



MOUNTAIN STATES

ADMINISTRATIVE SERVICES



Self-Funding 101

Q What is a self-insured health plan?

A Your company has chosen a self-insured health plan. A self-insured group health plan (or a “self-funded” plan) is one in which the employer assumes the financial risk for providing healthcare benefits to its employees. In practical terms, self-insured employers pay for claims as they are incurred, instead of paying a fixed premium to an insurance carrier, which is known as a fully insured plan.

Q Who administers claims for self-insured group health plans?

A Most self-insured employers subcontract this service to a third party administrator (TPA). TPAs help employers set up self-insured group health plans and coordinate provider network contracts and utilization review services. Mountain States Administrative Services (MSAS) is the TPA for your group health plan.

Why we request additional information

Q Why do I need to complete a general information form?

A An “other insurance” form is requested to ensure that we have the most current information on file regarding eligibility and other insurance information on all members. This information is requested approximately once per year, unless information received from a provider is different from the information we have on file.

Q Why does MSAS request full-time student verification?

A Please refer to the section of Eligible Classes of Dependents in your Plan Document. It defines the dependent age that the plan requires verification of full-time student status. Once your dependent reaches that age, we must verify that your child is a full-time student. If your dependent child is a full-time student, the accredited school that your child is attending must either complete the full-time student verification form or provide signed, written documentation of full-time student verification for the required semester/quarter. This information is requested twice a year.

Q Why did I receive a letter requesting accident details?

A We received a bill from your provider for services that appear could be related to an accidental injury. This could be related to any type of accident, not specifically an automobile accident. Please complete the requested questionnaire and return it to our office so that the claim(s) may be completed.

Q Why doesn't MSAS process a claim from a balance due statement?

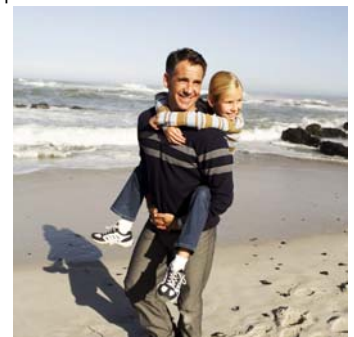
A There are certain pieces of information required to process a claim: provider name, provider tax ID number, patient name, date of service, CPT/procedure codes, diagnosis code, and charged amount for each code. A balance due statement does not include all of the above information necessary to review and process a claim.

Q Why do you ask for a certificate of creditable coverage?

A You should have been provided a certificate of creditable coverage (CCC) from your prior group health plan or health insurance carrier when your prior coverage terminated. You have rights regarding reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan. It is imperative that MSAS receive all certificates of creditable coverage from any health plan(s) that you may have been enrolled in during the year prior to your effective date with your current group health plan. The processing of claims may be delayed if the CCC is not received.

Q Why do you ask for names and addresses of prior treating physicians?

A This information is required to conduct a pre-existing condition investigation, as stated in your group's Plan Document. A pre-existing condition can be defined as a condition for which medical advice, diagnosis, care, or treatment was recommended within the six-month period prior to the member's enrollment date. If the member had a significant break in coverage or did not have prior coverage then any charges incurred are not payable unless incurred 12 consecutive months, or 18 months if a Late Enrollee after the person's Enrollment Date.





General insurance Definitions

Q What is a PPO?

A PPO is the abbreviation for a Preferred Provider Organization which is a group of physicians or other medical service providers. These participating providers have agreed to perform their services at a negotiated discount in exchange for payment and increased patient volume. Normally, higher levels of benefits are obtained using PPO providers. Any amounts listed on your Explanation of Benefits (EOB) as a PPO discount are not the responsibility of the patient.

Q What is a deductible?

A The initial portion of a covered expense that must be paid by the insured participant before the insurance policy will pay its part of the expense. For example, if the deductible is \$1,500, then you must pay the first \$1,500 of the covered medical costs before the insurance will pay.

Q What is co-insurance?

A Coinsurance is generally shown as a percentage of covered expenses above the deductible. For example, doctor and hospital visits may be covered on an 80/20 coinsurance – with your plan covering 80% of a \$10,000 hospital bill – while the participant is responsible for the remaining 20% or \$2,000.

Q What is an out-of-pocket maximum?

A Out-of-pocket costs are healthcare expenses that you pay even though you are insured and have already paid a premium. An out-of-pocket maximum is a cap on how much you will have to pay for your family's covered medical expenses in a calendar year. After you reach the out-of-pocket maximum, the plan pays 100% of all remaining covered expenses for that year; with the exception of those benefits specifically listed in your plan document as never paying at 100%.

Q What is Utilization Management?

A Utilization Management (UM) helps steer participants to in-network utilization of benefits and also verifies the medical necessity of services. UM establishes an integrated, comprehensive and systemic approach to the assessment of the important aspects of healthcare. As an advocate for participants, UM nurses help ease the stress and uncertainty of navigating the healthcare system. They steer plan participants to use in-network providers to help reduce expenses. In the event that an out-of-network provider is the only option, UM programs will refer the participant to Case Management for rate negotiations.

Q What is Case Management?

A Case Management identifies participants who have experienced or who are at risk for a catastrophic illness or injury and/or are a potentially large claim case. Case Managers will encourage appropriate use of healthcare services and help ensure access to quality care. Case Managers are trained to identify and intervene on cases with potential long-term medical complications.

Q Why do I need to pre-certify an admission?

A Utilization Management programs require pre-certification of admissions. UM programs are designed to help ensure that all covered persons receive necessary and appropriate healthcare while avoiding unnecessary expenses. Pre-certification requirements are outline in your Plan Document.

About MYMSAS.com

Q How do I register?

A Visit www.mymsas.com. On the left side of the webpage click on LOGIN. Complete the brief registration to access mymsas's valuable tools and resources.

Once you are registered on mymsas.com you will be able to view your claims and access your Explanation of Benefits (EOBS)

Q How do I request a new ID card?

A You can request a new id card two ways:

1. by calling MSAS at (800) 866-4731.
2. or by visiting our website www.mymsas.com. Click the header "Contact Us" at the top of the page. Click on the email address jmoran@mymsas.com and indicate your name, employer and the number of new cards you need and send the email. Cards are printed every Tuesday and Thursday.

