MEDICAL ASSOCIATES

MEMBER HANDBOOK

www.mahealthplans.com

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Welcome to Medical Associates Health Plans!

We appreciate the opportunity to assist you in getting the most out of your healthcare benefits. We have over 40 years of experience offering products and services to meet all of your healthcare needs.

This handbook is a guide to help you use your health insurance plan. We are available if you have any questions about your plan. You can contact us 24 hours a day, 7 days a week at (563) 556-8070 or toll-free at (800) 747-8900.

Wishing you good health,

Jill Mitchell, COO
Medical Associates Health Plans

Contact Information

Getting your questions answered	When to contact?	Contact Information
I want to speak with someone **face to face.**	**We are available from:** 8:00 AM to 5:00 PM Monday through Friday	**Our office is located at:** 1605 Associates Drive, Suite 101 Dubuque, IA 52002
I want to speak to someone on the **phone.**	**I need assistance with:** • choosing a doctor • requesting a replacement ID card • answering questions about enrollment • answering questions about my benefits • managing a disease or diagnosis • obtaining an authorization for an elective hospital stay • getting a referral approved for a provider outside of my network	**Member / Health Care Services** Monday – Friday, 8:00 a.m. – 5:00 p.m. (563) 584-4885 or 1-866-821-1365
	I need assistance with: • medical advice	**24 Hour Help Nurse / Patient Services** All day, every day (24/7/365) (563) 556-HELP (4357) or 1-800-325-7442
	I need assistance with: • general inquiries	**Health Plan Operator** Monday – Friday, 8:00 a.m. – 5:00 p.m. (563) 556-8070 or 1-800-747-8900
	I need assistance with: • assistance for deaf and mute communications	**TTY/TDD** 1-800-735-2943 An operator will assist you
I want to go online.	**I need assistance with:** • viewing my benefits • viewing my claims • requesting a duplicate ID card • obtaining eligibility verification	**My eLink** Use your ID card to Register for your online portal at: www.mahealthplans.com

Getting Started

Choosing a Primary Care Provider

A Primary Care Provider (PCP) is someone you choose to call first when you need medical care. You have direct access to any Participating In-Network primary care practitioner (Internal Medicine, Pediatrics, Family Practice, General Practice, and OB/GYN). We encourage all of our members to select a primary care provider to help coordinate healthcare needs. You can search the online Provider Directory at www.mahealthplans.com for a list of our participating providers and facilities that are available to provide you with the care you need.

Finding a Specialist

You will have direct access to many of our participating in-network specialists. If a specialist requires that you be referred from a primary care practitioner, you will be informed of this when you call the specialist. Please call our Member Services Department at (563) 584-4885 or 1-866-821-1365 for more assistance.

Preventive Services

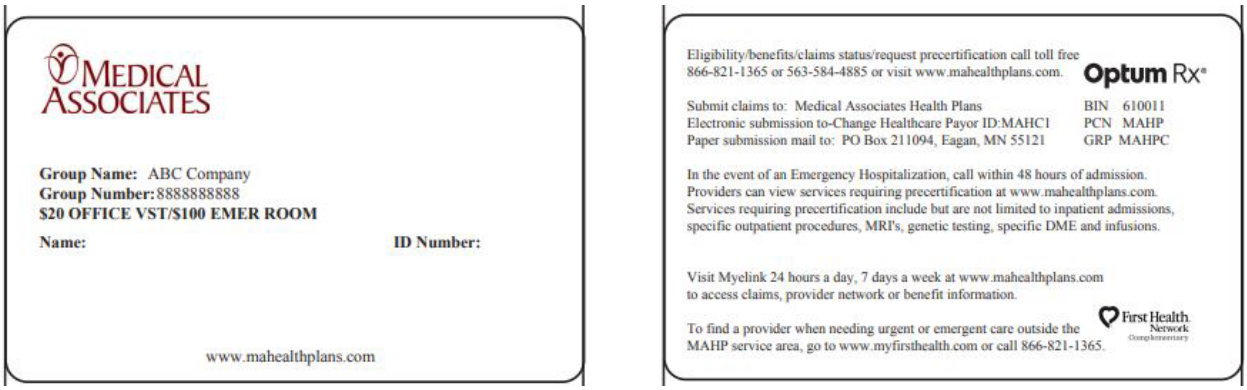
Medical Associates Health Plans believes in the importance of yearly wellness exams. These exams help find potential problems early so they can be treated early. Preventive services and immunizations are covered at no cost to you when using in-network providers. Some covered preventive services include:

- Adult preventive exams which include lab tests, pap smears, breast and pelvic examinations.
- Child and adolescent preventive exams for members ages 7-17 years, including preventive laboratory tests.
- Well baby and child preventive examinations for members through age 6, including preventive laboratory tests, audiometry, visual acuity and lead screening.
- Coverage for colorectal cancer screening
- Mammography examinations

Some limits apply. Refer to your subscriber agreement for specific benefit information.

ID Card Overview

You will receive your membership card in 10-14 days after we receive your enrollment information from your employer. Medical Associates Health Plan members are issued a membership identification card to be presented each time care is sought at a participating physician's office or hospital. An example of the identification card is below.



The face of your card includes your name and insurance ID numbers and your payment responsibility for office visits and emergency room visits. Health care providers use this information to submit claims to us.

On the back of your card, you'll find the Medical Associates Health Plan website address and phone numbers you can call for help. The Member Services number is handy if you have a question on coverage, prescription drugs, authorizations, or finding a provider.

