MercyCare

Employer Administrative Guide

MercyCare Health Plans

Table of Contents

Welcome to MercyCare

We are proud to assist you and your employees with your health insurance needs.

Important Information and Telephone Numbers

Street address
MercyCare Health Plans
580 N. Washington St.
Janesville, WI 53548

Mailing address
MercyCare Health Plans
PO Box 550
Janesville, WI 53547-0550

MercyCare customer service department
Wisconsin: (800) 895-2421/TTY line: (800) 947-3529
Illinois: (877) 908-6027
(for employees to call regarding specific coverage/benefit questions)

MercyCare sales department
(608) 752-3431/toll free: (800) 752-3431

MercyCare enrollment department
Phone: (800) 752-3431
Fax: (608) 752-3751
Email: mchpenrollment@mhemail.org

MercyCare website
mercycarehealthplans.com
(find valuable information about providers, facilities and services available to you and your employees)

State of Wisconsin Office of the Commissioner of Insurance
(800) 236-8517 (complaint hotline)
PO Box 7873
Madison, WI 53707-7873

Premium Billings – Quick Reference

Billing
- We mail statements approximately 10 to 15 days before they are due.
- Your premium is due the first of each month for that month.

Premium payment
Please send premium payment only to:
MercyCare Health Plans
P.O. Box 88300
Milwaukee, WI 53288-8300

- Please be sure to write your group number on your check, and return a copy of the invoice with your remittance.
- NSF checks will be charged a $50.00 service fee.

Late payment
- If your payment is not received by the 15th of the month it is due, a cancellation letter will be sent.

Questions regarding your bill
- Contact our finance department at (800) 752-3431, ext. 2750, if you have any questions.

Plan documents
To access your current benefit plan documents, visit mercycarehealthplans.com and select My Plan Documents in the Interactive Center. You will be asked to enter your group number, which you can find on your Member ID card. This is a safe, simple and secure way to access your insurance information online.

Plan documents include:
- Certificate of Coverage
- Schedule of Benefits/Drug Rider
- SBC (Schedule of Benefits and Coverage)

If you would like paper copies of your plan documents, please call the MercyCare customer service department, Monday-Friday, 8 am-5 pm.
Illinois: (877) 908-6027 or TTY (800) 947-3529
Wisconsin: (800) 895-2421

Premium Invoice Sample (page 1 of 2)

MercyCare Health Plans

Offered by: (1)
MercyCare HMO, Inc.
PO Box 550
Janesville, WI 53547
(800) 895-2421 • (877) 908-6027
mercycarehealthplans.com

(6) PREMIUM INVOICE FOR: 12/1/2020

Invoice for (2) ABC Company
123 Main Street
Anywhere, USA 12345

Account number: 1234 (5)
Invoice number: 10207-123 (4)
Invoice date: 12/10/20 (3)

Description	Amount
Current Month Invoice	$5,718.51
Previous Balance	$4,969.20
Payments Received	-$4,969.20
Current Amount Due	$5,718.51

Payment due by 12/1/2020 (7)
See following pages for statement details

This notice of premium is for your records. This is not a request to submit payment.

Per your authorization, MercyCare will withdraw the above monthly premium from your account the month in which the premium is due. ACH processing begins on the 10th of each month and may conclude in that following week.

Company/Member understands that if the funds are not available in their account, and ACH is returned to MercyCare Health Plans as NSF, there can be an additional NSF fee applied.

This authorization is to remain in full force and effect until MercyCare Health Plans has received written notification from Company/Member of its termination by the first day of the month the ACH is scheduled to be processed in, to afford MercyCare Health Plans and Depository a reasonable opportunity to act on notification.

Questions?
If you have any questions or would like to speak to a customer service representative, please call (800) 895-2421.

