultiPlan: (800) 557-6794 Online: <a href="http://www.multiplan.com">www.multiplan.com</a></p>

<b>PROVIDER RESPONSIBILITIES</b>
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**A. Member Verification**

Providers are required to verify member status by requesting a copy of the member ID card at the time of service. The member ID card is to be copied (front and back) for maintenance in the member's file. Additionally, the provider is to verify the member's social security number, current phone number (work and home) and current address, and photocopy all insurance cards. If member is covered by more than one insurance, provider is to verify which coverage is primary and which is secondary either with the patient or with the Claims Office. We recommend confirming this, in any event with the Claims Office. Remember special rules apply in the following instances:

1. **Medicare:** Coverage for members who are spouses or dependents of an active employee. In such cases, Medicare is secondary to the coverage provided by the actively employed member.
2. **Dependent Coverage:** Verify the names, address, dates of birth and insurance of BOTH parents. Generally, the primary coverage will be based on the birthday rule and in the case of divorced parents

the parent who has custody or who has legal responsibility for medical care of the child. Your records should make note of this information so that claims and pre-certification of benefits can be properly made and filed.

3. **Retirees:** Coverage under an actively employed spouse is primary to coverage as a retiree. Be sure to verify spousal coverage of any retiree.
4. **COBRA:** Coverage is contingent upon payment of COBRA premiums being made within 30 days of any due date. COBRA coverage may be paid by providers or any other party on behalf of the insured Member. COBRA coverage may be retroactively denied or reinstated in accordance with these rules.

#### **B. Timely Submission of Claims Required**

Providers are responsible for submitting bills within 60 days of the date of service and for routinely following up on unpaid bills. The provider must submit the initial claim within 90 days following the date of service or the date of payment. Late filed claims will be considered for payment only if there is reasonable cause shown for such late filing up to 12 months following the date of service. The maximum claim consideration period shall not exceed 18 months, which includes 180 day HIPAA appeal period. Reasonable cause must include proof of a good faith effort on the part of the provider or the member/patient to timely file the claim.

Failure to have the correct insurer or billing address does not constitute a reasonable effort, absence timely efforts to obtain and/or provide correct billing and insurance information, and submit the claims within these time frames. If this plan is secondary, a copy of the EOB and verification of primary payment and/or denial must be submitted with the claim. This plan operates on the same principal as most insurance plans. Claims not submitted for payment within one year from the date of service, are automatically denied.

#### **C. Penalties For Failure to Timely File Claims**

Providers are responsible for timely submitting claims to the Plan for payment based on the ID card in addition to the insurance information provided by the Member. Providers are also responsible for timely notifying the patient of outstanding amounts, including uncollected amounts from the insurer and for requesting updated insurance information, if appropriate. Failure to notify the patient precludes the patient from giving the provider updated billing information or from following up on why there is a problem in paying the claim with the insurer. Providers are responsible for accurately completing the UB82 and HCFA 1500 forms INCLUDING accurate notations pertaining to the primary and secondary insurance coverage AND providing a complete billing address for claims payment, including the phone #. Providers are responsible for insuring that their files, include a photocopy of the ID card (front and back) and for updating their internal records accordingly for any new information.

Penalties will be assessed and benefits will be reduced according to the Penalty Chart following the Pre-Certification section.

#### **D. Reimbursement Limited on Untimely Filed Claims**

A late filed claim is accepted for payment, for whatever reason, the plan reserves the right to limit the maximum allowable charges to \$500 for any single claim that is over one year old and no more than \$1,500 in late filed charges in total for that provider. See Penalty Chart below.

#### **E. Assignment of Benefits**

Benefits may be assigned to providers. An assignment authorizes the Plan to pay benefits directly to providers instead of the employee. However, the acceptance of such assignments or the direct payment to providers is not guaranteed under the Plan, nor does this relieve the member or their dependents of the liability for full payment of benefits.

When providers require an assignment of benefits and accept payment directly from Medicare or the insurance company, they have a responsibility to act in such a matter so as to protect their patients' benefits and to not create any additional financial liability for the patient due to negligent billing practices. Providers have a duty to keep the patient informed by sending patients copies of the billing notices and to follow up with the member on unpaid claims sent to the patients' insurer to verify the billing address, etc. A member cannot follow up on a claim where they are not aware that the provider has had a problem in receiving payment from the Plan. Providers also have the responsibility to inform members of their billing policies for secondary insurance. If the provider is provided with copies of both insurance i.d. cards,

the member has the right to assume that the provider will bill both insurance companies unless they are advised otherwise.

It is expected that PPO Providers will automatically obtain an Assignment of Benefits, which authorizes the plan to pay benefits directly to providers instead of to the Employee. However, the acceptance of such assignments or the direct payment to providers is not guaranteed under the Plan, nor does this relieve you as the member or your dependents of the liability for full payment of benefits. The Employee and/or patient have the responsibility to pay providers in full for all services. In the event an assignment request is not honored, the Plan shall have no liability to the provider for any payment made to the Employee. Benefits are not subject to garnishment, attachment, execution, or levy of any kind for a participant's debt or obligation. The Plan Sponsor may direct payment to provider of services or to both the participant and provider in whatever manner the Plan Sponsor may authorize. If a participant is incapable of giving a valid receipt for payment, and if no guardian has been appointed, the Plan Sponsor may make payment to the person or a person who, in the Plan Sponsor's opinion, has assumed the obligation of caring for the participant.

#### **F. PPO Discounts and/or Medicare Discounts**

Providers are responsible for crediting any PPO discount or negotiated rate to the patient's billing. Balance billing of any PPO or Medicare discount is not permitted under the Plan.

### **PRE-CERTIFICATION RULES**

#### **A. General Pre-Certification Rules**

Pre-Certification is a tool used to help provide quality care while managing costs. Pre-certification is neither a guarantee of eligibility nor a guarantee of Plan payment. Benefit payments and eligibility for benefits are determined at the time the claim is processed. Failure to timely file a claim may make a provider and member ineligible for any benefits. If a Plan Member is Planning or is scheduled to undergo surgery, prior approval is required. This also applies to outpatient surgery (if costs are expected to exceed \$1,000), any confinement or hospitalization program. The Utilization Review (UR) firm listed on your ID card and the cover page of this booklet must be contacted (the phone numbers are on your ID card) and written requests and reports must be mailed to the appropriate firm. The Plan reserves the right to change the UR firm at any time. Typical Utilization and Case Management Services include:

1. Planned and emergency hospital admission reviews.
2. Ongoing hospitalization reviews.
3. Voluntary individual Case Management.
4. Ambulatory surgery reviews.
5. Review of routine maternity admissions.
6. Prenatal program and review of ongoing prenatal treatment for sensitive pregnancies.
7. Pre-certification for skilled nursing facilities, home healthcare and home infusion therapy.
8. Voluntary second (and third, if desired) surgical opinions.

#### **B. Pre-Certification and Utilization Review Required for Certain Procedures**

Network and Non-Network providers are subject to the same review requirements for medical necessity and pre-certification. **Network (PPO) providers are expected to pre-certify the following on behalf of any NHA member.** Pre-certification is not generally necessary if the Plan is secondary, unless payments under the Primary Plan are exhausted or there are no benefits available under the Primary Plan. Pre-certification is not a guarantee of payment. Benefit determination and eligibility are determined at the time the claim is submitted and review for payment according to the Plan. **Pre-certification is required for all of the following:**

1. All non-emergency inpatient surgery, the physician must obtain approval prior to surgery;
2. Genetic Testing;
3. Any outpatient/inpatient surgery (when cost is expected to exceed \$1000) must be approved prior to

the surgery;

4. Emergency confinement: A telephone request must be made within 48 hours after confinement. Late requests will be accepted if it was not reasonably possible to make the request during the above time frame;

Example: Injury that, unless treated at once on an inpatient basis, would jeopardize the patient's life, or cause serious damage or impairment to the patient's bodily functions. Failure to pre-certify benefits in accordance with these rules is subject to a retrospective review under the appeals procedures if there are extenuating circumstances, at the sole discretion of the Plan, otherwise penalties for failure to pre-certify will apply.