When you check in at a hospital or clinic, or need to get a prescription drug, you will usually be asked for your member ID card. This is proof of your health insurance and gives the provider the information they need to submit the claim to Medical Associates Health Plan.

Carry your ID card in your pocket, wallet, purse, or briefcase … as long as your current member ID card is with you, it's in the right place. You can obtain additional or replacement ID cards by accessing My eLink or by contacting Member Services.

Accessing Care

Network Overview

Medical Associates Health Plans has robust relationships with physicians in multiple communities in Iowa, Wisconsin, and Illinois. Our Provider Networks include hundreds of Primary Care Physicians, Specialty Care Providers, Independent Providers, and many hospitals.

Our online provider search is available at www.mahealthplans.com. You can also print a Provider Directory through My eLink that will list the physicians and specialists available in your network.

If you need to access care outside of your network, please contact our Member Services at (563) 584-4885 or 1-866-821-1365 for assistance in requesting approval for a referral.

Assistance

24-Hour Help Nurse

Because we care about your health, we offer a staff of professional registered nurses who are available by telephone 24 hours a day, 7 days a week, to assist with accessing medical information when you need it. We are pleased to offer this personalized, free of charge, confidential service to you as a member of Medical Associates Health Plans.

Our friendly and knowledgeable nurses provide a wealth of medical information. All advice is based upon physicians' treatment protocols. Therefore, the advice you receive by physicians and providers will be in line with what you receive after hours. This ensures consistent and well managed care for you and for all patients who call our HELP line.

Here are some of the many ways the Medical Associates HELP Nurses assist our patients:

- offer medical advice for illness or injury
- determine the urgency of a problem
- access your electronic health information (when available)
- contact a physician during or after hours
- guide you to a medical facility if necessary
- answer a medication question
- assist in arranging an office appointment (when available)
- communicate with your provider or on-call physician
- provide information on community resources
- help you select a primary care provider if you do not already have one established

The 24-Hour Help Line provides medical assistance when you need it the most. When your child has a fever of 102 degrees and it is 2:00 a.m., or when you twist your ankle and are not sure what to do…call the Patient Services HELP Nurses. Our team of nurses will provide medical facts

and advice on just about any topic related to your health. We are here to provide HELP whenever you need it!

Our Patient Services HELP Nurses are just a phone call away. Please call (563) 556-4357 or at 1-800-325-7442.

Member Services Overview

We understand that not everyone wants to utilize the internet to find answers. If you prefer to talk with a representative, our Member Services team is available to answer questions as well as send you printed materials when needed. The Member Services department will answer your enrollment, benefit, and claims questions. They will walk you through your coverage for specific procedures or medical services.

Your Local Providers

Provider Finder

You can search the online Provider Directory at www.mahealthplans.com for a list of the providers and facilities that are available to provide the care you need.

We encourage you to choose a participating in-network primary care provider and establish a relationship. If you need to see a specialist, please contact them directly by calling the number listed on the search or in the Provider Directory. If a specialist requires that you to be referred from a primary care provider, you will be informed of this when you call the specialist. Remember that our Member Services team is ready to answer your questions about who you can see for your medical care needs.

Emergency and acute/urgent care coverage

It's important to save the hospital emergency room for true emergencies. Visiting the emergency room for a common illness or minor injury delays care for someone who is experiencing a true emergency as well as drives up the cost of health care. Acute/Urgent care, or walk-in care, helps patients with illnesses or injuries that are non-life threatening.

According to the American College of Emergency Medicine, **medical emergencies** include:

- Difficulty breathing
- Fainting
- Chest pain or pressure
- Uncontrolled bleeding
- Coughing or vomiting up blood
- Sudden, severe pain
- Poisoning
- Major injuries, such as head trauma
- Sudden facial drooping or weakness in an arm or leg

Acute/Urgent Care services received when in the Service Area must be received at a participating provider. Acute/Urgent care is care needed on an immediate basis for non-life-threatening conditions. Examples of Acute/Urgent care situations include, but not limited to:

- Cold or flu
- Earache
- Sore throat
- Broken bones
- Sprains
- Minor burns
- Minor cuts/lacerations

Care When You Are Out of the Area

Emergency Care Coverage

Medical Associates Health Plans (MAHP) covers emergent care outside of your service area. ***Emergency Care*** means health care that you require in life threatening, disabling, serious illness or injury situations. Under these emergency situations, you do not need prior authorization for emergency care when out of the area.

Out of the Area Coverage

If you or your dependents are out of the designated service area on business, vacation or attending school and feel you need medical attention for a condition that is non-emergent, you can call MAHP to discuss the medical problem. Please let us know as soon as possible of any potential care required outside the service area. We will help to monitor the care and provide answers to any benefit questions, especially in the case of hospital admissions. Always carry your Member I.D. Card when you travel. Show your card to the doctor or hospital where you get medical care.

- Call our toll-free number 1-866-821-1365. The number is on the back of your Member I.D. Card. A relative or friend can call for you if you are unable to make the call.
- If you are admitted to a hospital, call our Member Services Department and speak to one of our nurses within 48 hours. They will talk with the hospital and doctor to verify coverage.
- If you have a minor medical problem, call our Member Services Department and one of our nurses will assist you in obtaining pre-approval and to help identify a provider in your area.

Care Package Program

With the Care Package program, your dependent children who are enrolled in one of our health plans and live outside the designated service area may receive out-of-area coverage at the in-network level of benefits.