1. Plan identification for accounts receivable and payment information
2. Company information: company name, contact for billing and mailing addresses
3. Date that the invoice was printed
4. Invoice identification number for quick reference when discussing invoice with MercyCare Health Plans
5. MercyCare group number for quick reference when discussing invoice with MercyCare Health Plans (this is also your account number)
6. Billing period (the month for which the premium invoice is being billed)
7. Coverage period for which premium is due; will show future, current or retroactively

Premium Invoice Sample (page 2 of 2)

Current Month Summary
For period: 12/01/2020

GROUP: ABC Company

Plan Rider	Tier	Subscribers	Members	Amount
(10) IL SG-G HMO CO-80 $1250 DED 2020	FLAT RATE	4	16	$5,218.97

Total: 5,218.97

Current Month Activity

GROUP: ABC Company
Plan: IL Sg-G HMO CO-80

(8) Subscriber	(9) Tier	Coverage	Members	Date	Amount
John Doe	FLAT RATE	MEDICAL	5	12/01/20	$1,493.05 (11)
Jane Smith	FLAT RATE	MEDICAL	5	12/01/20	$1,699.06
Subtotal for ABC Company			10		$3,192.11

Total: $3,192.11 (13) (15)

Premium Charges for Prior Periods, Other Adjustments (11)

GROUP: ABC Company
Plan: IL Sg-G HMO CO-80

Adjustment	Type	Coverage Period	Comment	Amount
(12) John Doe	C	10/01/20	MEDICAL	-$1,243.28
	C	10/01/20	MEDICAL	$1,493.05
John Doe	C	11/01/20	MEDICAL	-$1,243.28
	C	11/01/20	MEDICAL	$1,493.05

Total: $499.54 (14)

TYPE KEY: C-Premium change

8. Name that coincides with member number
9. Tier represents the type of medical coverage each employee/subscriber elected and is billed for (sngl = single, empc = employee + child, emps = employee + spouse, fmly = family, emp1 = employee + one)
10. BPKG – benefit package identification number as selected
11. Premium Amount is amount owed for each employee/subscriber covered by the plan as designated by the chosen tier
12. Member total is the total amount of premium charged, or credit given, for that employee/subscriber, for that specific coverage period
13. Invoice total represents account activity for the month; this does not include any past due balance
14. See statement for corrected total amount due each month
15. Account total is the same as the invoice total

Change of Status Form Sample

MercyCare HMO, Inc.
PO Box 550
Janesville, WI 53547-0550

CHANGE OF STATUS FORM
Please Print

PHONE (800) 752-3431
FAX (608) 752-3751
mchpenrollment@mhemail.org

(1) GROUP/EMPLOYER/NAME						GROUP NUMBER (2)		EFFECTIVE DATE OF CHANGE (3)	
(4) SUBSCRIBER LATE NAME	FIRST	M.I.		(5) SEX ❑ M ❑ F		(6) SOCIAL SECURITY #		(7) TODAY'S DATE	
(8) SUBSCRIBER ADDRESS	CITY		ZIP		CHECK IF NEW (9) ❑	HOME PHONE (10)		CHECK IF NEW (11) ❑	

❑ **ADDITIONS** (12) **OR** ❑ **DELETIONS**

RELATIONSHIP	LAST NAME	FIRST	M.I.	SOCIAL SECURITY #	DATE OF BIRTH	SEX	PRIMARY CARE PHYSICIAN
(13)	(14)			(15)	(16)	(17)	(18)

PLEASE CHECK REASON FOR CHANGE: (19)

❑ BIRTH OR ADOPTION
❑ MARRIAGE - DATE:
❑ DIVORCE
❑ ADDRESS CHANGE
❑ OTHER (please explain)_____
❑ COBRA/CONTINUATION ❑ 18 MONTH ❑ 36 MONTH
❑ EMPLOYEE DISENROLLED
❑ EMPLOYEE INELIGIBLE
❑ EMPLOYEE LAID OFF
❑ DEPENDENT OVER AGE
❑ LEFT EMPLOYMENT
❑ MOVED OUT-OF-AREA
❑ EMPLOYEE DECEASED
❑ DEPENDENT DECEASED
❑ COORDINATION OF BENEFITS CHANGE/OTHER INSURANCE (please explain)_____

NAME CHANGE (20)
FROM: TO:

__I hereby apply for amendment of my application. It is mutually agreed as follows: That these changes shall not become effective unless and until accepted; that this application for change in coverage will become part of my original application and will be subject to the terms of agreement(s) in effect with MercyCare Health Plans.

