

# Catastrophe Major Medical Plan Claim Reference Guide

CATASTROPHE MAJOR MEDICAL PLAN  
Policy #CMMI-001

Sponsored by  
NYSUT Member Benefits Catastrophe  
Major Medical Insurance Trust



Sponsored by:



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## Why the Catastrophe Major Medical (CMM) Plan?

The CMM plan complements your basic health insurance plan by covering expenses for services that may be limited or not covered by your basic health insurance and/or Medicare, including out-of-pocket costs such as coinsurance, co-pays and deductibles.

## How Does The Catastrophe Major Medical Plan Work?

After satisfying the deductible, the CMM plan can help cover eligible, reasonable and customary expenses in excess of your basic health coverage. <sup>1</sup> The plan document fully describes the plan's coverage.

### IMPORTANT

- CMM Plan Certificate of Insurance (Policy # E-170,129), underwritten by the United States Life Insurance Company in the City of New York, remains in effect for benefit period effective dates 12/31/13 or before.
- CMM Plan Document (Policy #: CMMI-001), sponsored by NYSUT Member Benefits Catastrophe Major Medical Insurance Trust, is in effect for benefit period effective dates 1/1/14 or beyond.

## Plan Details

To qualify for the CMM plan, you must be covered under a basic health plan or Medicare parts A and B. The required basic health plan is a medical insurance plan that provides the following minimum benefits:

- Semi-private room and board of \$300 a day for a minimum of 70 days;
- \$25,000 in extra services; and
- \$5,000 surgical schedule.

If you do not have basic health insurance equal to the benefits specified above or Medicare parts A and B, any charges incurred for the following will not be covered:

- The first 70 days of hospital confinement;
- The first \$10,000 of radiation or chemotherapy, physical or speech therapy;
- The first \$50,000 of services received from all physicians; and
- The first \$2,500 of out-of-hospital prescription drugs.

*Note: Medicaid pays after all other plans and does not qualify as a basic plan.*

### Deductible

A \$25,000 deductible <sup>2</sup> must be satisfied under the CMM plan before any benefits are paid. You have up to three years to accumulate the \$25,000 deductible. You can use covered expenses paid by your basic health plan(s) and/or Medicare to satisfy the deductible in addition to out-of-pocket expenses.

### Eligible Expenses

Only charges that are for medically necessary care and are incurred by you or your basic health plan are eligible expenses under the CMM plan. Many basic health plans have discount arrangements with providers; therefore, a billed charge may be greater than what this plan considers an eligible expense.

### Benefit Period

Benefits are payable when a covered participant incurs eligible charges in excess of the deductible. The benefit period begins on the date the first eligible charge toward the deductible is incurred. The benefit period will end on the earliest of: five years from the day the eligible expenses toward the deductible were first incurred; or the end of 12 consecutive months during which no charge was incurred for an injury or sickness.

### Submitting a Claim

Please send your completed claim form, itemized bills and statements of payment or rejection from your basic plan(s), (also known as an Explanation of Benefits (EOB)) to:

### Mercer Consumer

PO Box 10362  
Des Moines, IA 50306-0362

**CLAIMS SUBMISSION DEADLINE** : Claims must be filed within five (5) years of incurring the claim expense for benefit period effective dates 1/1/14 or beyond.

<sup>1</sup> Certain benefit categories (nursing home, home health care and private-duty nursing) have specific lifetime or calendar year limits.

<sup>2</sup> Some CMM participants may have a \$15,000 deductible, in which case, 12 months is allowed to accumulate expenses to satisfy the deductible.

## Covered Charges

This listing is representative of the expenses eligible under the plan. Covered charges are detailed in the Plan Document.