Your dependent child may be able to participate in the Care Package program if he or she:

- is eligible for dependent child coverage as explained in your Subscriber Agreement and
- resides or attends school outside your plan's designated service area.

You may sign up your dependent child for the Care Package program by completing a Care Package Application. If you do not enroll your out-of-area dependent child in the Care Package Program, only Urgent and Emergent Coverage will be covered out of the service area.
Using the Care Package program:

- Always present your Member ID card so providers can contact Medical Associates Health Plans to verify coverage.
- Just like your in-network benefit, certain services require prior authorization. Failure to obtain the necessary prior authorization may result in a denial of benefits.

Services received out-of-area may be subject to usual and customary charges. Additional charges may be avoided by utilizing providers that agree to participate with MAHP. Please go to www.myfirsthealth.com to view potential providers in your service area. If you need to fill a prescription that has been written by a physician outside of our service area, the pharmacy will need to call MAHP to get prior authorization. If you have any questions, please contact Member Services Department.

Referrals

Referrals made by participating network practitioners to *non*-participating physicians or advance practice providers require prior approval by Health Care Services (with the exception of urgent or emergent care needs).

Understanding Your Benefits

Benefits Overview

When you enroll in your employer's health insurance plan with Medical Associates, you can be assured you are receiving comprehensive benefits from a company that focuses on partnering with providers that provide high-quality cost-effective care. MAHP's employer group plans feature preventive care paid at 100%, worldwide access to urgent & emergency care, and access to primary care providers and specialists who can provide the highest level of your healthcare needs.

What to expect when paying out of pocket

Visit www.mahealthplans.com, My eLink for plan information or contact Member Services.

When you visit the doctor…

Traditional Plans	High Deductible Health Plan
You pay a copayment for the visit, depending on your plan. You might pay more for extra tests, lab work or other medical services that result from that visit.	You pay the entire cost until you reach your annual deductible or out-of-pocket maximum. Note: The exception is preventive care, which is covered at 100% in all plans. There is no copay for preventive care and the cost does not apply to your deductible or out-of-pocket maximum.

When you get prescription drugs…

Traditional Plans	High Deductible Health Plan
You pay a copayment for your prescription drugs, depending on your plan. Brand name and generic drugs are covered, but you save money when you choose generic.	You pay the entire cost until you reach your annual deductible or out-of-pocket maximum.

When you're admitted to the hospital…

Traditional Plans	High Deductible Health Plan
You pay hospital costs until your deductible is met. After that, you and MAHP share the medical costs (coinsurance) until your out-of-pocket maximum is met. Then MAHP pays all your covered expenses.	You pay hospital costs until your annual deductible or out-of-pocket maximum is met.

Summary of Benefits

Each plan has a Summary of Benefits (SOB) that shows your costs when obtaining services. Below is an example of a Summary of Benefits. To view your plan's actual Summary of Benefits, you can access it on My eLink.

	In Network Member Liability
Annual Deductible (if applicable)	$1,000 Individual $2,000 Family
Out of Pocket Annual Limit (deductible included)	$2,500 Individual $5,000 Family
Lifetime Maximum Benefit	Unlimited
Deductible Carry-Over Provision	The Deductible Carry-Over applies.

Common Medical Event	Services you may need	Your cost if you use an In Network Provider	Your cost if you use an Out of Network Provider	Limitations and Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	Not covered	
	Specialist visit	$20 copay/visit	Not covered	
	Chiropractic Services	$20 copay/visit	Not covered	Medically Necessary
	Allergy Testing	$20 copay/visit	Not covered	Allergy testing and treatment are covered when medically Necessary.
	Allergy Injections	Paid in full	Not covered	
	Injections	Paid in full	Not covered	Injections for travel are not covered

Common Medical Event	Services you may need	Your cost if you use an In Network Provider	Your cost if you use an Out of Network Provider	Limitations and Exceptions
If you need immediate medical attention	Emergency room and Observation services	$250 copay/visit	$250 copay/visit	The Emergency Room Copayment will be waived if you are admitted to the Hospital; however, you will be responsible for the Facility Fee, which is subject to deductible/coinsurance. Your condition must meet the definition of an Emergency Service. If you are out of the service area and an Emergency Hospital Service is required, MAHP should be notified within 48 hours of your visit. Out-of-Network Emergency Services are subject to Usual & Customary charges.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	Medically Necessary services. Ground or air ambulance services.
	Urgent Care	$20 copay/visit	$20 copay/visit	Out of Network: Subject to Usual and Customary Charges.
If you have services in an outpatient setting	Physician Fee	$20 copay/visit	Not covered	
	Facility Fee	20% coinsurance after deductible	Not covered	
If you have a hospital stay	Facility Fee (e.g., Hospital room, long-term acute care) Coverage for semi-private room unless the patient can only be treated in a private room as determined by MAHP In Network Provider	20% coinsurance after deductible	Not covered	Requires Prior Approval.
	Physician/surgeon fee	20% coinsurance after deductible	Not covered	Requires Prior Approval.

Pharmacy

RX Plan / Prescription Coverage

Prescription drug coverage helps you pay for medications prescribed by your in-network prescriber. To ensure your pharmacy is part of MAHPs contracted network, please go to the Prescription tab on My eLink. There, you can verify that your pharmacy is in the network or find a pharmacy within the network. You will need to present your Member ID Card to the pharmacy when filling a prescription. If you encounter a problem, please have the pharmacist call Member Services for assistance in processing the prescription. The number can be found on the back of your Member ID card.