(21) SIGNATURE OF SUBSCRIBER

(22) SIGNATURE OF EMPLOYER (Required)

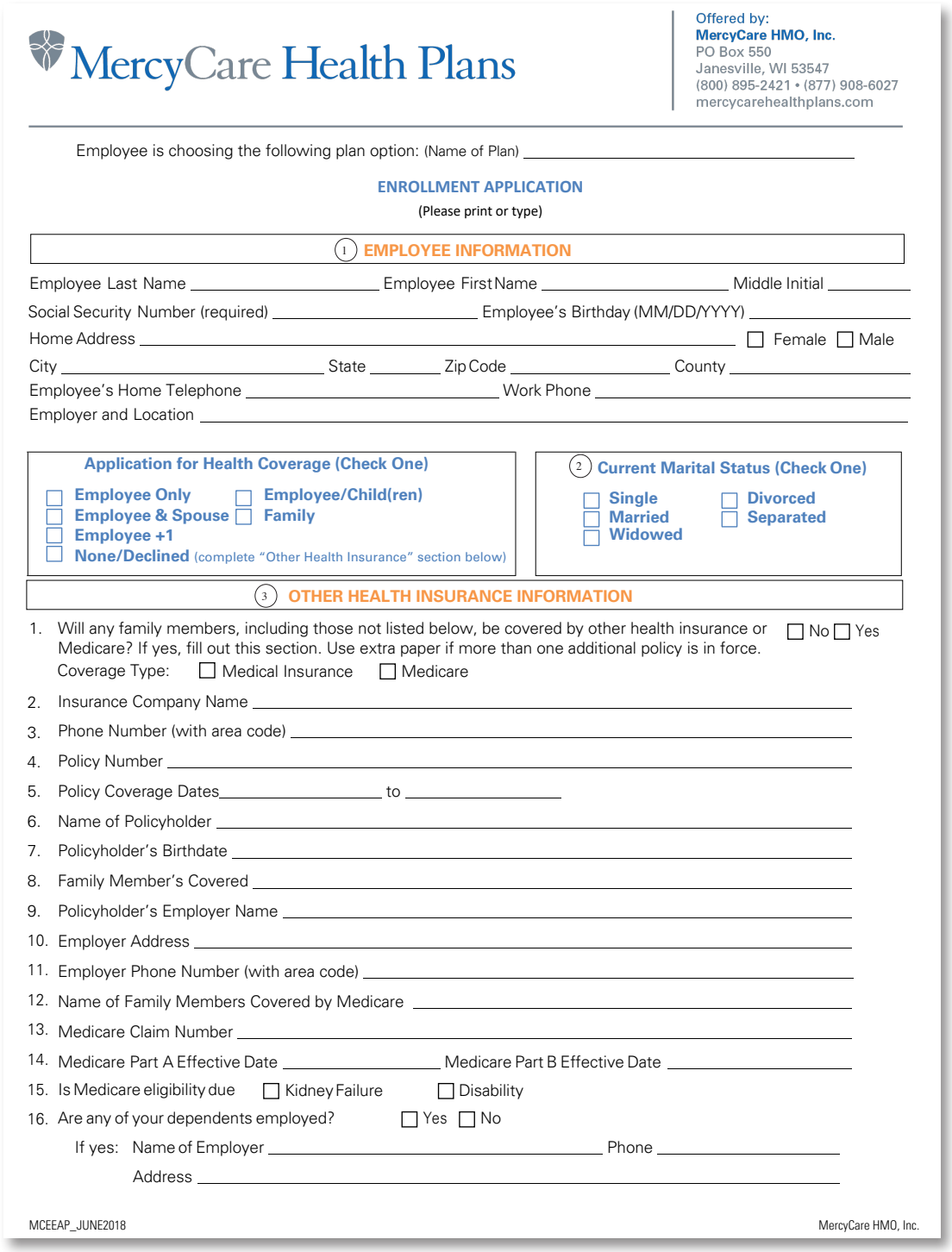
(23) DATE

MCCOSMAY2020 8705930 - N3

1. Name of your business
2. Your group number
3. Date you want the change to occur
4. Name of the employee
   If the change is to one of the employee's family members, you must still enter the name of the employee in this section.
5. Employee's gender
6. Employee's social security number
7. Date that you are filling out the form
8. Address of the employee
9. Check if the employee's address has changed (You also need to check "address change" in section 19)
10. The employee's phone number
11. Check if the employee has a new phone number
12. Only check here if you are adding dependents to the employee's coverage. Do not use this form to add an employee. All newly enrolled employees must complete an enrollment application.
    Only check "deletions" if you are removing coverage for an employee and/or his/her dependent(s).
13. Relationship of the dependent to the employee
14. Dependent's full name as indicated
15. Dependent's social security number
16. Dependent's date of birth
17. Dependent's gender
18. Name of dependent's primary care physician
    The PCP must be a part of the MercyCare network and his/her field of practice must be family practice, internal medicine or pediatrics. OB/GYNs cannot be listed as a PCP.
19. Please be sure to check a reason for change. This will avoid any confusion or possible delays in coverage.
20. Member's name to be changed and new name
21. Signature of employee
22. Signature of Employer (Required)
23. Date the form was signed

If you have any questions regarding the completion of this form please contact your agent or MercyCare Health Plans at (800) 895-2421.

Group Enrollment Application Sample (page 1 of 2)



MercyCare Health Plans

Offered by:
MercyCare HMO, Inc.