5. Prior to receiving any Home Healthcare or Home Infusion services;
6. Prior to admission to a Skilled Nursing Facility;
7. Prosthetics, orthotics or durable medical equipment (DME) expected to cost \$500 or more;
8. Drug/Alcohol and Mental/Nervous Treatment Programs must be pre-certified within 24 hours of admission. If admission takes place on a weekend, notification must be provided by 6:00 p.m. the first business day following admission. A treatment program must be submitted and approved within 10 days of admission for the treatment program to be covered;
9. Any extended or alternative benefits beyond what is specifically provided by the Plan must be pre-approved in advance of receiving those services. Extended or alternative benefits are at the sole discretion of the Plan and will be based on all relevant facts and circumstances, medical necessity and the appropriateness and/or success of the given treatment to-date. No such approval will be granted to any member who has failed to cooperate with the case management and pre-certification procedures of the Plan;
10. Any chiropractic or acupuncture visits in excess of 12 visits in any calendar year must be pre-certified and approved in advance of treatment;
11. All massage therapy must be pre-certified prior to treatment;
12. Any physical therapy treatment in excess of 20 visits in any calendar year must be pre-certified and approved in advance of treatment; and
13. Special testing that is expected to exceed \$1,000, including Cat Scans, MRI's. Colonoscopy and EGD's do not require pre-certification, unless pre-certifying due to medical necessity to test more than provided by the Plan.

Approval of the treatment program must be made prior to commencement of the program, except in situations when approval is granted retroactively due to reasonable circumstances. Advance approval is required for any change in a treatment Plan. Retrospective approval may also be made in a situation when extenuating circumstances warrant such approval.

Pre-certification generally is not necessary if this plan is secondary, unless:

1. Payments under the Primary Plan are exhausted;
2. There are no benefits available under the Primary Plan;
3. The illness or injury is catastrophic and expenses are expected to exceed \$50,000.

#### **C. Enrollment is Required for "Special" Benefit Programs That Requires Pre-Enrollment**

These programs include: Out-of-area (OOA) status for retirees, full-time students living out of state a minimum of six months a year, Diabetic Benefit Program, Prenatal Program, Infertility Program, etc. Special benefits are not covered until the date the member enrolls in the applicable program. The Prenatal program requires enrollment in the first trimester or when first eligible for the Plan. OOA enrollment is for those members who permanently move out of the NHAI area as established by the Plan.

#### **D. Pre-Certification Is Not a Guarantee of Payment**

Benefit determinations and eligibility are determined at the time the claim is submitted and review for payment according to the Plan. However, you can verify the current eligibility of a member and the available benefits by contacting the claims office.

**E. Penalties for Failure to Pre-Certify Benefits**

If pre-certification is not obtained prior to Admission/Treatment, claims payments shall be reduced as set out in the Plan. The plan payment is reduced by 10% up to a maximum of \$100 outpatient and \$500 inpatient. In extraordinary circumstances retrospective certification may be permitted if in the sole judgment of the Plan it would be reasonable to do so based on the facts and circumstances involved. In the event the primary provider fails to adhere to the pre-certification rules of the plan, it is expected the provider will be responsible for these penalties, not the member.

Plan benefits will be reduced for claims not retrospectively pre-certified in absence of treatment. Members should verify at the time of service that their provider obtained the necessary pre-certification or approval as required by the Plan. No benefits requiring Pre-Certification will be paid if the Pre-Certification does not occur within one year from the original date of service. All penalties will be assessed at the sole discretion of the Plan based on all facts and circumstances. **Failure to pre-certify Chiropractic, Massage Therapy or behavioral treatment will result in nonpayment of benefits per the Plan rules for these benefits. Any other specific penalties provided for a given benefit such as Massage Therapy will apply in lieu of the penalties provided in this section.**

**PENALTY CHART  
FOR LATE/FILED CLAIMS AND/OR FAILURE TO PRE-CERTIFY BENEFITS**

<b>Days Following Date of Service (DOS)</b>	<b>0-90 Days After Date of Service (DOS)</b>	<b>91 to 180 Days After Service (DOS)</b>	<b>180 to 360 Days After Service (DOS)</b>
Failure to pre-certify benefits prior to treatment	10% reduction in benefits up to a maximum of \$100 for outpatient services and \$500 for inpatient services.	20% reduction in benefits up to a maximum reduction of \$100 per day for outpatient services and \$500 for inpatient services.	50% reduction in benefits. Maximum benefit is limited to \$25,000, if the claim is not filed within 90 days of service, unless reasonable cause is provided, as determined by the Plan.
Late filing of claims by the provider or member.	No penalty if filed within 90 days from DOS.	10% penalty	20% minimum penalty or 50% penalty if sufficient reasonable cause is not documented and provided for the late tiling provided, at the sole discretion of the Plan.
If the claim was untimely filed AND required pre-certification was not obtained timely.	10% reduction in benefits up to a maximum reduction of \$100 for outpatient services and \$500 maximum reduction for inpatient services.	30% reduction in benefits up to \$100 per outpatient visit and \$1,000 for any inpatient treatment.	50% reduction in benefits and maximum benefit is limited to \$25,000 if the claim is not filed within 90 days of service, unless reasonable cause is provided, as determined by the Plan.
<b>Penalties for Failure to Complete Behavioral Programs</b>	Benefits for detoxification will be reduced if the individual fails to complete a treatment program following detox.		
<b>Penalties for Failure to Obtain Approval for Chiropractic/ Massage Therapy</b>	Benefits may be disallowed in their entirety for failure to pre-certify benefits as required by the Plan.		

## GENERAL APPEALS RULES

### A. Rights of Review and Appeal

A Claimant has up to 180 days to file an appeal of an Adverse Benefit Determination. As part of the appeal process, a Covered Person has the right to:

1. Review the Plan and other relevant documents;
2. Argue against the denial in writing; and
3. Have a representative act on behalf of the Covered Person in the appeal.

All relevant documents will be provided free of charge, upon request by the Claimant, after receiving an Adverse Benefit Determination. A document, record, or other information is considered relevant if it was relied upon in making the benefit determination, if it was considered or generated in the course of making the benefit determination, if it demonstrates compliance with the administrative processes, or if it constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the determination.

If the Claimant/Authorized Representative appeals an Adverse Benefit Determination, NHAI will respond to the appeal within 72 hours for an Urgent Care Claim, 30 days for a Pre-Service Claim and 60 days for a Post-Service Claim. The notice will specify the reason for the denial or describe the additional information required to process the claim.

Written denial will include:

1. Specific reasons for denial with reference to applicable Plan Document provisions;
2. Description and need for any other material pertinent to the claim; and
3. An explanation of the Plan's review procedure and the names of any medical professionals consulted as part of the claims process.

A full and fair review of an Adverse Benefit Determination will be performed by an appropriate named fiduciary, who is neither the party who made the initial adverse determination, nor the subordinate of the person. The review will not defer to the initial Adverse Benefit Determination. The review will take into account all comments, document, records and other information submitted by the Claimant, without regard to whether such information was previously submitted or considered in the initial determination.

If the review results in another Adverse Benefit Determination, it will include specific reasons for denial, written in a manner understandable to the Covered Person and will contain specific reference to the pertinent Plan provisions in which the decision was based.

### B. Pre-Certification and Medical Necessity Appeals

In the event of a dispute over a treatment Plan, appropriateness of treatment, or medical necessity of treatment, an appeal may be filed in writing with the Pre-Certification Provider from the standpoint of medical necessity and the Compliance Office from the standpoint of what is covered by the Plan.

In the case of an urgent situation, a decision will be made within 24 hours, excluding weekends, otherwise, a decision will be made within five (5) working days, unless it is deemed or specifically requested that the matter be sent for peer review.

All decisions will be rendered as expeditiously as possible taking into account all aspects of the situation, including the patient's perspective.

When the Plan is unclear or ambiguous, decisions will be made in favor of the participant as to payment of benefits as provided by the Plan and as determined by the Compliance Office by reviewing all factors, including pre-certification and medical guidelines provided by experts in the respective fields.

In the event emergency treatment is performed without pre-authorization due to extenuating circumstances, the provider or the patient may make a request for retrospective review to the Compliance Office and Pre-Certification Department. A decision will be made at the sole discretion of the Plan.

