HOW TO SUBMIT A CLAIM

All claims should be mailed to:

Health Network America, Inc.
P.O. Box 310
West Long Branch, New Jersey 07764
Attn: Claims Department

Submit claims using a Health Network America form and/or standard medical claim form.

Attach original itemized bills for expenses (copies are not accepted).

WHEN CLAIMS MUST BE FILED

Claims must be filed with the Claims Administrator within 90 days of the date charges for the service(s) were incurred. Claims filed later than that date may be declined or reduced.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested.

CLAIMS REVIEW PROCEDURE

In cases where a claim for benefits payment is denied in whole or in part, the claimant may appeal the denial. This appeal provision will allow the claimant to:

1. Request from the Plan Administrator a review of the eligibility status for any claim denied in whole or in part.

2. Request from the Plan Administrator a review of any claim payment. Such request must include: the name of the Employee, his/her social security number, the name of the patient and the Group Identification Number, if any.

3. File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim or claims.

The request for review must be directed to the Plan Administrator within 90 days after the claim payment date or the date of notification of denial of benefits.

A review of the denial will be made by the Plan Administrator and the Plan Administrator will provide the claimant with a written response within 60 days of the date the Plan administrator
receives the claimant's written request for review. If, because of extenuating circumstances, the
Plan Administrator is unable to complete the review process within 60 days, the Plan
Administrator shall notify the claimant of the delay within that 60 day period and shall provide the
date the Plan Administrator received the claimant's written request for review.

The Plan Administrator's written response to the claimant shall, if the denial is upheld, cite the
specific Plan provision(s) upon which the denial is based.

CUSTOMER SERVICE

You may contact Customer Service for the following information:

Benefits Information
Claim Payment Information
Member Eligibility

Please have the patient's name and employer ready.

PROVIDER RELATIONS

You may contact Provider Relations for:

Physician Inquiry
Contract Agreements
Fee Schedules

877-846-0847
HEALTH NETWORK AMERICA

MEDICAL APPROPRIATENESS REVIEW AND REFERRAL SYSTEM

UTILIZATION MANAGEMENT

The Health Network America Medical Appropriateness Review and Referral system (MARRS) is comprehensive. The process is prospective, concurrent and retrospective.

Prospective Review: Health Network America’s MARRS includes the Medical Appropriateness Protocol system (MAPS), a state of the art expert computer system that uses input from patients and doctors with the help of nurses trained on the system to advise the patients and their physicians if their planned use of medical resources is appropriate. If the planned treatment appears appropriate for the medical problem, no second opinion is required and the patient and the physician are encouraged to proceed.

If the planned treatment raises questions about the appropriateness of the plan, then all efforts to obtain additional information for the patient and the doctor are made.

All hospital admissions are pre-certified through an 800 number. Frequently used and expensive high volume procedures are also reviewed. If the planned procedure is one of approximately 20 on our expert system, the procedure is also pre-certified or referred to an alternative plan (i.e., second opinion, other treatment, etc.) using an on-line artificial intelligence system.

Concurrent Review, Retrospective Review and Discharge Planning: These occur through direct and continuing contact on all cases where case management is required. The initial judgment as to which cases require case management is based on the diagnosis.

The Utilization management Committee (UMC) is made up of physicians and nurses as well as a Medical Librarian and Claim Manager. The UMC meets weekly and is directly involved in the review of all questionable claims.

Over-utilization and under-utilization is reported and handled through our UMC. Because we do not differentiate with respect to utilization management between in-network and out-of-network physicians, we apply our protocols and systems to all claims.

Although we refer to the Milliman & Robertson guidelines, as well as the expert system to determine appropriateness of admission and estimated length of stay, Health Network America, unlike other “managed care companies” and insurance companies, does not deny care to anyone. Only the attending physician and the patient make final decisions about health care.

If evidence shows that the physician and the patient may be proceeding in an inappropriate manner, we give them information which may guide them to a better decision. The approach is usually sufficient, as patients and their physicians, when confronted with good information, will act prudently. Our Medical Appropriateness Review and Referral System (MARRS) process is to educate, not to deny. The ultimate decision for care rests with the patient and his/her physician. We have excellent experience to show that when given enough helpful information, patients and their doctors make good decision about the use of health care resources.
Perception is quantified through surveys; medical outcome is compared to expected success rates for treatment of medical conditions reported by each academy of specialty medical practice.

**Quality of care indicators are used in the quality assurance process as follows:** The computer systems at Health Network America produce the following audit trails needed to accomplish the above task:

1. Longitudinal study by diagnosis and procedure.
2. Longitudinal study of patient performance.

We also employ simple tools to be indicators of the appropriateness of care, i.e., we survey medical events and triggers that alert us to possible inappropriate treatment. Procedures, laboratory studies and patient visits that appear inappropriate are forwarded for review.