Medical Associates Health Plans is partnered with Optum RX to ensure you receive a high-quality prescription drug benefit. This partnership is directly aligned with our patient-centered focus. We have an onsite Clinical Pharmacist to provide additional value to our clients as part of the team managing the pharmacy benefits at MAHP. The pharmacist is available for discussions relating to benefits and drug coverage. They also provide assistance to our Health Care Services nursing staff and Member Service representatives.

Formulary

When you enroll in a health insurance plan, find out if your medicines are listed in the plan's drug formulary. The formulary is a list of generic and brand-name medications that are covered by your health plan. The formulary gives you broad access to drugs and supplies at a reasonable overall cost.

A committee of doctors and pharmacists decides what drugs are on the formulary. The committee considers many factors. Is the drug safe? Is it effective? Is it unique? Other market conditions factor into the decision as well. If your drugs aren't on the formulary, your health plan may still provide some coverage. You will, however, likely pay more out of your own pocket.

Online Access

Using My eLink, members can access the Optum Rx website to compare prices of medications at various local pharmacies, so you can be sure you're getting the best deal possible. Features of this prescription management website include information for setting up a profile with Optum's Specialty or Mail Order pharmacy, seeing all your recent prescription medication claims, and refilling medications through the Mail Order pharmacy. Log in to your My eLink member portal and click on the Prescriptions tab to learn more!

Pharmacy Options

Retail

Prescriptions may be filled at any pharmacy located within the MAHP service area. When outside the service area, you can fill you prescription at any of the pharmacies on the National Chains list. If you need help locating a pharmacy, please use the Prescription tab in your My eLink. When filling a prescription at your pharmacy, you will need to present your Member ID Card. If you encounter a problem, please have the pharmacist call Member Services.

Mail Order

My eLink allows members to see the cost of a 90-day supply through Optum mail order pharmacy. Additional features of this prescription management website include refilling medications through the mail order pharmacy.

Specialty Pharmacy

Our Preferred Specialty Pharmacy Network provides patients with comprehensive support services and coordinated delivery related to high-cost oral, inhaled, or injectable specialty medications, used to treat complex conditions. Optum RX assists in patient care management to control side effects, provides patient support and education to ensure compliance or continued treatment, and specializes in handling and distribution of medications directly to the patient or care provider.

Managed Pharmacy Care

Generic Incentive

Using a generic drug is the most effective thing you can do to reduce your prescription drug costs. The average brand-name drug claim is more than $175. That's seven times more than the average generic claim of about $25.

Generic drugs have the same active ingredients, risks, and benefits as the brand-name versions. If a chemical copy of your medication is not available, there could be another generic drug that treats your symptoms. Atorvastatin, for example, is a chemical copy of the cholesterol-lowering drug Lipitor. If you take Lipitor, Crestor, or another brand-name cholesterol-lowering drug, Atorvastatin may be an appropriate alternative.

Note: Over-the-counter medications can save money as well. Many medications formerly available by prescription, such as Claritin and Zyrtec, are now available over the counter. Over-the-counter pain relievers, such as ibuprofen (Advil or Motrin) and acetaminophen (Tylenol) are an effective option for everyday aches and pains. You may be directed to try an over-the-counter product when available for a medication that was prescribed by your provider.

Step Therapy

With certain prescription drugs, step therapy may apply. This means trying a preferred drug as the first step in treating your medical condition. The preferred drug is safe, clinically effective, cost-effective, and often a generic drug. You can get non-preferred drugs, but only if the preferred drug is not effective or tolerated well. This means you must try the preferred drug first. For example, before you use the brand name type 2 diabetes drug Ozempic®, you must try one of the preferred generic medications that is used first line for controlling your blood sugar, such as metformin or glimepiride.

Prior Authorization

Some prescriptions medications require approval before you can fill your prescription. The medications that require Prior Authorization are generally classified as Specialty Medications and treat conditions such as Crohn's disease, Rheumatoid arthritis, and severe asthma. Prior approval is required to ensure that the medication prescribed is both effective in treating your diagnosis and is the most cost-effective option.

Using your Benefits

Manage Your Account

Eligibility / Enrollment

The eligibility requirements of plans vary by employer. Contact your Human Resources representative to find out how long you must be working as a new employee before you have access to their health plan or to understand the amount of premiums you'll be asked to pay towards your coverage.

Your employer offers an annual open enrollment period each year. The open enrollment period is the time when you're able to enroll or make changes to your coverage. Unless you have a Life Event, this is the only time you're able to make changes to your coverage.

Life Events

Life events are the major changes to you or your family's situation that allows for you to make changes to coverage during the year. Below are a few examples of those life events:

- Getting married or divorced
- A change in number of dependents – birth, death, adoption, legal guardianship, etc. A newborn child who meets the definition of a dependent will be covered automatically from the date of birth if Family Coverage is in effect. You need only notify MAHP of the birth within 31 days so that we may update our records. If your contract does not include benefits for dependent children, you must request enrollment within 31 days of the child's birth and pay any additional required premiums.
- A child of employee reaches age 26

- Entitlement to Medicare
  - ~ We believe reaching age 65 is a time for joy and celebration! When you work all your life and pay into Medicare, you deserve to reap the benefits. Even if you are still working, becoming entitled to Medicare is a life event that would allow you to change coverage. We encourage you to consider if Medicare is right for you. Our team of Medicare specialists is ready to help answer your questions about costs and eligibility and will help you compare this option to your employer's plan.
- Moved to or from the designated service area
- Changing employment. We understand this can be an uncertain time. It's good to know that you have access to coverage through your transition period with COBRA.
  - ~ You may be eligible to continued health benefits through COBRA. COBRA coverage is triggered by the occurrence of a "Qualifying Event" that results in the loss of coverage under the Employer's plan. Contact your employer to determine if you are eligible to continue coverage under COBRA.

