Claim Reference Guide

Catastrophe Major Medical Plan

Sponsored by:

NYSUT Member Benefits Catastrophe Major Medical Insurance Trust

Policy #: CMMI-003 / CMMI-004

Why would I need the
Catastrophe Major Medical (CMM) Plan?

Regardless of your age or the type of basic medical insurance (Basic Plan) you have, you and your family members could still be left with extraordinary out-of-pocket medical expenses. This is especially true if you have a serious medical issue, are confined to a nursing home or convalescent care facility for convalescent or custodial care, or need home health care.

The CMM Plan offers supplemental coverage that you and your eligible family members may need. Once the deductible has been satisfied, this plan provides benefits for eligible expenses that your Basic Plan may not fully cover.

How does
the CMM Plan work?

Note - Full plan details can be found in the CMM Plan Document.

To be eligible for benefits under the CMM plan, you must be covered under a basic health plan (Basic Plan), as defined in the CMM Plan Document. The Plan reimburses a percentage of expenses for medically necessary covered charges after your Basic Plan(s) has paid its benefits, you have met the annual out-of-pocket deductible, and/or you have satisfied any applicable benefit eligibility criteria.

What the Plan pays depends on whether you used a provider who was considered an In-Network provider or an Out-of-Network provider under your Basic Plan. If you receive medical services or supplies from a provider who was contracted with the network of the Basic Plan (In-Network), this Plan will reimburse you a higher amount and you will be responsible for paying less money out of your pocket. Additionally, your annual out-of-pocket expenses for In-Network Essential Health Benefits services and supplies will be limited in accordance with the federal health law.

For prescription drugs, what the Plan pays depends on whether your medication is listed on the formulary of your Basic Plan. Medications that are not listed on the formulary of your Basic Plan are considered Out-of-Network drugs, are subject to a higher cost-sharing, and the amount you pay does not count toward the In-Network out-of-pocket maximum.

What is
the Plan's deductible?

The CMM Plan is designed to provide coverage for eligible medical expenses that are not covered by your basic health plan after you satisfy your annual out-of-pocket deductible.

The deductible is the amount you owe each calendar year before this plan begins to pay benefits.

Description	In-Network	Out-of-Network
Preventive Benefits	No deductible	No deductible
Overall Annual Out-of-Pocket Deductible	$2,500/Individual $5,000/Family	$5,000/Individual
Custodial Care in a Convalescent Home, Custodial Care Facility, Nursing Home, Assisted Living Facility or Skilled Nursing Facility	No deductible. Benefits start on the 20th day of confinement. (This is not an annual requirement.)	No benefits for an Out-of-Network facility.
Home Health Care	No deductible. Benefits start after the 60th hour of home health care has been paid.	No deductible. Benefits start after the 60th hour of home health care has been paid. The Plan then pays 20% of the eligible expenses.

Non-eligible charges do not count toward the deductibles. Charges incurred In-Network are not counted toward the Out-of-Network deductible and charges incurred Out-of-Network are not counted toward the In-Network deductible.

What is
the Plan's benefit period?

"Benefit period" means the period of time during which benefits are payable. The CMM Plan's benefit period is the calendar year and runs from January 1 to December 31.

How do
I submit a claim?

The CMM claim process requires the claimant to complete a form and submit certain documentation, which may include Explanation of Benefits (EOB) statements from your basic health insurance plan(s), itemized bills from service providers and payment receipts.

Send your claim form and documentation to:

Mail: HealthSmart Benefit Solutions, Inc.
PO BOX 1014
Charleston, WV 25324-1014
Fax: 806.473.2535
Online: healthsmart.com/nysut.

Claim Submission **Deadline**

Claims must be filed within two (2) years of incurring the claim expense.

Claims associated with benefit period effective dates prior to January 1, 2018 should continue to be sent to Mercer Consumer. Contact Mercer at 888-386-9788 to verify a previous claim submission or benefit period effective date.

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Frequently Asked Questions
Claim Submissions

Q. How can I obtain a copy of the CMM Plan Document?

A. For the Voluntary CMM Plan Document (Policy # CMMI-003), you can download a copy at healthsmart.com/nysut or call HealthSmart Benefits Solutions, Inc. (HealthSmart) toll-free at 844-552-7805. For the Group CMM Plan Document (Policy # CMMI-004), contact NYSUT Member Benefits CMM Insurance Trust at 800-626-8101.