Expenses must be considered reasonable and customary, incurred for necessary treatment, and for services and/or supplies ordered by a physician. Eligible expenses include:

- Hospital charges for daily room and board, intensive care and services and supplies;
- Diagnosis, treatment and surgery by a licensed physician, whether in a hospital, in the office, or at home;
- Out-of-pocket deductibles, co-payments and co-insurance required by basic medical and prescription drug plans;
- Physiotherapy given by a licensed physiotherapist;
- Anesthetics and their administration;
- X-ray or laboratory services for diagnosis and treatment;
- Oxygen and rental of equipment for its administration, rental of wheelchairs and hospital beds;
- Rental of other mechanical equipment for medical or surgical treatment;
- Ambulance service to or from a hospital;
- 85 percent of reasonable and customary, medically necessary private-duty nursing charges for services rendered in a hospital or at home — \$120 per eight-hour shift up to a lifetime maximum of \$35,000 per insured;
- Expenses for room and board, general convalescent care services and supplies for convalescent or custodial care as an inpatient in a convalescent/nursing home up to \$500 per week. This benefit has a lifetime maximum of \$80,000;
- Up to 1,200 hours of home health care visits per calendar year. Home health care services must be provided by a licensed and certified home health care agency. The visits must be under a program prescribed by your physician and provided by a home health care agency licensed by your state department of health or as defined in Title XVIII of the Social Security Act. Treatment must be in lieu of a confinement in a hospital or skilled nursing facility;
- Charges made by a hospice program for 210 consecutive days of confinement or home care and outpatient services, including drugs and medical supplies. Up to five visits per benefit period for bereavement counseling to the family of the terminally ill insured;
- Charges incurred for diagnosis and treatment of alcoholism, alcohol abuse, substance abuse or substance dependency while hospitalized; for inpatient or outpatient rehabilitation in a certified or accredited alcohol or substance abuse treatment center;
- Charges incurred for diagnosis and treatment of psychiatric, mental, nervous, or emotional disorders, ailments or illnesses while hospitalized or outpatient visits provided according to plan specifications; and
- Dental treatment is covered only if natural teeth are injured by a non-job related accident.

## Charges Not Covered

This listing is representative of the charges not covered. All exclusions and limitations are detailed in the Plan Document.

This plan does not cover loss caused by or resulting from one or more of the following:

- Intentionally self-inflicted injuries;
- War or acts of war;
- Experimental treatment, including drugs and such treatment that is not essential for the care and treatment of an injury or sickness;
- Treatment that would be given free of charge if the person were not covered under this plan;
- Treatment given by a claimant's family member or employer; or
- Treatment given while serving full-time active duty in the armed forces.

The plan does not cover charges to buy or rent:

- Air conditioners;
- Air purifiers;
- Motorized transportation equipment;
- Escalators or elevators in private homes;
- Eyeglass frames or lenses;
- Hearing aids;
- Swimming pools or supplies for them; or
- General exercise equipment.

The plan does not cover:

- Charges for routine physical exam, except charges for preventive mammography and cytologic screening; or
- Charges for bed holds in a convalescent home or custodial care facility.

## Questions and Answers

### General Claims

**Q: Where do I submit my claim?**

**A:** Please send your completed claim form, and itemized bills, statements of payment or rejection from your basic plan(s), also known as Explanation of Benefits (EOB) to Mercer Consumer (formerly Marsh), P.O. Box 10362, Des Moines, IA 50306-0362.

**Q: Who do I call with questions about my claims?**

**A:** You can call Mercer Customer Service toll-free at 888-386-9788.

**Q: Is Medicaid considered a basic health plan?**

**A:** No, Medicaid is not considered a basic health plan. The Medicaid program by law is intended to be the payer of last resort; all other government and private health care programs, including private insurance, must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid.

**Q: Who can sign claim forms and HIPAA forms?**

**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: Are cancelled checks or balance due statements acceptable proof of a claim?**

**A:** No. Cancelled checks and balance due statements do not contain the necessary information needed to make a determination regarding the eligibility of a service. Itemized bills and the corresponding EOB from all base carriers are needed.

**Q: What is contained in an itemized billing statement?**

**A:** An itemized bill contains the patient's name; the date(s) of service; a description of the services, prescriptions or supplies; appropriate medical or drug coding (CPT/HCPCS/Revenue codes or NDC #); the fee for each service, prescription or supply; the diagnosis or ICD-9 code; and the name, address, telephone number, professional status and Federal Tax Identification number of the health care provider.