### C. Claims Payment/Benefit Appeals

You will be notified in writing if benefits are reduced. Please refer to Important Numbers to file all appeals.

All appeals must be submitted in writing as provided by the Plan. You may appeal the decision in writing within 180 days of a benefit reduction or claim denial, if:

1. You believe extenuating circumstances prevented you from complying with the Pre-Certification and Utilization Management requirements;
2. You followed the doctor's recommendation even though it was contrary to the Utilization Management's opinion as to the type of care;
3. You believe that Utilization Management reduced benefits incorrectly; or
4. You believe the benefit was paid incorrectly or was not paid in accordance with the Plan.

#### **D. Authorized Representative**

The Plan will recognize an Authorized Representative, including a healthcare provider, acting on behalf of a Claimant. The Plan will recognize a Healthcare Professional with knowledge of a Claimant's medical condition as the Claimant's representative in connection with an Urgent Care Claim. Procedures will be established by the Plan to verify that a representative has been authorized to act on behalf of a Claimant. Members must have an HIPAA Authorization on file to permit NHA staff to discuss confidential information to anyone other than the member or a dependent, who is a minor.

Example: Authorization should be on file to permit a member to discuss their spouse's claim.

### **CLAIMS PAYMENT**

All claims should be filed with the Claims Supervisor, as directed on your ID card. In the review and processing of claims, the Claims Supervisor may rely on standard operating procedures and guidelines as established by the TPA for similar claims or circumstances for any plans administered.

Generally, claims will be paid within 10-15 working days (30 on complex claims) following the date of service after allowing for mail time, etc. Excessive phone calls will actually slow down the turnaround time, since this time takes away from the time that the claims processor has for paying claims. However, providers are expected to follow-up on unpaid claims every 60-90 days either by phone or by refiling the claim. If a claim is not paid after it has been filed twice, phone follow-up should be made to verify the billing address and/or receipt of the claim. In the case of lost or delayed mail, the claim can be refilled via fax and payment will be expedited on such claims.

**Note:** Claims must be timely filed. Repeated filing of a claim without follow-ups for confirmation or receipt, problems, etc. may result in untimely filing of claims and non-coverage for failure to have appropriate business procedures in place to insure timely billing of claims to the correct billing address.

The Plan reserves the right to refuse to pay benefits until ALL requested information is provided, including any agreements dealing with coordination and subrogation issues. All subrogation papers must be timely executed and filed within 60 days of the request provided the claims were timely filed as required below, in order for your claims to be considered eligible for payment under the plan. Claims filed after these dates will not be paid, unless there are reasonable circumstances for the delayed filing of the claims, or documentation of prior filing of these claims. A timely written notice of a medical or health insurance claim must be given within the time limit as provided in this Article in order for the Plan to be liable.

**"Loss"**, as used in this provision, means covered expenses incurred, disability or accidental death or dismemberment, as provided in this Plan. When the notice of claim is received, the Plan Sponsor or Claims Supervisor will send the claimant forms for filing proof of claim. If these forms are not given to the claimant within 10 working days, the claimant will meet the proof of claim requirements by giving the Plan Sponsor or Claims Supervisor a statement in writing of the nature and extent of the loss. Positive proof of claim must be given to an authorized claim office for a medical or health insurance claim, which exceeds \$1,000, by the dates, as required under this Article. If it was not reasonably possible to give notice and proof in writing in the time required, the Plan Sponsor or Claims Supervisor shall not reduce or deny the claim for this reason if proof is filed as soon as reasonably possible. Otherwise, late filed claims will be denied.

## CLAIM DENIAL AND APPEAL RULES

The following grievance and appeal procedures are provided to give each member (or provider) the optimum opportunity to access the benefits provided by this plan and these procedures are set out in the spirit of offering a viable Patient Bill of Rights for the membership that goes beyond what has been proposed by Congress.

All appeals must be filed with the Compliance Office. See Compliance Office and Compliance Guidelines. NHAH Plans are ERISA plans and are exempt from state insurance laws.

**Level 1: Initial Investigation of Payment.** First contact the Claims Supervisor regarding routine questions on how a claim was paid or questions on claims status. The Claims Supervisor shall accept any claim for benefits made in the manner provided by the Plan, and after due investigation and verification of the statements contained in the application, determine the eligibility of the Participant for benefits. If the facts stated in such application are determined on investigation by the Claims Supervisor to entitle the Participant to receive payment of benefits or additional benefits from the Plan, the Claims Supervisor shall adjudicate the proper payment from the Plan. All claims paid under a plan shall be paid in a uniform, consistent and nondiscriminatory manner. No claims shall be paid outside the Plan unless written direction from the Plan Sponsor is received.

**Level 2: Appeal of Pre-certification or Medical Necessity.** If your appeal involves the pre-approval of an urgent treatment or procedure, immediately call the Pre-certification Hotline. Your appeal will be responded to within 24 hours of receipt of the required medical information from your provider via fax and/or phone conversation. In requesting claims status, please allow a reasonable time for processing. See General Appeals Rules.

**Level 3: ERISA Complaints and Appeals after Level 1 and 2 Have been Exhausted.** A Compliance Office has been established to review all appeals, complaints and questions on Plan Interpretation. To protect members rights, ERISA requires that you file an appeal not later than 60 days following a denial or issuance of an Explanation of Benefits (EOB) denying benefits or failing to pay benefits according to the plan in the opinion of the member or a provider. While the Compliance Office will make every effort to resolve your complaints via phone call, fax or e-mail, you must submit your grievance, complaint or appeal in writing to protect member's rights.

The plan requires that a separate written appeal be filed for each patient. The initial notice of denial shall be noted on the Explanation of Benefits (EOB) form in the remarks area or via other written notice that gives the employee the additional information necessary to permit the claim to be processed, if appropriate. If the claimant disagrees with the way a claim is paid, the member must appeal the denial in writing. **Only claims filed as required by the Plan will be responded to.**

A claimant or provider may request the following:

1. A review of the decision by written application to the Compliance Office for this Plan, no later than 60 days after receipt by the claimant of written notification of denial;
2. A copy of pertinent documents;
3. Further consideration upon written submission of additional issues and comments; and
4. To have a representative act on claimant's behalf in the appeal.

The appeal should include any additional facts or information to aid in the review process. A second appeal may be made if there are additional facts not presented in the initial appeal. To protect your appeal rights, a written response with the requested information must be provided by the claimant, provider or member as appropriate.

**Level 4: A Second Appeal of a Previously Denied Claim.** The appeal must be filed within 30 days following receipt of the original denial. All Level 4 Appeals must be in writing and must be directed specifically to the Compliance Office. If extended time is needed, a decision shall be rendered within a reasonable period of time, but no later than 120 days after receipt of a request for review. The decision on review shall be in writing and shall include the specific reason(s) for the decision and the specific reference(s) to the pertinent policy provisions on which the decision is based. Nothing provided in the above claims procedures shall modify or amend the various other claim provisions set out in this Plan. The Compliance Office shall have the authority to interpret the Plan in a nondiscriminatory manner in light of all available information.

**Level 5: In the event of a second or subsequent appeal, or a complex, unique claim.** The claim will be reviewed by a Claims Review Committee and/or sent out for Peer Review, at the sole discretion of the Plan Administrator's. A second or subsequent appeal must be filed with the Compliance Office.

In reviewing any claim, the Committee will consider all the facts and circumstances, including, but not limited to, the following:

1. Hospital/provider notes;
2. Recommendations of an independent medical review firm or physician;
3. Past or current practices as may be appropriate; and/or
4. Legal advice or recommendations from outside counsel.

The Compliance Officer will coordinate and present any claim for review by the Claims Committee on a strictly confidential basis, with no reference to the Claimant, to insure confidentiality and an independent, unbiased review and decision. Any decision by the Trustees/Plan Administrator, or Claims Review Committee shall be final and binding on all parties. However, the Plan Administrator, at their sole discretion, may reopen any claim for further review and may act, without prejudice, in determining payment or denial with respect to such claim upon reopening the claim.

