WISCONSIN PROVIDER REQUIREMENTS

1. Liability Insurance Requirements.

A. Providers/Practitioners/Facility.

All Providers must have a cash or surety bond, self-insurance or professional liability policy with a minimum limit of $1,000,000 per occurrence/$3,000,000 aggregate, except for practitioner types like Public Health Service as discussed below:

Public Health Service: Federally-supported health centers are deemed to be employees of the federal government and as such, are protected under the Federal Tort Claims Act (FTCA). These may include specified community health centers and Indian reservations. There are no liability limits specified, but FTCA meets any malpractice insurance coverage limits that may be required.

2. Continued Provision of Health Services for Certain Members after Termination of the Agreement or Termination of Facility Provider or Clinic Provider Participation.

Unless otherwise provided in the Administrative Requirements, in the event the Provider Participation Agreement is terminated by Provider for any reason, the Agreement is terminated by Medica without cause, or, notwithstanding anything herein to the contrary, in the event of any removal of Provider, a Clinic Provider, a Facility Provider, or a Provider location from Medica's networks that gives rise to a legal continuity of care obligation with regard to the services of a Provider, a Clinic Provider, a Facility Provider, or a Provider location, Provider will, and will cause Facility Providers and Clinic Providers to, continue to provide Health Services according to the terms of the Agreement to Members covered under a Benefit Contract after such termination. Such continuation of care will apply when requested by a Member and Medica determines that such Member meets the statutory criteria for in network benefits or continuity of care. Health Services provided in accordance with this subsection 9.4.3 of the Provider Participation Agreement will be provided for:

A. Medica will, with respect to covered benefits, provide coverage to a Member for the services of a Provider, regardless of whether the Provider is a participating provider at the time the services are provided, if the defined network plan represented that the Provider was, or would be, a participating provider in marketing materials that were provided or available to the Member at any of the following times:

i. If the plan under which the Member has coverage has an open enrollment period, the most recent open enrollment period.
ii. If the plan under which the Member has coverage has no open enrollment period, the time of the Member's enrollment or most recent coverage renewal, whichever is later.

B. Medica will provide the coverage required under A. above with respect to the services of a Provider who is a primary care physician for the following period of time:
   i. For a Member of a plan with no open enrollment period, until the end of the current plan year.
   ii. For a Member of a plan with an open enrollment period, until the end of the plan year for which it was represented that the Provider was, or would be, a participating provider.

C. If a Member is undergoing a course of treatment with a participating provider who is not a primary care physician and whose participation with the plan terminates, Medica will provide coverage under A. above with respect to the services of the Provider for the following period of time:
   i. Up to ninety (90) days if the Member was undergoing a current course of treatment for one or more of the following conditions at the time of termination:

Individual & Family Business (IFB) Members:

a. An ongoing course of treatment for a serious acute condition, such as chemotherapy for the treatment of cancer;
b. An ongoing course of treatment for a chronic condition;
c. Undergoing a course of institutional or inpatient care from the Provider or facility;
d. Scheduled non-elective surgery, including postoperative care;
e. If Member is pregnant and undergoing a course of treatment for pregnancy, Health Services may continue to be provided through the postpartum period for woman and infant; or
f. An ongoing course of treatment for a health condition for which a treating physician or Provider attests that discontinuing care by that physician or Provider would worsen the condition or interfere with anticipated outcomes.

Commercial Members:

In-network benefits will continue to apply to health services Member receives from a Provider (1) if that Provider was listed as a network provider in the Medica provider directory at Member's last enrollment period or Member's last coverage renewal period, or (2) Medica Member's employer terminates its health plan and their current treating Provider is not a network provider, for the following periods of time:

i. Up to ninety (90) days if the Member was undergoing a current course of treatment for one or more of the following conditions at the time of termination:

a. An ongoing course of treatment for a serious acute condition;
b. An ongoing course of treatment for a chronic condition;
c. Undergoing a course of institutional or inpatient care from the Provider or facility;
d. Scheduled non-elective surgery, including postoperative care; or
e. If Member is pregnant and undergoing a course of treatment for pregnancy, Health Services may continue to be provided through the postpartum period for woman and infant.

ii. Continuation of services or treatment may extend to the remainder of Member's life, if life expectancy is 180 days or less.