PO Box 550
Janesville, WI 53547
(800) 895-2421 • (877) 908-6027
mercycarehealthplans.com

Employee is choosing the following plan option: (Name of Plan) _____

ENROLLMENT APPLICATION

(Please print or type)

1 EMPLOYEE INFORMATION

Employee Last Name _____ Employee First Name _____ Middle Initial _____

Social Security Number (required) _____ Employee's Birthday (MM/DD/YYYY) _____

Home Address _____ ☐ Female ☐ Male

City _____ State _____ Zip Code _____ County _____

Employee's Home Telephone _____ Work Phone _____

Employer and Location _____

Application for Health Coverage (Check One)

☐ Employee Only ☐ Employee/Child(ren)
☐ Employee & Spouse ☐ Family
☐ Employee +1
☐ None/Declined (complete "Other Health Insurance" section below)

2 Current Marital Status (Check One)

☐ Single ☐ Divorced
☐ Married ☐ Separated
☐ Widowed

3 OTHER HEALTH INSURANCE INFORMATION

1. Will any family members, including those not listed below, be covered by other health insurance or Medicare? If yes, fill out this section. Use extra paper if more than one additional policy is in force. ☐ No ☐ Yes
   Coverage Type: ☐ Medical Insurance ☐ Medicare
2. Insurance Company Name _____
3. Phone Number (with area code) _____
4. Policy Number _____
5. Policy Coverage Dates _____ to _____
6. Name of Policyholder _____
7. Policyholder's Birthdate _____
8. Family Member's Covered _____
9. Policyholder's Employer Name _____
10. Employer Address _____
11. Employer Phone Number (with area code) _____
12. Name of Family Members Covered by Medicare _____
13. Medicare Claim Number _____
14. Medicare Part A Effective Date _____ Medicare Part B Effective Date _____
15. Is Medicare eligibility due ☐ Kidney Failure ☐ Disability
16. Are any of your dependents employed? ☐ Yes ☐ No
    If yes: Name of Employer _____ Phone _____
    Address _____

MCEEAP_JUNE2018 MercyCare HMO, Inc.