Other Coverage Options

Employees may have more than one health insurance plan option. Your employer may offer more than one plan, or you may have access to a plan through your spouse or parent. It is important to consider all your plan options and do what is most appropriate for you. Our Member Services team is knowledgeable about the coordination rules that plans have in place and would be happy help you to understand your options.

Claims

In general, when you receive your health care from a participating provider, you will only be required to pay any deductible or co-payment specified in your insurance policy. Generally, providers will bill MAHP for services.

If you receive authorized services from a non-participating provider or outside of the local service area, you may be required to pay for services at the time they are received, or you may get a bill at a later date. Medical Associates Health Plans will reimburse you for medically necessary services covered under your policy. You must submit your claim to Medical Associates Health Plans within 90-days after the date of such service. Failure to submit a claim within 90-days will not cancel or reduce any claim if it was not reasonably possible to give proof within the time required, provided such claim is submitted as soon as reasonably possible, and in no event later than one year from the date of service.

In some situations, a provider may not be willing to submit a claim to Medical Associates. That situation is rare in this electronic age, but if you are in that situation, ask for a completed medical claim form such as the "HCFA 1500 Universal Form" that includes all patient and provider information needed to process your claim.

If the physician does not use the universal claim form, the following information is needed for us to process your bill. Ask the provider for a receipt that includes:

1. Name of your health insurance policy as listed on your membership card
2. Name of the policy holder as listed on your membership card
3. Name of the patient receiving medical services
4. Name, address, and telephone number of the physician or health care provider
5. Type of health care services rendered, with diagnosis and procedure codes
6. Date service was given
7. Charges for services given

Mail the claim to:
Claims Department
Medical Associates Health Plans
1605 Associates Dr. Suite 101
Dubuque, IA 52002

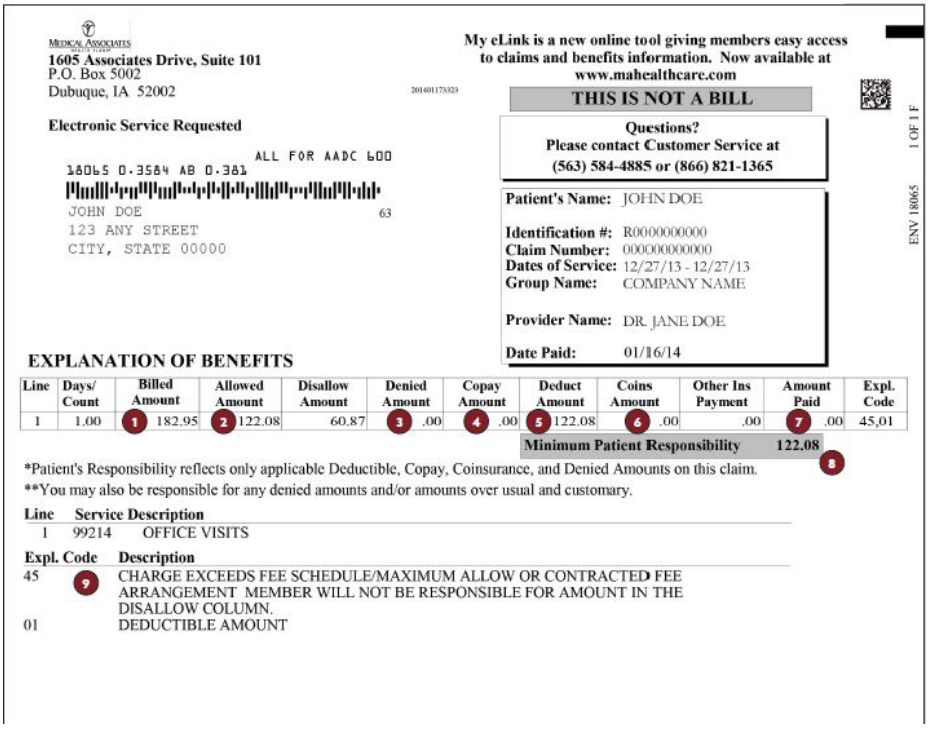
EOB – Explanation of Benefits

Each time we get a claim for health care services you receive, we generate an Explanation of Benefits (EOB). This document explains how your claim was processed and will breakdown the responsibility of payment for the claim.

When you get an EOB, understand that it is not a bill and payment is not owed at that time. Do not send payment for this service. If there is additional member liability, you will be billed by the provider so the EOB will be useful to verify the amount we applied to your member liability matches the amount billed by the provider.

Look at the sample EOB below and refer to the numbered list for details about the information contained on the EOB.

1. Billed Amount: The total amount charged by the provider
2. Allowed Amount: This is the contracted rate for the service. Medical Associates Health Plan negotiates this discount on your behalf.
3. Denied Amount: The amount you are required to pay for a non-covered service.
4. Copay Amount: This is the fixed co-pay amount you pay for the service.
5. Deduct Amount: This is the amount applied to your deductible.
6. Coinsurance Amount: This is the percent of the allowed amount you pay for the service.
7. Amount Paid: The amount of the charge paid to the provider by Medical Associates Health Plan.
8. Minimum Patient Responsibility: The amount you owe to the provider. This amount should match the invoice from the provider.
9. Expl. Code: This is the code that explains how your claim processed.