D. The coverage discussed here may not be provided or may be discontinued if any of the following applies:
   i. The Provider no longer practices in the defined network plan's geographic service area.
   ii. The insurer issuing the defined network plan terminates or terminated the Provider's contract for misconduct on the part of the Provider.
E. Health Services provided in accordance with Subsections 9.4.3 of the Provider Participation Agreement will be reimbursed by Medica in accordance with the terms of the Appendices to the Agreement.
F. As stated in your Provider Participation Agreement, Provider will accept as payment in full Medica's reimbursement to Provider for such Health Services at the contracted rates applicable prior to termination, as set forth in the Appendices to the Agreement.

3. Prompt Pay.

Medica will pay claims that are clean within 30 calendar days (for claims submitted electronically) after the date upon which Medica or its Affiliate received the claim.

If a clean claim is not paid timely (within 30 calendar days), the rate of interest paid by Medica or Affiliate shall be 7.5 percent per annum.

"Clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, including, but not limited to, coordination of benefits information, or particular circumstance requiring special treatment that prevents timely payment from being made on a claim.

4. Medical Records.

Medica does not reimburse participating providers for the cost of collecting, copying or delivering requested medical records, except when required by law. Participating providers, and any subcontractors or third parties who may collect, copy and/or deliver records for such Providers, may not bill Medica or any Medica Member for expenses related to a records request from Medica.

REV 1/2024

THIS NOTICE DESCRIBES HOLD-HARMLESS PROVISIONS WHICH AFFECT YOUR ABILITY TO SEEK RECOURSE AGAINST HMO MEMBERS FOR PAYMENT FOR SERVICES

Section 609.94, Wis. Stat., requires each health maintenance organization insurer (HMO) to provide a summary notice to all of its participating providers of the statutory limitations and requirements in §§ 609.935, and § 609.97 (1), Wisconsin Statutes.

SUMMARY.

Under Wisconsin law a health care provider may not hold HMO members or policyholders ("members") liable for costs covered under an HMO policy if the provider is subject to statutory provisions that "hold harmless" the members. For most health care providers application of the statutory hold-harmless is "mandatory" or it applies unless the provider elects to "opt-out." A provider permitted to "opt-out" must file timely notice with the Wisconsin Office of the Commissioner of Insurance ("OCI").

Some types of provider care are subject to the hold-harmless statutes only if the provider voluntarily "opts-in." An HMO may partially satisfy its regulatory capital and surplus requirements if health care providers elect to remain subject to the statutory hold-harmless provisions.

This notice is only a summary of the law. Every effort has been made to accurately describe the law. However, if this summary is inconsistent with a provision of the law or incomplete, the law will control.

Filings for exemption with OCI must be on the prescribed form in order to be effective.

HOLD HARMLESS.

A health care provider who is subject to the statutory hold-harmless provisions is prohibited from seeking to recover health care costs from an member. The provider may not bill, charge, collect a deposit from, seek remuneration or compensation from, file or threaten to file with a credit-reporting agency or have any recourse against an member or any person acting on the member's behalf, for health care costs for which the member is not liable. The prohibition on recovery does not affect the liability of an member for any deductibles or copayments, or for premiums owed under the policy or certificate issued by the HMO.

A. MANDATORY FOR HOLD HARMLESS

An member of an HMO is not liable to a health care provider for health care costs that are covered under a policy issued by that HMO if any of the following are met:

i. Care is provided by a provider who is an affiliate of the HMO, owns at least 5% of the voting securities of the HMO, is directly or indirectly involved with the HMO through direct or indirect selection of or representation by one or more board members, or is an Individual Practice Association ("IPA") and is represented, or an affiliate is represented, by one of at least three HMO board members who directly or indirectly represent one or more Independent Practice Associations ("IPAs") or affiliates of IPAs.

ii. Care is provided by a provider under a contract with or through membership in an organization identified in 1.

iii. To the extent the charge exceeds the amount the HMO has contractually agreed to pay the provider for that health care service.

iv. The care is provided to an enrolled medical assistance recipient under a Department of Health and Social Services prepaid health care policy.

v. The care is required to be provided under the requirements of Wisconsin Administrative Code, Section Ins 9.35.

B. "OPT-OUT" HOLD HARMLESS

If the conditions described in A do not apply, the provider will be subject to the statutory hold harmless unless the provider files timely election with OCI to be exempt if the health care meets any of the following:

i. Provided by a hospital or an IPA.

ii. A physician service, or other provider services, equipment, supplies or drugs that are ancillary or incidental to such services and are provided under a contract with the HMO or are provided by a provider selected by the HMO.

iii. Provided by a provider, other than a hospital, under a contract with or through membership in an IPA that has not elected to be exempt. Note that only the IPA may file election to exempt care provided by its member providers from the statutory hold harmless. (See Exemptions and Elections, No. 4.)