**Level 6: The Plan Administrator/Board of Trustees, at its sole discretion, may submit any unresolved claim or issue to binding arbitration.** Or, it may agree to binding arbitration at the request of the member subject to the member agreeing to pay half of the cost of such arbitration if the ruling is in favor of the Plan. The arbitration must be agreed to by both parties.

**Important:** Members must proceed through and follow each of the above appeal steps IN ORDER to protect their rights. Only after exhausting the appeals efforts as outlined above may a member proceed to either Binding Arbitration or Litigation. No covered person may file any legal action against this Plan in conjunction with any claim until all administrative and appeal rules have been exhausted as provided by this Article.

## BINDING ARBITRATION

The Claims Supervisor reserves the right to request the Compliance Officer and/or Plan Administrator to make a final determination on any claim which is unusually complex or which may result in potential litigation against the Plan. The Plan Administrator has the ultimate responsibility for all claims decisions. Further, the plan reserves the right to submit the claim to binding Arbitration with half the cost to be paid by the plan and half paid by the member if the decision of binding arbitration is in favor of the Plan. If the decision is in favor of the member, all costs will be paid by the plan. Binding arbitration is a much quicker way to resolve any disputed issue and much less expensive for both the member and the Plan. If a member refuses to accept binding arbitration, such member shall be precluded from filing any litigation against the Plan.

National Health Administrators, Inc. serves in accordance with its service agreement and acts on behalf of the Plan Sponsor/Administrator, and at the direction of the Plan Sponsor/Administrator. The acts of the Claims Supervisor are deemed the acts of the Plan Sponsor/Administrator, except to the extent that National Health Administrators, Inc. is grossly negligent in performing its duties in accordance with the service agreement.

## COMPLIANCE OFFICE

NHAI's goal is to “**personalize**” and “**consolidate**” compliance issues by having an independent office and one primary contact for complaints, appeals and questions on plan interpretation. Consolidation of the investigative efforts and related decisions insure uniformity and non-discrimination. The Compliance Office insures that all complaints are handled in accordance with ERISA procedures with appropriate written documentation of the action taken and plan interpretation, along with communication to the employee and instructions to the Claims Office, if needed, to correct claims, etc. This procedure extends to verbal complaints, faxes, e-mails, etc., even when the appeals process, as provided in the Plan, is not formally followed.

By having constant interface with the employees and providers, this enables the Compliance Office to independently review and audit claims; identify potential problems in the adjudication process; and make appropriate plan design recommendations and suggestions. In effect, the Compliance Office functions as a coordinator, in an oversight capacity. We are able to identify ambiguous plan language or where the plan should be amended, clarified or changed.

When a critical situation is at hand, the Compliance Office functions as a facilitator and coordinator between the various offices to insure that all actions are not only in conformance with the plan, but take into account the individual situation and what is medically necessary. In this capacity, the compliance officer functions as a “non medical” person to add “*balance*” to the decision making process. Our objective is to do what is “right” within the scope of the plan—not to look for ways to deny benefits that are medically necessary. On the other hand, when appropriate, we take a firm stand to insure that the Plan is not taken advantage of and to enforce plan rules.

## COMPLIANCE GUIDELINES

The Compliance Office was established to take into account the following plan rules in making decisions with respect to appealed or late filed claims. Failure to abide by these rules will result in denied claims. Our goal is to have a positive working relationship with providers and covered members to insure that they receive the benefits they are entitled to under the Plan by taking into account the medical recommendations of their providers.

**Rule #1 Timely Submission of Claims:** Claims are to be submitted within 90 days following the date of service and/or following the date of payment by the primary carrier. Late filed claims will be considered for payment if there is reasonable cause shown for such late filing up to 12 months following the date of service. In no event will any claim be considered for payment that is filed more than one year following the date of service. Any unpaid claim (with or without an EOB or formal denial) is to be considered as having been denied by the provider and the 180 day appeal period shall expire within 18 months from the date of service, at the latest. No further consideration will be given claims after that date. Reasonable cause must include proof of a good faith effort on the part of the provider or the member/patient to timely file the claim.

Failure to have the correct insurer or billing address does not constitute a reasonable effort absent timely efforts to obtain and/or provide correct billing and insurance information, and submit the claims within these time frames. If this plan is secondary, a copy of the EOB and verification of primary payment and/or denial must be submitted with the claim. Note: Virtually all group health and insurance plans automatically deny any claim that is not submitted for payment within 1 year from the date of service as the insurance is no longer valid after one year.

The maximum benefit payable in any event will not exceed \$1,500 on any late filed claims without clear documentation that the failure to pay the claim was due to an error on the part of the Plan or if late payment is required due to Medicare Secondary Payor Program.

Providers will be required to provide the following information to substantiate reasonable efforts to timely file claims with NHA. Failure to provide this information within the time frame requested will result in no further consideration being given that claim and loss of appeal rights.

1. A legible copy of the ID card (front and back) with the claims address.
2. Specific dates and addresses where the claims were filed.
3. Documentation of the member’s billing, i.e., was the member automatically copied on all claims or the dates when copies of claims were sent to the member so that they had an opportunity to correct any missing or incorrect information and/or to follow up on the claim status personally.
4. Dates of any phone follow up with the claims office on the filing status of these claims.
5. Dates of any phone follow-up with the patient.
6. Name of the individual to contact if any questions.

**Rule #2 Current Group Health ID Cards:** ID cards are to be requested and maintained on file (including

any secondary coverage) by the provider. The provider is responsible for properly noting the CURRENT AND CORRECT billing address and Phone # for claims submission at the time of service and following the date of service if there is an outstanding or pending bill. This may involve following up by phone with National Health Administrators and with the patient to verify the correct billing address.

**Rule #3 Assignment of Benefits:** Most providers REQUIRE that patients assign benefits directly to the provider and the provider, in turn, agrees (*implicitly*) to bill the insurer for services. This includes timely and appropriate billing and subsequent follow-up to insure that the claim was received and/or submitted to the insurer's claims office a minimum of once every six months in addition to notifying the provider per Rule 4. (*Good business practice would dictate that follow-ups should be made at least every 90-days and should include phone follow-ups and other communication - not merely a regeneration of unpaid bills without verifying the claims address, etc.*). Provider is responsible for billing both primary and secondary insurer of record, unless they notify member/patient otherwise.

**Rule #4 Duty to Notify Patient:** Providers are responsible for timely notifying and contacting the Patient of outstanding amounts, including uncollected amounts from the insurer and for requesting updated insurance information, if appropriate. Failure to notify the patient precludes the patient from giving the provider updated billing information or from following up on why there is a problem in paying the claim with the insurer.

**Rule #5 Patients Responsible for Timely Filing of Claims Paid Directly:** Patients are responsible for timely filing for claims reimbursement on any claim where they have paid the bill in full and/or where the provider has not accepted an assignment of benefits. Failure to timely file for reimbursement will result in the patient/member being liable for the charges. This is not an HMO plan where claims are automatically filed with the Plan. Patients are ultimately responsible for insuring that claims are filed and for disputing untimely filed claims directly with the providers if the providers are at fault for not having appropriate and timely billing procedures and practices in place when they have accepted and required Assignment of Benefits. Note: If the patient pays the bill in full, the provider is under no obligation or responsibility to submit a bill to the insurance company. Patients should verify directly with provider of their policy with respect to billing secondary insurance.

**Rule #6 Accurate Completion of Claims Forms:** Providers are responsible for accurately completing the UB82 and HCFA 1500 forms INCLUDING accurate notations pertaining to the primary and secondary insurance coverage AND providing a complete billing address for claims payment, including the phone #. Providers are responsible for insuring that their files include a photocopy of the ID card (front and back) and for updating their internal records accordingly for any new information.

All services, procedures and diagnosis codes must be appropriately coded. "Unbundled" charges for services that were/are covered by the primary procedure code, per AMA guidelines, will not be paid in addition to the primary code. They will be denied and deemed to have been included and paid on an "unbundled" basis.