1. Employee information: Please ensure this information is completed in full. We must have mailing addresses for employees so as to send them newsletters and updates to coverages, as needed.
2. Type of coverage and marital status: These two areas are where the employee/subscriber tells MercyCare of their desired coverage tier. It is here that an employee/subscriber may also decline coverage at the time of eligibility. Should this be the case, the employee/ who is waiving coverage must still complete the entire enrollment application. Also, if an employee/subscriber chooses to elect coverage for themselves and their child/children, please have them check 'employee/children'. the premium amount is the same whether they have one or more children.
3. Other coverage: This is needed to ensure coordination of benefits with an additional plan(s). Even if the employee is declining coverage, it is essential that they complete this section. MercyCare Health Plans requires a minimum of 70% participation. If an employee is declining coverage because they have coverage elsewhere, they do not count when determining group participation levels.

Group Enrollment Application Sample (page 2 of 2)

(4) 17. Do any of your eligible dependents have health insurance through their employer? ☐ Yes ☐ No

If yes: Name of Dependent _____

Name of Insurance Company _____

Address of Insurance Company _____

Contract Number _____

Type of Coverage: ☐ Single ☐ Family

(5) Eligible Applicants Last Name/First Name	MI	Social Security # **(REQUIRED)**	Birth Date	Sex	Name of Physician	Currently a patient?
Employee						Y/N
Spouse						Y/N
Child						Y/N
Child						Y/N
Child						Y/N
Child						Y/N
Child						Y/N

I certify that I have read the statements in this application or that they have been read to me, and that they are, to the best of my knowledge and belief, true and complete. I understand and agree that my statements will be the basis for my coverage issued; that any material misrepresentation in this application that is relied on by MercyCare HMO, Inc. (Company) may be used to reduce or deny a claim or void the coverage; that no agent has the authority to waive a complete answer to any question, pass on insurability, make or alter any contract, or waive any of the Company's other rights or requirements; and that no coverage is effective until the date specified by the Company on a Certificate of Coverage. As may be required, I hereby authorize deduction for this coverage from my pay. The deductions shall continue until such authorization is revoked in accordance with the employer's policies and procedures.

PRINT NAME _____ DATE _____

(6) EMPLOYEE SIGNATURE _____ DATE _____

SPOUSE SIGNATURE _____ DATE _____

DEPENDENT SIGNATURE (If over 18 years) _____ DATE _____

EMPLOYER MUST COMPLETE THE FOLLOWING:

Full-time Date of Hire (Month/Date/Year) _____

Coverage Effective Date _____

Group Number _____

Authorized Signature **(REQUIRED)** _____

(7)

Reason for Enrollment (Check One)

- ☐ Open Enrollment (If Applicable)
- ☐ New Hire
- ☐ Loss of Other Coverage (Certificate of Credible Coverage)
- ☐ Late Applicant
- ☐ Rehire Date _____
- ☐ Return From Layoff Date _____
- ☐ Part-Time to Full-Time Status Date _____
- ☐ Other Qualifying Event _____

MCEEAP_JUNE2018 MercyCare HMO, Inc.

4. Other Coverage for Dependent: This ensures coordination of benefits with an additional plan(s).
5. Family Information: The employee/subscriber needs to complete this section for himself and any family members he/she wishes to provide coverage for. Please have them fill out all areas as accurately as possible. Under the section marked 'primary care physician', please be sure that the employee/subscriber chooses a physician from the MercyCare provider directory. The directory can be found online at mercycarehealthplans.com or request a printed copy by calling customer service at (800) 895-2421.
6. Signature: It is imperative that we receive signatures for both the employee/subscriber and his/her spouse, if applicable. Also, if there are any dependents who are 18 years old, or older, when coverage is effective, their signatures are also very important to obtain.
7. Employer and Health Plan Section: This section is to be completed by you, the employer. Please be sure to include your group number, the date the employee/subscriber is to be eligible for coverage, which plan they are enrolling in (some groups may have more than one option) and a signature. If the employee/ subscriber was originally hired on a part-time basis but is not full-time, please check 'qualifying event' and indicate the date that the employee/subscriber became full-time.