Q. Who do I contact with questions about my claim?

A. Visit HealthSmart at healthsmart.com/nysut or contact them toll-free at 844-552-7805 to ask questions and/or obtain a claim form. HealthSmart's customer service hours are Monday through Friday from 8 a.m. to 5 p.m. (EST).

Q. How will I receive my claim payment?

A. There are two ways you can receive your claim payment - by check through the mail or via direct deposit to a checking or savings account. To select the direct deposit option, you will need to fully complete the Authorization Agreement for Direct Deposit form and send it to HealthSmart. Setup requires ten (10) business days from the date of receipt to activate. Direct Deposit forms are available at healthsmart.com/nysut or by calling 844-552-7805.

Q. Is Medicaid, a State Children's Health Insurance Plan (CHIP), Tricare, or an individual plan that is purchased on or off any state/federal Marketplace/Exchange considered a basic health plan?

A. No, these plans are not considered Basic Plans under the CMM Plan. See the CMM Plan Document for a full description of Basic Plan and how the CMM Plan coordinates with these programs.

Q. Who can sign the claim form?

A. The claimant should sign all required forms. If the claimant is incapacitated, the person or persons named in a durable power of attorney, health care power of attorney or health care proxy can sign the forms on behalf of the claimant. A copy of the document is required. If the claimant is a minor, the parent or legal guardian should sign all forms.

Q. What information is needed for claim submission?

A.
1. An Explanation of Benefits (EOB) from all of your insurance providers;
2. An itemized statement from your service provider; and
3. Proof of payment.

For prescription drug claims, you will need to include a pharmacy receipt and prescription details provided by the pharmacy. For convalescent/custodial care and home health care claims, see the FAQs for Nursing Home, Home Health Care & Private Duty Nursing and the Checklist found later in this document.

Q. What is an acceptable proof of payment?

A. A receipt, canceled check or credit card statement showing that you paid a service provider would suffice as proof of payment.

Q. What is contained in an itemized statement?

A. An itemized statement contains the patient's name; the date(s) of service; a description of the services, prescriptions or supplies; appropriate medical or drug coding (CPT/HCPC/Revenue codes or NDC #); the fee for each service, prescription or supply; the diagnosis or ICD-10 code; and the name, address, telephone number, professional status and Federal Tax Identification number of the health care provider.

Q. What does Out-of-Network mean?

A. Out-of-Network means services or supplies provided by a Physician, provider or facility that is not a member of a Basic Plan's Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), or Health Maintenance Organization (HMO) or, when Medicare is the Basic Plan, by a provider that is not enrolled in Medicare. The information in an Out-of-Network provider's itemized statement is used to determine the reasonable and customary fee for the service provided.

Q. What does reasonable and customary mean?

A. It means the amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar service. When processing claims, for the purposes of reaching the deductible or reimbursement requests for eligible expenses, the reasonable and customary allowance will be applied and may result in the amount being less than submitted.

Q. When does my benefit period begin?

A. This Plan's benefit period is a calendar year and runs from January 1 to December 31. For benefit period effective dates on or before December 31, 2017, the Prior Plan(s) applies until the end of the five (5) year benefit period. To determine the start date of your current benefit period, contact Mercer Consumer at 888-386-9788.

Q. How do I file an appeal on a claim?

A. If your claim is denied, or if you disagree with the amount paid on a claim, you may submit your appeal within 180 days of the date on this Plan's EOB to HealthSmart Benefit Solutions, Inc., PO Box 1014, Charleston, WV 25324-1014. In your appeal, please include the claimant's name, the policy number (CMMI-003 or CMMI-004), the claim number(s) you wish to appeal, the issues, concerns and comments you would like considered, and any additional information, not originally submitted, that you would like reviewed.

Q. What information is needed to file a claim on behalf of a deceased participant?

A. The death certificate should be included with the claim submission. If benefits are assigned to a provider, the Plan will release benefits directly to the provider. If the benefits have not been assigned, the Plan will pay benefits to the executor or administrator of the participant's estate otherwise the Plan will determine the beneficiary according to the CMM Plan Document (Policy #CMMI-003).

Questions

Call HealthSmart toll-free at 844-552-7805, Monday through Friday 8 a.m. to 5 p.m. EST or visit healthsmart.com/nysut.