**Rule #7 Provider Adjustments Due to Provider Error:** It is National Health Administrators' belief that the provider should write-off any charges where the provider has failed to employ sound business practices including billing the insurer for charges on a timely basis and following up on a timely basis, which results in the liability shifting to the Patient or Member. The Provider accepts and assumes certain liabilities when they require an assignment of benefits and they have a legal obligation not to jeopardize the patient's right to group health coverage under their plan. On the other hand, we believe that this plan's liability is extended beyond 11 months when there is evidence that the provider and/or member did in fact timely file claims, and the fault rests with the insurer/Plan and/or the claims office for untimely payment and handling of any claim for payment.

**Rule #8 Patient Responsibility:** Patients have a responsibility to provide providers with a current copy of their ID card and to update the provider if there are any changes in coverage, billing address, or their home address or phone #. Additionally, patients are responsible for following up on copies of statements where National Health Administrators, Medicare or any other coverage does not show payment. If claims are not paid within 60 days from the date of service, SOMETHING IS WRONG! Follow up with the Claims Office!

Members are responsible for clearly notifying the provider when this plan is Primary to Medicare, i.e., where the member is actively employed and a dependent is covered by Medicare, be sure to

notify the Plan to file claims FIRST with NHA. If the member is retired, then claims must be filed FIRST with Medicare. The member is responsible for verifying with the provider that they will file for payment from NHA following payment by Medicare. If not, the member is responsible for filing the secondary claims.

**Rule #9 Enrollment in Special Benefit Programs:** Members are responsible for actually enrolling in any special benefit program PRIOR to receiving special benefits. This includes the Pre-Natal Program that requires enrollment during the first trimester; Out of Area status for retirees and full time students enrolled out of state; the Infertility Program and the Diabetes Program. These programs are voluntary and if you are not enrolled, benefits will be paid the same as any other benefit.

**Rule #10 Non-PPO Providers:** Whenever a member goes to a NPPO provider, the plan deductible will apply as well as the NPPO schedule of benefits. The only exception to this is when the patient is enrolled as an OOA (Out of Area) member prior to the date of service or when there has been an advance request through the Pre-Certification Office for a specific provider due to the unavailability of a certain type of specialists in the network or due to an unusual procedure AND National Health Administrators has negotiated some sort of special fee arrangement with that provider. It is the member's responsibility to verify PPO status at the time of service.

This can be done by calling the PPO office or checking the web site at **www.nhai.net**.

The National Health Administrators Hotline will connect you to the appropriate office. Call 1-888-679-2400: Ext. 1 is the Claims & Eligibility Office; Ext. 2 is Pre-certification; Ext. 3 is National Health Administrators Behavioral Health; Ext. 4 is the PPO Office; and Ext. 5 is the Compliance Office, to appeal any claim.

**Rule #11 Electronic Filing of Claims:** Prior to filing any claim electronically, providers must contact the NHA Claims Office for specific instructions on how and where to file electronic claims.

## CASE MANAGEMENT

At NHA, we do not try to overly control, restrict or deny benefits as may have been your experience with the typical insurance company. We respect your unique role as the provider and the one who is closest to the situation. Your judgment and recommendations are of utmost concern so as to provide the most appropriate level of care for the patient. While our interest and responsibility is also to control costs, where possible, we believe that you will find our case management approach and attitude much different than the norm.

The Plan Administrator or Claims Supervisor may, at their option, institute Case Management anytime there is a potentially catastrophic claim due to injury or illness, or when there is a question as to the treatment being received. Case management is not to limit medical treatment, but rather to monitor and coordinate treatment and to negotiate more favorable rates, if possible, for certain services.

Where appropriate, the Case Management Representative may recommend consideration of alternative forms of treatment. For example, home nursing care or hospice care may be recommended. Or the Plan may elect to cover a certain procedure or appliance that normally would not be covered under the Plan, as a cost-control measure. The costs of these special treatments and services, as approved, will be covered as any other covered expense under the Plan, unless otherwise noted. Under case management, special fees may be negotiated for certain services. Extended benefits, if approved, will be paid at a reduced rate (50-75%) of the basic Plan benefit. The member is responsible for the copay and additional coinsurance.

As a preferred provider, you are required to submit treatment plans and cooperate with the Case Manager.

### A. Case Management

When extensive treatment is expected, due to an illness or injury, the member will be assigned a case manager to follow up with both the providers and the member to insure that appropriate medical treatment is provided and to determine the progress of treatment. Case management is a tool used by the Plan to determine whether or not extended benefits are appropriate and medically necessary or if alternative treatment is appropriate. Any extraordinary or extended benefit approval of out-of-network providers, on a case-by-case basis, can only be provided when the member and his/her family cooperate fully with the case manager.

Case management nurses are immensely helpful to Plan members and can assist the member in the

course of their treatment program. They can advise members of available network specialists and providers or assist members by negotiating with out-of-network providers to secure contractual discounts, which will lower Plan costs for both the member and the Plan. Case management is not used as a tool to prohibit treatment, or override recommendations by your doctor, or to deny coverage. It is used to monitor medical necessity and eligibility for certain benefits. Extended benefits or special benefit programs are subject to case management approval and require cooperation and communication with the case manager, as requested. Any extension of benefits or approval of alternative treatment beyond the benefits specifically provided is at the sole discretion of the Plan.

## **B. Urgent Care Claims**

Determination for Urgent Care Claims (whether adverse or not) must take place as soon as possible but not longer than 72 hours, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are medically necessary or covered under the Plan. In the case of such failure, NHAJ will notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. NHAJ will notify the Claimant of the Plan's benefit determination as soon as possible, but no later than 48 hours after the earlier of:

1. The Plan's receipt of the specified information; or
2. The end of the period afforded the Claimant to provide the additional information.
3. Urgent Care Claims must be decided within 72 hours. There is no extension of time allowed for claims involving urgent care.

## **C. Pre and Post-Service Claims**

Pre-Service Claims must be decided within a maximum of 15 days at the initial level and up to 30 days following an Adverse Benefit Determination. In the case of failure by a Claimant, or an Authorized Representative of a Claimant, to follow the Plan's procedures for filing a Pre-Service Claim, the claimant or representative will be notified of the failure and the proper procedures to be followed to file a Claim for Benefits. The notification will be provided to the Claimant or Authorized Representative, as appropriate, as soon as possible, but no later than five (5) days following the failure. Notification may be oral, unless the Claimant or Authorized Representative request written notification.

Post-Service Claims must be decided within 30 days for the initial decision and a maximum of 60 days to review.

## **D. Filing Extensions**

The Plan may extend determination on both Pre-Service and Post-Service Claims for one additional period of 15 days after expiration of the relevant initial period, if NHAJ determines that an extension is necessary for reasons beyond the control of the Plan. Delays caused by cyclical or seasonal fluctuations in claims volume are not considered to be matters beyond the control of the Plan that would justify an extension.

If the reason for taking the extension is the failure of the Claimant to provide necessary information, the time period for making the determination is tolled from the date on which notice of the necessary information is sent to the Claimant until the date on which the Claimant responds to the notice. The time periods for making a decision are considered to commence to run when a claim is filed in accordance with the reasonable filing procedures of the Plan, without regard to whether all the necessary information to decide the claim accompanies the filing.

## **E. Concurrent Care Decisions**

If a Plan has approved an ongoing course of treatment to be provided over a period of time, or number of treatments, any reduction or termination by the Plan (other than by Plan amendments or termination) before the end of such period of time or number of treatments will be considered an Adverse Benefit Determination. NHAJ will notify the Claimant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments for a claim involving urgent care, will be decided as soon as possible, taking into account the

medical exigencies and NHA will notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

#### **F. Adverse Benefit Determination**

The notice of an Adverse Benefit Determination will include either the protocol, which it was based upon, or a statement that a protocol was relied upon and that a copy is available free of charge upon request by the Claimant.

Notification of an Adverse Benefit Determination (at both the initial level and on review) based on medical necessity, experimental treatment, or other similar exclusion or limit will be explained as to the scientific or clinical judgment of the Plan to the Claimant's medical circumstances, or an Explanation will be provided free of charge to the Claimant upon request. When the Plan utilizes a specific internal rule or protocol, it must furnish the protocol to the Claimant or their Authorized Representative upon request.