Member Rights and Responsibilities

MercyCare Health Plans is a partnership of you—the member, your doctor and your plan, which has a goal of assuring that you receive appropriate, quality health care. The foundation of MercyCare Health Plans is to have each member develop a relationship with his/her primary care physician (PCP) who coordinates and manages your medical care. The member's rights and responsibilities, as part of the MercyCare partnership, are described below.

Rights

As a member, you have the right to:

- Receive information about the MercyCare organization, services, practitioners, hospitals, other providers and your member rights and responsibilities
- Know how to obtain health care services
- Know what your benefits are
- Be treated with respect and recognition of your dignity and right to privacy
- Confidentiality of your personal health information as described in your HIPPA notice of privacy practices
- Be a part of the decision making regarding your treatment and understand the purpose and probable results and risks of your treatment
- Discuss openly and freely all appropriate and medical necessary treatments, procedures and services without regard to cost or benefit coverage with your provider
- File or voice a complaint or appeal about the organization or service that you receive as a MercyCare member and receive a prompt response
- Make recommendations regarding the organization's member rights and responsibilities

Responsibilities

As a member, you are responsible for:

- Reading your MercyCare member handbook, certificate of coverage, schedule of benefits and MercyCare provider directory so you understand how to use MercyCare Health Plans
- Choosing a PCP with whom you will coordinate your care
- Identifying yourself as a MercyCare member by presenting your MercyCare Health Plans' membership card before receiving health care services
- Paying your co-payments
- Keeping your appointments
- Providing information [to the extent possible] about your past illnesses, hospitalizations, medications and other matters concerning your health that will help your provider understand your health care needs
- Participating in and understanding any health problems you may be experiencing and developing mutually agreed upon treatment goals with your health care provider
- Cooperating with and following the instructions for care of your health care provider that has been mutually agreed upon
- Discussing any questions you have about your health with your provider
- Notifying MercyCare Health Plans of address, telephone and other status changes within 30 days of a change

Privacy and Confidentiality

MercyCare Health Plans is committed to strict procedures ensuring that our member's personal health information remains confidential. Only appropriate, authorized, MercyCare Health Plans staff with a need to know; have access to your personal health information.

MercyCare members have the right to consent to, or deny, the release of medical information by MercyCare, except when the release is required by law. When MercyCare transmits or releases personal identifiable information to another organization, MercyCare requires that the other organization protect the member's information from unauthorized or inappropriate use.

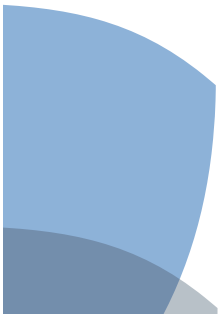
MercyCare authorized staff may collect and use the member's personal health information; without authorization, for future, known or routine needs that may include:

- Treatment
- Coordination of care
- Quality assessment and measurement, including surveys of members
- Accreditation
- Billing and claim payment
- Reporting to state and/or federal agencies when law requires such a release

MercyCare may use a member's aggregated, unidentifiable, personal health information and data. Such information is not subject to privacy restrictions and may be used and disclosed by MercyCare without restriction. (The member's personal identity is always protected.)

In order to protect your employee, our member's confidentiality, MercyCare does not share member identifiable information with any employer unless an authorization to do so has been signed by the employee.

NOTES



NOTES

Live well.
We'll insure you do.™

MercyCare Health Plans

PO Box 550
Janesville WI 53547
WI (800) 895-2421
IL (877) 908-6027
mercycarehealthplans.com

4414265