MEDICAL ASSOCIATES HEALTH PLAN
1605 Associates Drive, Suite 101
P.O. Box 5002
Dubuque, IA 52002

Electronic Service Requested

ALL FOR AADC 600
18065 0.3584 AB 0.381
JOHN DOE
123 ANY STREET
CITY, STATE 00000

My eLink is a new online tool giving members easy access to claims and benefits information. Now available at www.mahealthcare.com

20140117323

THIS IS NOT A BILL

Questions?
Please contact Customer Service at
(563) 584-4885 or (866) 821-1365

Patient's Name: JOHN DOE
Identification #: R00000000000
Claim Number: 000000000000
Dates of Service: 12/27/13 - 12/27/13
Group Name: COMPANY NAME
Provider Name: DR. JANE DOE
Date Paid: 01/16/14

1 OF 1 ENV 18065

EXPLANATION OF BENEFITS

Line	Days/ Count	Billed Amount	Allowed Amount	Disallow Amount	Denied Amount	Copay Amount	Deduct Amount	Coins Amount	Other Ins Payment	Amount Paid	Expl. Code
1	1.00	1 182.95	2 122.08	60.87	3 .00	4 .00	5 122.08	6 .00	.00	7 .00	45,01

Minimum Patient Responsibility 122.08 8

*Patient's Responsibility reflects only applicable Deductible, Copay, Coinsurance, and Denied Amounts on this claim.
**You may also be responsible for any denied amounts and/or amounts over usual and customary.

Line	Service Description
1	99214 OFFICE VISITS

Expl. Code	Description
45 9	CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOW OR CONTRACTED FEE ARRANGEMENT MEMBER WILL NOT BE RESPONSIBLE FOR AMOUNT IN THE DISALLOW COLUMN.
01	DEDUCTIBLE AMOUNT

Appeal

An appeal is when you disagree with a benefit determination. If you, as a member, have a dispute relating to any adverse benefit determination regarding a Pre-Service Claim, Post-Service Claim, Urgent Care Claim, or any aspect of the Plan, you should contact MAHP's Member Services Department about filing a written or verbal appeal. At any time during the appeal process, you have the right to allow an authorized representative to act on your behalf.

The appeal procedure is used to resolve any adverse determination regarding any Pre-Service Claim, Post-Service Claim or Urgent Care Claim according to the following time frames:

A. Urgent Care Claims- MAHP will notify you of the decision of your appeal no later than 72 hours. If you request an expedited appeal of this benefit denial, all necessary information, including the MAHP's decision via telephone and followed up in writing.
B. Pre-Service Claims- MAHP will notify you of the decision of your appeal within a reasonable period of time appropriate to medical circumstances but not later than 30 days after the plan receives your appeal.
C. Post-Service Claims- MAHP will notify you of the decision of your appeal within a reasonable period of time but not later than 60 days after MAHP receives your appeal.

If you, your authorized representative, or MAHP is not satisfied with the decision at the appeal level, you, your authorized representative or MAHP has the right to file a written grievance. This process is further detailed in your Subscriber Agreement.

Online Access

We have helpful information published on our member page at www.mahealthplans.com. This information includes:

- how to obtain language assistance
- hours of operation
- how to find primary care services including points of access
- how to find specialty care and behavioral healthcare services and hospital services
- how to obtain care after normal business hours
- how the organization evaluates new technology for inclusion as a covered benefit
- an overview of your rights and responsibilities as a member
- numerous resources to assist in improving and maintaining your health

My eLink

My eLink is a convenient, confidential web portal offering online access to your personal health plan information 24 hours a day, 7 days a week.

Some of the features available to you through My eLink:

- view benefits
- search for a provider
- submit basic questions
- request I.D. cards
- obtain eligibility verification
- check and view claims
- renew and refill prescriptions
- compare medication pricing
- Access to Explanation of Benefits (EOB)
- Check the deductible amount that you've paid
- View your archived personal claims information is available 24/7 online.
- Change your address and other personal information
- Grant an authorization to release information

Our courteous and expert staff are available in our Dubuque office, Monday through Friday from 8:00 a.m. to 5:00 p.m. Our Member Services department will be happy to answer any questions you have about My eLink.

To access My eLink

1. Go to **www.mahealthplans.com** and click on My eLink, I am a Member.
2. On the login page, first-time users need to click on "Proceed to our sign-up process" to register.

Assistance in Navigating Your Healthcare Needs

Referrals

Referrals made by participating network practitioners to ***non*-participating** physicians or advance practice providers, require prior approval by Health Care Services and/or the Medical Associates Health Plan Chief Medical Officer (with the exception of urgent or emergent care needs).

Authorization Process:

- A Health Care Services Nurse reviews each referral request and may approve "routine requests" according to established guidelines. Referral requests, which are not considered routine, or requests suggesting lack of medical necessity are reviewed by the Chief Medical Officer. The Chief Medical Officer authorizes the scope of services and the number of visits allowed or makes a recommendation for alternative treatment. In the event of the latter outcome, your provider's office will be notified for further discussion. In most cases, a request to seek care with a non-participating specialist requires a referral request from a participating provider of the same specialty. For example, a participating Cardiologist must submit a request for referral to a non-participating Cardiologist.