### **MEDICAL NECESSITY**

Only treatment which is medically necessary and which conforms to the treatment protocols for the diagnosis or for the specific diseases and illnesses will be covered, except for those preventive and wellness benefits covered by the plan. Experimental treatment or treatment that has not been approved by the FDA is not covered. It may be necessary to submit treatment plans where extensive therapy or other ongoing treatment is required and/or expected. Any behavioral health treatment is subject to pre-certification and must be provided through the NHAIB network of providers.

The NHA plans have generous preventive and wellness benefits. These are listed in the Schedule of Benefits. Any preventive treatment not specifically listed will not be covered. You can access benefit information online at [www.nhai.net](http://www.nhai.net), or call the **hotline at 1-888-679-2400, Ext. 9**, for detailed benefit information on Plan benefits.

Annual physicals, including one mammogram, pap smear or prostate exam per year--either performed at the same time or separate from the annual physical are covered. Providers are required to properly code all claims forms for the treatment rendered. If a patient requests an annual physical, it should be coded as such regardless of whether or not there are procedures coded for services provided for additional prognoses at that time or symptoms which precipitate the request for an annual physical. Failure to properly code claims forms can result in termination of a provider from the NHA network. Unbundling of charges is not permitted. Benefits will be paid based on the primary CPT Code and any unbundled charges will be included in such payment for the primary procedure per A.M.A. guidelines.

### **PRIVACY AND CONFIDENTIALITY**

Privacy and confidentiality is of vital concern to all of us. We at NHA have been charged with coordinating the privacy policy on behalf of all NHA plans. The privacy policy is based on and in anticipation of proposed regulations to be finalized in 2002; even though they will not be effective 2 years following their issuance, these policies will automatically be updated to incorporate any changes required by the effective date of such final regulations. We have taken steps to incorporate the key aspects of various proposals dealing with patient's rights. Patient's rights under this plan are protected under our Claim Appeal Procedures.

These policies will automatically be updated to incorporate any changes required by the effective date of such final regulations. We have taken steps to incorporate the key aspects of various proposals dealing with patient's rights. Patient's rights under this plan are also protected under our Claim Appeal Procedures.

Providers are expected to adhere to the privacy and confidential policies under HIPAA and as summarized here. Providers are charged with the responsibility to appropriately notify and train your staff members and any subcontractors or third parties with whom you deal to adhere to these rules as well. Providers are responsible for maintaining the chain of confidentiality for any information that is released to or provided by NHA staff, as NHA staff is responsible for maintaining the confidential nature of all information provided by any provider in conjunction with any claim, appeal, pre-certification, case management, etc., on behalf of our members.

#### **A. Person in Charge of Privacy Policies and Complaints**

Contact Gloria Gillespie, Executive Vice-President of NHA Compliance Officer, for any questions or problems in this area.

#### **B. Where to File Complaints**

Contact Gloria Gillespie, Vice President of NHA Compliance Officer, for any questions or problems in this area. (See contact page.)

#### **C. Medical Release and Authorization**

In order to be eligible for benefits, each covered member who is 18 or older, including dependents, are required to sign an appropriate enrollment form that includes a Medical Release and Authorization. A release is required in order for the Plan to obtain the information necessary from providers to determine medical necessity and entitlement to benefits. This information is also used for the purpose of pre-certifying benefits and for instituting case management, including certain disease state case management programs. Additional releases may be required, as appropriate, for Behavioral Health treatment.

#### **D. Authorized Individuals**

The individuals who routinely will have access to and who are responsible for administering your medical benefit program include the following entities and/or their successors:

- NHA PPO Staff
- NHA Behavioral PPO Staff
- Claims Supervisor and authorized staff, including NHA sub-contractors
- NHA Compliance Office – for purposes of handling complaints and coordinating benefits and treatment among the various providers and or parties of interest to insure compliance with the Plan, ERISA and Privacy Laws.
- Century Health Solutions – NHA Pre-certification, Case Management and Medical Staff
- PPO Networks contracted by the Plan and their staff
- The Prescription Benefit Manager (PBM) in charge or monitoring Rx card prescriptions and the mail order drugs.
- Stop Loss Carriers and Underwriters for purposes of underwriting the stop loss coverage of the plan and paying certain benefits as provided by the Stop Loss Coverage, including their agents and brokers or agents and brokers working on behalf of this plan or NHA.
- The respective Plan Administrator, Plan Trustees and Trust Staff may have “limited” access to confidential knowledge on a need-to-know basis. Providers and members are cautioned to contact the appropriate office directly, e.g. NHA Behavioral, Claims Office, Pre-cert Firm or the Compliance Office with respect to sensitive medical information.

### **COORDINATION OF BENEFITS (COB)**

This provision applies to all health expense benefits under this Plan. The coordination with Medicare shall apply to all persons eligible for primary Medicare coverage regardless of whether or not the person is actually enrolled in Medicare. Any employee becomes eligible for Medicare once they are no longer actively employed and have attained age 65, unless entitled to earlier coverage due to end stage renal failure or disability. If a member is not enrolled for primary Medicare cover, Medicare benefits will be “presumed” and “estimated”. In general, this means that the maximum benefit payable under this plan for any benefit that would have been covered by Medicare is limited to 20% of the allowable charges.

No payment will be made to any member who is enrolled for primary coverage under a Medicare-sponsored HMO or PPO plan if the HMO or PPO benefits are denied due to failure to follow the HMO procedures for coverage. Further, this plan shall be considered secondary for any member who is enrolled in an HMO or PPO Medicare plan and benefits will be limited to 20% of the allowable charges for any out of network provider services. See Coordination Chart at the end of this section.

## A. Allowable Expense

A healthcare service or expense that includes deductibles, coinsurance and co-payments, and is covered at least in part by any **Plan** that covers the claimant. When a **Plan** provides benefits in the form of a service, like an HMO, the reasonable cash value of each service is considered an **Allowable expense** and a paid benefit. An expense or healthcare service not covered by any **Plan** that covers the claimant is not an **Allowable expense**. For **COB rules**, the following are examples of expenses or services that are not **Allowable Expenses**:

- The difference in cost between a semi-private hospital room and a private hospital room. The claimant's stay in a private hospital room is medically necessary in terms of generally accepted medical practice or one of the Plans routinely provides coverage for hospital private rooms. This is not an **Allowable expense**.
- If a claimant is covered by two (2) or more **Plans** that compute benefit payments on the basis of usual and customary fees, relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an **Allowable expense**.
- If a claimant is covered by two (2) or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees, are not an **Allowable expense**.
- If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another **Plan** that provide benefits or services on the basis of negotiated fees, the **Primary Plan's** payment arrangements will be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary Plan** to provide the benefit or service for a negotiated fee or payment amount that is different from the **Primary Plan's** payment arrangement and, if the provider's contract permits, the negotiated fee or payment will be the **Allowable expense** used by the Secondary Plan to determine its benefits.

The amount of benefit reduction by the **Primary Plan**, because the claimant failed to comply with the Plan provisions, is not an **Allowable expense**. Examples of these Plan provisions include second surgical opinions, pre-certification of admissions, and preferred provider arrangements.

## B. Closed Panel Plan

A **Plan** that provides healthcare benefits to covered persons, primarily in the form of services through a panel of providers, that has contracted with or is employed by the Plan, and limits or excludes coverage for services provided by other providers, except in case of emergency or referral by a panel member. See below for reduced benefits for failure to use primary plan.

## C. Order of Benefit Determination Rules for COB

If a claimant has health coverage under two (two) or more **Plans**, the rules for determining the order of payment of benefits are as follows:

1. The **Primary Plan** pays or provides its benefits according to its terms of coverage without regard to the benefits under another **Plan**.
2. The following provisions always control, except:
  - As stated in the following paragraph below, a Plan that does not provide a coordination of benefits provision consistent with this regulation and is primary, unless the provisions of both Plans states the complying Plan is the primary Plan.
  - Coverage obtained by virtue of membership in a group designed to supplement part of a basic package of benefits and provides that supplementary coverage is excess to any other part of the Plan provided by the contract holder. An example of this type of situation: major medical coverage that is superimposed over a base hospital Plan and surgical benefits and insurance-type coverages written in conjunction with a Closed panel Plan to provide out-of-network benefits.