Our QA committee conducts periodic quality of care studies. An example is the "Use of Ultrasounds in Pregnancy." Obstetrical practice patterns were reviewed for the application and the cost associated with the use of ultrasounds during pregnancy. Wide variations in the use of ultrasounds were discussed at teaching rounds in a state university. The effect of the reviews and presentation had an immediate impact on the physicians participating, and we anticipate favorable results.

**MEDICAL MANAGEMENT**

A brief description of each major service offered by our UR program is as follows:

- Precertification of all elective hospital procedures, inpatient and outpatient, as well as MAPS Protocols.
- Concurrent review of hospitalizations and focused diagnoses cases.
- Retrospective review of emergency admissions and care.
- Large and small case management.
- Reporting and coordination of large case management with stop loss carriers.

The following criteria and norms are used for admission and certification. Milliman & Robertson Length of Stay Guidelines are referenced for LOS for inpatient admissions, and for those procedures that should be ambulatory or managed in the doctor's office or patient's home. MARRS reviews procedures and judges appropriateness of the procedure prior to admission. MARRS procedures are updated as often as research mandates.

Physician consultants enter the review process during pre-admission certification and continued stay review. The RN reviewer refers cases to a physician consultant first by telephone, then by providing requested documents to the physician consultant (by mail, fed-ex or on-site meetings at Health Network America).
when given enough helpful information, patients and their doctors make good decision about the use of health care resources.

QUALITY ASSURANCE PROGRAMS

The following is a complete description of the role and function of the quality assurance committee(s). Quality Assurance Committee includes our Medical Director (Eugene Cheslock, MD); selected physician consultants (Harvey Waxman, MD and Barry Schifrin, MD) the Claims Manager (Judy Strocchio); and the Nurse Case Management Team.

Following is a detailed description of the quality assurance program, including written procedures for:

a. Problem identification

"Problems" are identified for review by any of the following: patient verbal or written request, physician request, client request, claims review or member benefit history report.

b. Evaluation

The Claims Processors and Health Services staff compile needed materials for referred to the Q/A Committee. Evaluation is done based upon the materials presented or additional documentation will be requested.

c. Resolution

Resolutions are communicated in writing to all involved parties. Resolutions are documented in the MIS system and in case management files if appropriate.

d. Follow-up

All parties involved are advised of the outcome of the appeal process and advised to submit additional materials for review if necessary.

e. Re-assessment

The Committee Process is repeated.

We perform profiling of provider practice patterns. Member benefit history reports allow review of a specific provider and all services rendered to a single patient or to all patients covered by the client. MARRS protocols for referred cases are reviewed, and providers whose protocols refer repeatedly are reviewed by the Medical Director.

We utilize formal quality of care indicators. Health Network America’s focus is on quality of care. Quality at HNA is quantified. The following equation is used to define health care quality for our clients:

\[
\text{Quality} = \text{perception} + \text{medical outcome} \quad \text{Value} = \frac{\text{Quality}}{\text{Cost} (\$)}
\]
Described below are some of the diagnoses employed to identify large case management candidates. In addition we review every case which exceeds 50% of the stop loss carrier's individual stop loss point.

- AIDS
- Spinal Cord Injuries
- Head Traumas
- Premature Births
- Coronary Bypass
- Serious Burns
- Cancer

- Multiple or serious fractures
- Amputations
- Crushing or massive internal injuries
- Organ Transplants
- Artificial Implants
- Serious psychoneurosis impairment
- Hospitalizations of one month or more

Case management assessments and activities are usually performed by telephone. Initial identification of the case is done by phone but certain stop loss carriers perform on-site case management. Ongoing telephone management is performed by both case management staffs.

SUMMARY

Utilization Management at Health Network America seeks to achieve the appropriate level of care for patients. Our utilization program is purely one of patient advocacy because Health Network America does not benefit financially from averted claims. To fulfill our mission to get as many patients to the right level of care the first time, we must remain, "the advocate" of patients and their physicians without financial conflicts of interest. 100% of all medical care savings achieved by Health Network America goes to employers and their employees based upon cost sharing arrangements described in their health benefit plans.

It is not merely the unit cost of medical service, but rather what medical services are received over time that determine health costs, patient outcome and provider income.
PRE-CERTIFICATION REQUIREMENTS

- At least 7 days prior to hospitalization or within 2 business days of an emergency, you or your doctor must call Health Network America at 1-800-942-7772.
- Consult your "Summary of Benefits" for additional pre-certification requirements.
- Failure to follow pre-certification procedures may result in a reduction of benefit.
- Send claims to:
   142 Monmouth Parkway • West Long Branch, NJ 07764

THE MULTIPLAN STICKER ON THE ID CARD ONLY ALLOWS THE MEMBER TO ACCESS MULTIPLAN'S FACILITY NETWORK ONLY.

HNA'S CONTRACT SUPERcedes ALL OTHER DISCOUNTS.