- The Health Care Services Nurse will communicate verbal and/or written approval of the referral to the patient, to the referring physician's office, and to the office where the patient is being referred. The referring physician's office will coordinate and schedule the appointment. Copies of the Prior Authorization letter will be mailed to the patient and to the referral site. All questions regarding out-of-plan referrals can be directed to Member Services.

Preauthorization

Many medical services will be covered by your Medical Associates Health Plan. Some services, however, need approval from Medical Associates before they are performed. This preauthorization ensures they will be covered.

Preauthorization is the process of requesting approval from Medical Associates for specified services. A participating provider, like a doctor or hospital, is responsible for obtaining preauthorization for you. Even if you are transferred from one type of facility to another, the new provider is responsible for the preauthorization.

To obtain a preauthorization for these services or for questions about the process, the participating network practitioner or his/her office staff should contact Member Services to request a referral authorization by calling (563) 584-4885 or 1-866-821-1365 or by faxing to (563) 584-4893, or www.mahealthplans.com and click on My eLINK.

Your subscriber agreement will list all services that require prior authorizations. The list includes but is not limited to:

- Skilled Nursing Facility, Transitional Care Unit, inpatient admission to a Rehabilitation Facility, Hospice, Home Health Care, or Long-Term Acute Care Facility,
- For Medical/Surgical Out-of-Area inpatient admissions,
- Psychiatric/Substance Abuse admissions,
- Non-emergent inpatient hospitalization,
- Cosmetic surgery or reconstructive surgery,
- Infertility,
- Durable medical equipment rental or purchase,
- Outpatient MRIs

Case Management

Case Management identifies eligible health plan members who have experienced a catastrophic event or diagnosis in which the complexity of the illness requires extensive use of resources. The goals of case management are to promote continuity of care, improve self-management, promote positive health outcomes, reduce the cost of care and reduce unplanned hospital admissions and inappropriate emergency room use.

Different from traditional case management, a Health Coach is a partner who facilitates education and the development of self-management skills. The focus is on the client, with additional emphasis on treatment plans provided by the healthcare professional. Health coaching incorporates education, prevention, community resources, and optimal health goals within the social context of the client's life in order to affect change. The population served by a Health Coach consists of those at lower risk, in comparison to traditional case managers who assist patients with severe and complex health needs.

Our Health Care Services Department has dedicated nurses available to you. To contact a Health Coach or Case Management nurse, please contact our Member Services at (563) 584-4885 or 1-866-821-1365.

Disease Management

Disease Management is initiated with select health plan members who have chronic illnesses that require continuing medical care and education to prevent acute complications and to reduce the risk of long-term complications. The goals of disease management are to reduce and/or eliminate hospital admissions, to promote wellness and members' active participation in their health care, to provide ongoing education, and to achieve a more personalized approach to disease management.

Our Health Care Services Department currently has two active disease management programs in place to assist members with Diabetes and Hypertension. Contact the Member Services at (563) 584-4885 or 1-866-821-1365 to see if you qualify.

Health Insurance 101

FAQ

What is the difference between preventive and medically necessary services?
Preventive services include routine screenings and tests recommended by a doctor-based age or family history to check for signs of a potential problem. Examples may include cholesterol screenings, mammograms, pap smears, or colorectal screenings. A doctor orders diagnostic services to diagnose the reason for an existing problem. Examples may include x-rays for a hurt foot, testing a mole for cancer, or sleep studies.

Example:
A colonoscopy is a medical procedure performed on the bowel using a camera. It allows a doctor to see the inside of the colon. This service is considered preventive when your doctor wants to screen you for signs of colorectal cancer based on your age or family history, even if you have no symptoms. A colonoscopy is considered diagnostic when you're having a health problem or show symptoms, such as bleeding or irregularity.

If my doctor orders a test, is it automatically covered?
To find out if a test is covered or needs preauthorization or prior approval:

- ~ Check you Summary Plan Description.
- ~ Ask you provider to contact Medical Associates Health Plans.

What happens in an emergency? If you are out of the area, you can receive emergency care from a non-participating provider without preauthorized approval. However, you or a family member should call Member Services within 48-hours. Your coverage is limited to medical care and supplies needed during the emergency.

Emergency Care means health care that you require in life threatening, disabling, serious illness or injury situations. This includes severe pain that worsens suddenly or if not treated could result in loss of life or permanent damage. You do not need prior authorization for emergency care. (Please refer to your Subscriber Agreement for a thorough definition of "Emergency Services.")