A **Plan** may consider benefits paid or provided by another **Plan** to calculate payment of its benefits when it is secondary to the other **Plan**. (**Clarification for NHA I Plans: In the case of a closed panel Plan,**

or when Medicare is the Primary Plan to an NHA Plan, NHA's benefits will be limited, as provided by the Plan, whenever a member fails to use a covered provider under his/her Primary Plan. Special COB rules apply to members when Medicare is the Primary Plan.)

Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent Rule:** The Plan that covers the person (*not as a dependent*), for example: an employee, member, policyholder, subscriber, or retiree is the **Primary Plan**, and the Plan that covers the person as a dependent is the **Secondary Plan**.
2. **Exception to the Non-Dependent/Dependent Rule:** If the person is a Medicare beneficiary and, as a result of federal law, Medicare is the secondary Plan to the Plan covering the person as a dependent, or it is the primary Plan to the Plan covering the claimant who is not a dependent (*a retired employee or inactive employee*), the order of benefits between the two **Plans** is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber, retiree, or inactive employee is the Secondary Plan and the other **Plan** is the primary Plan.

The effect of these rules in the case of a retiree covered by Medicare who is also covered as a dependent under an actively employed spouse, the dependent coverage pays first as the primary Plan, the non-dependent coverage (e.g., retiree coverage) pays second and Medicare pays third.

3. **Active Employee, Retired, or Laid-off Employee:** The Plan that covers a person as an active employee (an employee who is not laid-off or retired) is the **Primary Plan**. The Plan that covers the same person as a retired or laid-off person is the **Secondary Plan**. The same is true if the person is a dependent of an active employee and the same person is also a dependent of a retired or laid-off employee. **If the other Plan does not have this rule and the Plans do not agree on the order of benefits, this rule is ignored.** This rule does not apply if rule #1 above (Non-Dependent versus Dependent rule) determines the order of benefits. **(This rule does not apply when a person is covered under his/her own Plan as an active employee, retired employee, or laid-off employee and is also a dependent under his/her spouse's Plan provided to the spouse on the basis of active employment). In this situation, the Non-Dependent/Dependent rule applies.**
4. **Dependent Child Covered Under More Than One Plan:** If a dependent child is covered by more than one **Plan**, the order of benefits is determined as follows:
  - a. A dependent child whose parents are married or are living together, whether or not they have ever been married:
  - b. The Plan of the parent whose birthday falls earliest in the calendar year (*without regard to the year of birth*) is the Primary Plan; or
  - c. If both parents have the same birthday, the Plan that has covered the parent the longest is the **Primary Plan**.
  - d. A dependent child whose parents are divorced or separated, or not living together, whether or not they have ever been married:
    - (1) If a court decree states, one of the parents is responsible for the dependent child's healthcare expenses or health insurance coverage, and the Plan of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to the Plan years after the Plan is provided notice of the court decree.
    - (2) If a court decree states, both parents have joint custody, without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the dependent child, the provisions of Subparagraph (b) of this paragraph will determine the order of benefits.
  - e. If there is no court decree allocating responsibility for the dependent child's healthcare expenses or health insurance coverage, the order of benefits for the child is as follows:
    - (1) The Plan covering the **Custodial parent**;
    - (2) The Plan covering the spouse of the **Custodial parent**;
    - (3) The Plan covering the **non-custodial parent**; and/or
    - (4) The Plan covering the spouse of the **non-custodial Parent**.

- f. A dependent child covered under more than one Plan by individuals, who are the parents of the child, the provisions of Subparagraph (a) or (b) above will determine the order of benefits, as if the Individuals were the parents of the child.
5. **COBRA or State Continuation Coverage:** If a person's coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the Plan covering the person as an employee, member, subscriber, or retiree, or covering the person as a dependent of an employee, member, subscriber, or retiree is the **Primary Plan**. COBRA, state or other federal continuation coverage is the **Secondary Plan**. If the other **Plan** does not have this rule, and the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled Non-Dependent or Dependent Rule can determine the order of benefits.
6. **Longest or Shortest Length of Coverage:** The Plan covering the person as an employee, member, subscriber, or retiree the longest length of time is the **Primary Plan** and the Plan covering the person the shortest length of time is the **Secondary Plan**.

If the preceding rules do not determine the **Primary Plan**, the **Allowable Expenses** will be shared equally between the Plans meeting the definition of **Plan**. In addition, the Plan will not pay more than it would have paid if it were the **Primary Plan**.

#### D. Effect of COB on the Benefits of the Plan

When the Plan is a secondary Plan, it may reduce benefits so the total benefits paid or provided by all **Plans** during a **Claim Determination Period** are not more than 100% of total **Allowable Expenses**. To determine the amount paid for any claim, the **Secondary Plan** will calculate the benefits it would have paid in the absence of other healthcare coverage and apply the calculated amount to any Allowable Expense under its Plan, that is unpaid by the **Primary Plan**. The **Secondary Plan** can reduce its payment by that amount so that, when combined with the amount paid by the **Primary Plan**, the total benefits paid or provided by all Plans for the claim does not exceed the total Allowable expense for that claim. In addition, the Secondary Plan will credit to its Plan's deductible any amounts it would have credited to its deductible, in the absence of other healthcare coverage.

1. Determine its obligation to pay or provide benefits under the terms of its contract;
2. Determine whether a benefit reserve has been recorded for the covered person; or
3. Determine whether there are any unpaid **Allowable Expenses** during the **Claim Determination Period**.

If a covered person is enrolled in two or more **Closed Panel Plans** and if, for any reason, including the provision of service by a non-panel provider, benefits are not paid by one **Closed Panel Plan**, COB will not apply between that **Plan** and another **Closed Panel Plan**.

#### E. Right to Receive and Release Needed COB Information

Certain facts about healthcare coverage and services are required to apply COB rules and to determine benefits payable under the Plan and other plans. The Compliance Office and/or the Claims Office may get the facts it needs from or give them to other persons for the purpose of applying the rules and determining benefits payable under the Plan and other plans that cover individual claim benefits. The NHA Compliance Office is responsible for determining the order of payment under the COB rules for the Plan. The Compliance Office does not need to tell or get the consent of any person. Each person who claims benefits under the Plan must give the NHA Compliance Office and/or Claims Office any facts it needs to apply the rules and to determine payable benefits.

#### F. Facility of Payment/Right of Recovery

A payment made under another **Plan** could include an amount that should have been paid under the Plan. If it does, NHA can pay or reimburse the amount to the organization that made the payment. The amount will be treated as though it were a benefit paid under the Plan. There will be no responsibility for NHA to pay the amount again. The term "**payment made**" includes providing benefits in the form of services. "**Payment made**" means the reasonable cash value of benefits provided in the form of services.

#### G. Right of Recovery By The Plan

If the amount of payment made by NHA, on behalf of the Plan, is more than "it should have paid" under the COB provision, it has the right to recover any overpayment from one or more of the persons it has

paid, for whom it has paid, or any other person or organization that is responsible for the benefit or service provided for the covered person. The “amount of the payment made” includes reasonable cash value of any benefits provided in the form of services.

#### **H. Special Rules for Medicare Coordination**

The Plan is intended to provide secondary coverage to supplement Medicare and to cover expenses not covered by Medicare, once Medicare is primary, for the covered member, and/or member’s spouse, or dependent. Plan benefits will be limited under COB rules depending on the type of provider used and services provided, which will fall in one of the following four (4) categories. In no event will the total amount paid exceed the allowable charges. NHA1 allowable charges will be based on the greater of the allowable charges by Medicare, or NHA1 contractual rates and benefits will be determined based on the following, after taking into account normal deductibles, copays, or coinsurance.

Important Notice: This provision applies to all health expense benefits under the Plan. Coordination with Medicare will apply to all persons eligible for primary Medicare coverage regardless of whether or not the person is actually enrolled in Medicare. Any employee becomes eligible for Medicare once he/she is no longer actively employed and has attained age 65, unless entitled to earlier coverage due to end-stage renal failure or disability. If a member is not enrolled for primary Medicare coverage, Medicare benefits will be “presumed” and “estimated” for the purpose of determining NHA1 benefits. No payment will be made to any member who is enrolled for primary coverage under a Medicare-sponsored HMO or PPO Plan. If HMO or PPO benefits are denied, due to failure in following HMO procedures for coverage, the Plan will be considered secondary for any member who is enrolled in an HMO or PPO Medicare Plan. Benefits will be limited for any out-of-network provider services. See special Medicare COB rules below.