**Q: What is a non-participating provider?**

**A:** A non-participating provider (also known as an out-of-network provider) is a health care professional that has not contracted with a health insurance company to provide services at a reduced fee. When that occurs, the information in an itemized billing 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 charge is the normal charge for a certain procedure or service performed by individual medical providers in your area. When applying expenses toward the deductible, the eligible expenses will be the reasonable and customary allowance, which may be less than the medical provider charged.

**Q: How do approved amounts, negotiated rates and discounts affect the amount of eligible expenses being applied toward my deductible?**

**A:** This Plan only provides coverage for those medical expenses listed as eligible in the plan document, which the patient actually incurred and has paid or is legally obligated to pay, or a minor's legal guardian has paid or is legally obligated to pay. When a provider gives a discount or agrees to accept the base plan allowance as payment in full, the provider is agreeing to reduce their charges and the balance of the charge is written off. Since you are not legally obligated to pay the amount written off by the provider, that amount cannot be applied toward your deductible. Claims involving Medicare, HMOs, PPOs, pharmacy discounts and prompt payment discounts are examples of such situations.

**Q: When does my benefit period begin?**

**A:** The benefit period begins with the first covered charge, which is applied toward the deductible. All charges submitted will be considered in accordance with the provisions of the plan. Submitted charges cannot be withdrawn.

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

**A:** The Death Certificate and the estate papers or letters testamentary should be included with the claim submission. If benefits are assigned to the provider, we will be able to release those benefits directly to the provider. If benefits are unassigned, benefits cannot be released without estate papers or letters testamentary. If no estate has been created, we may pay benefits directly to the nearest of kin with a completed Release and Indemnity Agreement. However, we will not pay any benefits totaling more than \$10,000 without a court appointment.

**Q: How do I file an appeal on a claim?**

**A:** Please submit your appeal within 180 days of the date on this plan's EOB to Mercer Consumer (formerly Marsh), P.O. Box 10362, Des Moines, IA 50306-0362. In your appeal, please include the claimant's name, the group policy number (CMMI-001), 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.

## 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. Once the deductible is met, benefits begin on the sixth day of confinement which is due to an injury or sickness and has been prescribed by the attending physician. Facilities such as convalescent homes, extended-care facilities, custodial-care facilities, skilled nursing homes, assisted-living facilities and personal-care homes are examples of the types of facilities defined in the plan. A copy of the facility license will be required to determine if the facility qualifies under the plan. 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 \$500 per week. 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 while you are recovering, the plan will cover up to 1,200 hours per calendar year. Coverage is provided for part-time or intermittent nursing care, home health care aide services, physical therapy, occupational therapy and speech therapy. The visits must be under a program of care prescribed by your physician and provided by a home health care agency licensed by a state department of health or as defined in Title XVIII of the Social Security Act. Treatment or service must be in lieu of a confinement in a hospital or skilled nursing facility.

**Q: Is a registry, employment agency or other personal care firm the same as a home health care agency licensed by a state department of health?**

**A:** No; registries, employment agencies or other personal care firms are not the same as home health care agencies licensed by a state department of health. Some states may allow registries, employment agencies or other personal care agencies or firms to operate under a business license and provide non-medical care services, but they are not required to meet a state department of health's 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: Does a Medicare-certified home health care agency meet the plan requirements as a home health care agency?**

**A:** Yes; a Medicare-certified home health care agency meets the plan's requirements as a home health care agency. Medicare-certified home health care agencies are listed on Medicare's website at [www.medicare.gov](http://www.medicare.gov) or call 1-800-MEDICARE.

**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 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 85 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.

## Coverage and Administrative Issues

### Q: How do I change my name or address?

A: Please call toll-free at 888-386-9788 or mail your request to Mercer Consumer (formerly Marsh), P.O. Box 10362, Des Moines, IA 50306-0362. Please include your group policy number on any correspondence sent to us.

### Q: How can I obtain a copy of my plan document?

A: You can request a copy of the plan document from Mercer Consumer. Please call toll-free at 888-386-9788 and a copy will be mailed to you.



## Questions

- Call Mercer Consumer toll-free at 888-386-9788.