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Frequently Asked Questions
Nursing Home, Home Health Care, Private Duty Nursing

Q. What is the convalescent/custodial care benefit and how does it work?

A. Benefits are provided for certain facilities, which provide medically necessary inpatient care, usually following a hospitalization. Benefits begin on the 20th day of confinement which is due to an injury or sickness and has been prescribed by the attending physician. Facilities such as convalescent homes, custodial care facilities, skilled nursing homes and assisted living facilities are examples of the types of facilities defined in the Plan. A copy of the facility's license may be required to determine if the facility qualifies under the Plan. A facility is considered "in-network" if it is Medicare-certified, or in the case of an Assisted Living Facility, is licensed or certified to operate under the laws of the state in which it is located. The maximum benefit for expenses for room and board, general convalescent care services and supplies for convalescent or custodial care as an inpatient in a convalescent/nursing home is $72 per day. This benefit has a lifetime maximum of $80,000.

Q. What is the home health care benefit and how does it work?

A. If you need care at home, after 60 hours of home health care are paid each calendar year, the plan will cover up to 25 hours per week, up to 6,000 hours lifetime. The visits must be deemed medically necessary, part of a program of care prescribed by your physician, and provided by a home health agency that is Medicare-certified or licensed or certified by a state department of health or other state regulatory authority responsible for licensing or certifying home health care agencies. Treatment must be in lieu of a confinement in a hospital or skilled nursing facility. Coverage is provided for part-time or intermittent nursing care, home health care aide services, physical therapy, occupational therapy and speech therapy. Home health care benefits provided by a licensed or certified individual care giver who is not employed by an approved Home Health Care Agency will be paid at 20% of the eligible expense.

Q. Is an employment agency the same as a home health care agency that is licensed or certified by a state department of health or other state regulatory authority?

A. No. Employment agencies are not the same as home health care agencies licensed or certified by a state department of health or other state regulatory authority. Some states may allow employment agencies to operate under a business license and provide non-medical care services, but they are not required to meet state or federal regulations as a home health care agency.

While each state has its own licensing standards for home health care agencies, generally, states require that a home health care agency must provide background checks on their employees, verify the certification/licensure of all personnel, provide ongoing education for personnel who provide direct care to patients, provide supervisory visits by a registered nurse to the home of a patient receiving home health aide services, establish a plan of care or plan of treatment with the patient's physician, and maintain clinical records.

Q. How can I find out if a home health care agency is Medicare-certified?

A. Medicare-certified home health care agencies are listed on Medicare's website at www.medicare.gov or call 1-800-MEDICARE.

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Q. Will the Plan pay convalescent/custodial care and home health care benefits at the same time?

A. No. Benefits will not be paid for both convalescent/custodial care and home health care received on any given day. If the participant is receiving home health care while in an assisted living or other facility where convalescent/custodial care is being received, claims will be paid based only on the higher claim amount.

Q. What is the private duty nursing benefit and how does it work?

A. Private duty nursing is the provision of medically necessary, complex skilled care, in the home or while hospitalized, on a fee-for-service basis by a Registered Nurse (RN) or Licensed Practical Nurse (LPN). A letter from the ordering physician will be required, which details the complex skilled care to be performed, the number of hours ordered, and the frequency and duration of care. If services are provided while hospitalized, the letter will need to include why the skilled care could not be performed by the hospital's staff nurses. Coverage is provided for eligible private duty nursing services at 100 percent of the submitted expense, up to a maximum of $120 per eight hour shift, or $360 per day. The maximum benefit payable for these services while insured is $35,000. Certified nursing assistants and/or home health aides are not nurses, but rather nursing assistants/aides, and are not covered under the private duty nursing provision.

Questions

Call **HealthSmart** toll-free at 844-552-7805, Monday through Friday 8 a.m. to 5 p.m. EST or visit healthsmart.com/nysut.

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✓ Checklist for Catastrophe Major Medical Claims

Do you have everything you need?

To process your claims, we will need the following documents, otherwise your reimbursement may be delayed. All documents listed below are required. *Please note, anything followed by an asterisk (*) is only needed for the initial claim unless the provider changes.*

This checklist should be used as a guide.

	Type of Claim		
	Medical (Including Rx)	Facility	Home Health Care (HHC)
CMM Claim Form	X	X	X
Itemized Bill	X	X	X
Explanation of Benefits from all other plans (including Medicare)	X		
Proof of Payment	X	X	X
Initial Treatment Plan from Physician		X	X
Facility Questionnaire *		X	
Facility License (copy)		X	
HHC Questionnaire *			X
HHC Agency License (copy) *			X
HHC Daily Logs			X
LTC Policies		X	X

This list is not all inclusive.

Note: The Facility Questionnaire and HHC Questionnaire are available online at healthsmart.com/nysut or by calling Customer Service at 844-552-7805.