#### **I. Services Provided by a Provider Who Accepts Medicare Assignment of Benefits**

NHA1 will pay the difference between what is covered by Medicare and the allowable charges after taking into account normal NHA1 deductibles, copays, or coinsurance.

#### **J. Medicare Providers Who Do Not Accept Assignment of Benefits**

Special rules under Medicare allow these providers to charge up to 15% more than what is otherwise allowed by Medicare. These providers require the patient to pay them directly and the patient will then be reimbursed by Medicare. The Provider will bill Medicare but generally they will not bill the secondary insurance. This is the responsibility of the member.

Example: Medicare’s allowed charge is \$100, the provider may charge \$115. In this case, Medicare would pay \$80. If NHA1 is the secondary or tertiary plan, the maximum allowable benefit paid by NHA1 for these providers is limited to 35% for medical services and 65% for behavioral services, after taking the normal plan deductibles, copays, and coinsurance. NHA1 would then pay a maximum of 35%, after the normal plan deductible, coinsurance, or deductible.

#### **K. Contract Providers Not Covered by Medicare**

The maximum benefit paid to Medicare Primary Members who elect to use a contract provider, the maximum benefit paid by NHA1 is 35% (*65% for behavioral services only*). A Contract Provider for purposes of this section refers to providers who refuse to accept a Medicare assignment or to bill Medicare, thus, Medicare does not cover any services provided by these providers. The term also includes any providers or services in a situation when the member elects to be covered by a non-traditional Medicare Plan (Regional HMO or PPO Plan).

#### **L. Benefits Not Covered by Medicare**

The Plan will pay the same benefits it would pay as if it were the Primary Plan.

#### **M. Reduced Benefits**

If a member or a dependent has primary coverage under another plan (such as an HMO), and that plan fails to pay benefits because of a member’s refusal to use that plan’s providers, benefits under the Plan will be limited to the maximum benefit, as provided under the General Provisions Section and Coordination of Benefit rules. The Plan, as the secondary plan, will be primary only with respect to benefits not covered or available under the Primary Plan, or when the member has reached the maximum limit under the Primary Plan, otherwise benefits under the Plan will be limited.

When another Plan is the Primary Plan, the Plan will follow COB rules, similar to those that apply to members covered by Medicare. If another Plan is the primary Plan for any member or dependent, the benefits under the Plan will be limited to the least of the following under one or two (2) below.

1. Any benefits, normally covered by the Primary Plan in or out-of-network, the Plan's benefits will be limited to the maximum benefit that would have been paid if the Primary Plan paid their portion of the benefit in full. It is assumed an HMO will cover benefits at 100% and a PPO Plan will cover benefits at 80%, if no documentation is available. The Plan's benefits will be computed and then offset or reduced by what would have or should have been paid by the Primary Plan.
2. If any member or covered dependent of the member voluntarily chooses not to use PRIMARY providers and services and instead uses the services of the Plan, the maximum benefits payable under the Plan will be limited to 50% of all covered charges, subject to a deductible of \$500, with an out-of-pocket limit of \$10,000. The member will be responsible for all excess charges.

The limits in one and two (2) above will be ignored for any services specifically excluded from coverage under the PRIMARY Plan. A copy of the PRIMARY booklet must be provided to the Compliance Office for review, prior to payment of benefits. The Plan will pay benefits as if the Plan is the primary plan.

**Example:** PRIMARY Plan does not cover chiropractic. Chiropractic is covered under the Plan the same as for any other member when the Plan is primary coverage.

## COORDINATION OF BENEFITS (COB) CHART

Medicare is not ever primary if there is coverage on either an employee or dependent under a Plan of anyone who is actively employed. If one of the following situations does not fit your exact circumstances, contact the Compliance Officer for clarification.

<b>You and your spouse are covered also under NHA1 and your spouse has a group health plan with his/her employer.</b>	<b>NHA1 Plan</b>	<b>SPOUSE'S PLAN (either as an active employee or retiree), spouses' plan as an employee or retiree is always primary to NHA1 coverage as a dependent except when Rule #3 applies.</b>
1. You are both actively employed.	Primary for you and secondary for your spouse.	Primary for your spouse and secondary for the NHA1 member.
2. You are actively employed and your spouse is retired and <u>not</u> eligible for Medicare.	Primary for you and secondary for your spouse.	Retiree coverage is primary for your spouse and secondary for you.
3. You are actively employed and your <u>spouse is both</u> retired and eligible for Medicare.	Primary for both you and your spouse. Medicare is tertiary for your spouse.	Spouses' plan is secondary for you and your spouse. Medicare is tertiary for your spouse.
4. You are both retired and Medicare eligible.	Medicare is primary and NHA1 is secondary for you and tertiary for your spouse.	Medicare is primary for your spouse, his/her retiree Plan is secondary and NHA1 tertiary.
5. You are <u>both retired</u> and only your spouse is Medicare eligible.	Primary for you, tertiary for your spouse.	Medicare is primary for your spouse. Spouses' plan is secondary for your spouse. NHA1 is tertiary for your spouse.
6. Your spouse is actively employed. You are retired and Medicare eligible.	Your spouse's plan is primary for you NHA1 is secondary for both of you; Medicare is tertiary for you.	Primary for both you and your spouse. NHA1 would be secondary for your spouse.
7. Your spouse is actively employed. You are retired and <u>not</u> Medicare eligible.	Primary for you and secondary for your spouse.	Primary for your spouse and secondary for you.

You and your spouse are covered also under NHAi and your spouse has a group health plan with his/her employer.	NHAi Plan	SPOUSE'S PLAN (either as an active employee or retiree), spouses' plan as an employee or retiree is always primary to NHAi coverage as a dependent except when Rule #3 applies.
8. Rx Coverage when member and spouse are retirees and Medicare eligible, provided neither elect Medicare Part D coverage.	Primary for member only, spouse has other Rx coverage. Your spouse <u>cannot use</u> the NHAi ID card for Rx if they have their own Rx coverage as a retiree or employee.	Primary for your spouse, secondary for you based on plan rules. Rx claims must be submitted to NHAi claims office for reimbursement under COB rules as a secondary Rx plan.
9. Both are retired and Medicare eligible and spouse has Medicare Supplemental Coverage as a Retiree with <u>no Rx</u> coverage.	Medicare is primary for both member and spouse. NHAi is secondary for you and tertiary for your spouse for Medicare benefits.	Medicare's supplement is secondary only for benefits covered by Medicare for your spouse. NHAi would be secondary for Rx and other non-covered benefits under Medicare for your spouse.
10. Dependents (standard NAIC rule)	<p><u>Birthday Rule</u>: Plan of parent born earlier in the year (ignoring the year of birth) determines which plan is primary.</p> <p>Children of divorced parents are subject to court order and other rules may apply.</p> <p>Parents are responsible for properly advising providers of primary/secondary coverage.</p>	

## CREDENTIALING

National Health Administrators is dedicated to providing their members with access to effective and necessary healthcare. NHAi values this standard and requires that physicians who are accepted for enlistment and selected by our members are to be board certified or, if not board certified become boarded within five (5) years of satisfactory completion of an accredited residency/fellowship program.

NHAi periodically reviews the credentials of all its providers in our network as one aspect of maintenance and improvement of the quality of care and services delivered to NHAi members. Additional information regarding credentialing may be obtained on our web-site at [www.nhai.net](http://www.nhai.net).

## ADDITIONAL INFORMATION

- Additional information for an NHAi Plan, call 1-888-679-2400, Ext. 9.
- To contact the Pre-Certification Department, call 1-888-679-2400, Ext. 2.
- To contact the NHAi Compliance Office, call 1-800-645-1195 or 1-888-679-2400, Ext. 5.
- Go to [www.nhai.com](http://www.nhai.com) for a copy of the Plan or specific benefit provisions.