Definitions

Premium – This is what you pay each month for your health plan coverage.
Coinsurance – This is your share of the cost for a service covered in your plan. You pay the coinsurance plus any deductible you owe.
Deductible – This is the amount you pay for health care services before your plan begins to pay. For example, let's say your deductible is $1,000. You will pay all expenses up to $1,000. After that, the plan will share the cost of covered services. Some services, like preventive services, may be paid right away, before you meet your deductible.
Copayment – A fixed amount a member pays for a covered health care service, typically paid at the time of the service. The amounts vary depending upon the service received.
Out-of-pocket maximum – This is the most you would pay in a year before your health plan begins to pay 100% for covered services, including copays. The out-of-pocket maximum doesn't include your premium or charges that are over and above what are allowed in
A Network is a clinic or group of independent physicians. They have agreed to accept MAHP negotiated rates as payment.
In-Network – In-Network describes services you receive from a provider in your chosen network.
Out-of-network – Out-of-network describes services you receive from a provider outside your chosen network. Higher cost share will apply to out-of-network services. Avoid Out-of-network costs by obtaining an approved referral.
Approved referral – Network providers can request an authorization for you to receive care from an out-of-network provider. This request is reviewed by Health Care Services and in some cases the Chief Medical Officer. When an approved referral is obtained, the higher benefit level will apply. These referrals are not granted for personal preference, family convenience, or other non-medical reasons.
Explanation of Benefits (EOB) – An explanation of Benefits (EOB) is a document you receive after a claim for services has been processed by Medical Associates Health Plan.
Allowed charge or allowance – The maximum dollar amount upon which a procedure or service is based, as determined by Medical Associates Health Plan.
Formulary drug – A formulary drug is a brand name or generic prescription medication that is considered safe, therapeutically effective, high quality and cost effective. A committee of physicians and pharmacists determines the listing of these drugs, called the drug formulary or drug formulary list.
Non-formulary drug – A non-formulary drug is any drug not on the formulary drug list.
Generic drug – A generic drug is the established or official chemical name of a drug.
Brand name drug – A brand name drug is the registered trademark name given to a prescription medication by its manufacturer, labeler, or distributor.
Maintenance drug – Maintenance drugs are prescription medications that are allowed to be dispensed in amounts up to a 100-day supply.
Non-Maintenance drug – Non-Maintenance drugs are prescription medications that are allowed to be dispensed in amounts up to a 34-day supply.
Preferred drug – This qualified drug listing, also called a formulary, is a comprehensive list of preferred medications including both generic and brand name drugs. Formulary drugs are considered safe, efficient and may help reduce your out-of-pocket costs.
Non-preferred drug – Drugs not listed on the Optum formulary.
Specialty Drug – Medications or drugs that are generally high cost and may have other considerations such as special administration, limited availability, unique delivery and dispensing, or unique and/or required patient support of monitoring.

Forms

- Enrollment Application
- Care Package Program Application
- Authorization to Release Medical Information
- Medical Associates Claim Form for Payment Reimbursement
- Optum RX Pharmacy Home Mail Order Form

Disclaimers

Non-Discrimination

Medical Associates Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Medical Associates Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Medical Associates Health Plans provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats.

Medical Associates Health Plans provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Member Services at 563-584-4885 or 1-866-821-1365.

If you believe that Medical Associates Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Member Services, Address: 1605 Associates Drive Dubuque, IA 52002, Phone: 563-584-4885 or 1-866-821-1365, TTY: 1-800-735-2942, Fax: 563-584-4760, Email: memberservices@mahealthcare.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Access Services:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-821-1365 (TTY: 1-800-735-2942).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-821-1365 (TTY: 1-800-735-2942)。CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-821-1365 (TTY: 1-800-735-2942).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-866-821-1365 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-735-2942).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-821-1365 (TTY: 1-800-735-2942).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم1-866-390-3872(رقم هاتف الصم والبكم: 1-800-735-2942).

ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-866-821-1365 (TTY: 1-800-735-2942).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-821-1365 (TTY: 1-800-735-2942)번으로 전화해 주십시오.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-821-1365 (TTY: 1-800-735-2942) **पर कॉल करें।**

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-821-1365 (ATS: 1-800-735-2942).

Wann du [Deitsch (Pennsylvania German/Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-866-821-1365 (TTY: 1-800-735-2942).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-866-821-1365 (TTY: 1-800-735-2942).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-821-1365 (TTY: 1-800-735-2942).

ဟ်သူဉ်ဟ်သး– နမ့ါကတိၤ ကညီ ကျိာ်အဃိ, နမၤနှ့ါ ကျိာ်အတ်မၤစၢၤလၢ တလၫ်ဘူဉ်လၫ်စ့ၢ် နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 1-866-390-3872 (TTY: 1-800-735-2942).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-821-1365 (телетайп: 1-800-735-2942).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-866-821-1365 (TTY: 1-800-735-2942)

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezplatnej pomocy językowej. Zadzwoń pod numer 1-866-821-1365 (TTY: 1-800-735-2942).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-866-821-1365 (TTY: 1-800-735-2942).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-821-1365 (TTY: 1-800-735-2942).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال 1-866-821-1365 (TTY: 1-800-735-2942).کریں

ATTENZIONE: In caso la lingua parlata sia l'italiano, s ono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-821-1365 (TTY: 1-800-735-2942).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-866-821-1365 (TTY: 1-800-735-2942).

Members Rights and Responsibilities

Member Rights

You have the Right:

- To receive information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.).
- To be treated with fairness, respect and recognition of dignity and the right to privacy at all times.
- To participate with practitioners in making decisions about your health care. We must support your right to make decisions about your care.
- To a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- To receive timely access to your covered services.
- To receive information about the Health Plan, its network of providers, rights and responsibilities and your covered services.
- To voice complaints or appeals about the Health Plan or the care it provides.
- To make recommendations regarding the organization's member rights and responsibilities policy.

Member Responsibilities

You are expected:

- To become familiar with your covered services and the rules you must follow to get these covered services.
- To tell us if you have any other health insurance coverage in addition to our plan.
- Tell your doctor and other health care providers that you are enrolled in our plan.
- To supply information (to the extent possible) to the Health Plan, your doctors and other providers needed in order to provide care.
- To ask questions, follow plans and instructions for care that you have agreed to with your provider.
- To understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- To be considerate.
- To pay what you owe.
- To tell us if you move.
- To call Member Services for help if you have questions or concerns.

Privacy Statement

Medical Associates Health Plan is committed to protecting your privacy and confidentiality of your health and financial information. You can view the Medical Associates Privacy Practices by logging into your My eLink account.