C. "OPT-IN" HOLD HARMLESS

If a provider of health care is not subject to the conditions described in A or B, the provider may elect to be subject to the statutory hold-harmless provisions by filing a notification with OCI stating that the provider elects to be subject with respect to any specific HMO. A provider may terminate such a notice of election by stating the termination date in that notice or in a separate notification.

D. CONDITIONS NOT AFFECTING IMMUNITY

An member's immunity under the statutory hold harmless is not affected by any of the following:

i. Any agreement entered into by a provider, an HMO, or any other person, whether oral or written, purporting to hold the member liable for costs (except a notice of election or termination permitted under the statute).

ii. A breach of or default on any agreement by the HMO, an IPA, or any other person to compensate the provider for health care costs for which the member is not liable.

iii. The insolvency of the HMO or any person contracting with the HMO, or the commencement of insolvency, delinquency or bankruptcy proceedings involving the HMO or other persons which would affect compensation for health care costs for which an member is not liable under the statutory hold harmless.

iv. The inability of the provider or other person who is owed compensation to obtain compensation for health care costs for which the member is not liable.

v. Failure by the HMO to provide notice to providers of the statutory hold-harmless provisions.

vi. Any other conditions or agreement existing at any time.

E. EXEMPTIONS AND ELECTIONS

Hospitals, IPAs, and providers of physician services who may "opt-out" may elect to be exempt from the statutory hold harmless and prohibition on recovery of health care costs under the following conditions and with the following notifications:

i. If the hospital, IPA, or other provider has a written contract with the HMO, the provider must within thirty (30) days after entering into that contract provide a notice to the OCI of the provider's election to be exempt from the statutory hold-harmless and recovery limitations for care under the contract.

ii. If the hospital, IPA, or other provider does not have a contract with an HMO, the provider must notify OCI that it intends to be exempt with respect to a specific HMO and must provide that notice for the period January 1, 1990, to December 31, 1990, at least sixty (60) days before the health care costs are incurred; and must provide that notice for health care costs incurred on and after January 1, 1991, at least 90 days in advance.

iii. A provider who submits a notice of election to be exempt may terminate that election by stating a termination date in the notice or by submitting a separate termination notice to OCI.

iv. The election by an IPA to be exempt from the statutory provisions, or the failure of an IPA to so elect, applies to costs of health care provided by any provider, other than a hospital, under contract with or through membership in the IPA. Such a provider, other than a hospital, may not exercise an election separately from the IPA. Similarly, an election by a clinic to be exempt from the statutory limitations and restrictions or the failure of the clinic to elect to be exempt applies to costs of health

care provided by any provider through the clinic. An individual provider may not exercise an election to be exempt separate from the clinic.

v. The statutory hold-harmless "opt-out" provision applies to physician services only if the services are provided under a contract with the HMO or if the physician is a selected provider for the HMO, unless the services are provided by a physician for a hospital, IPA or clinic which is subject to the statutory hold-harmless "opt-out" provision.

F. NOTICES

All notices of election and termination must be in writing and in accordance with rules promulgated by the Commissioner of Insurance. All notices of election or termination filed with OCI are not affected by the renaming, reorganization, merger, consolidation or change in control of the provider, HMO, or other person. However, OCI may promulgate rules requiring an information filing if any of these events occur.

Notices to the Office of the Commissioner of Insurance must be written, on the prescribed form, and received at the Office's current address:

P.O. Box 7873, Madison, WI 53707-7873

G. HMO CAPITAL AND SECURITY SURPLUS

Each HMO is required to meet minimum capital and surplus standards ("compulsory surplus requirements"). These standards are higher if the HMO has fewer than 90% of its liabilities covered by the statutory hold-harmless. Specifically, beginning January 1, 1992, the compulsory surplus requirement shall be at least the greater of $750,000 or 6% of the premiums earned by the HMO in the last 12 months if its covered liabilities are less than 90%, or 3% of the premiums earned by the HMO in the last 12 months if its covered liabilities are 90% or more. In addition to capital and surplus, an HMO must also maintain a security surplus in the amount set by the Commissioner of Insurance.

H. FINANCIAL INFORMATION

An HMO is required to file financial statements with OCI. You may request financial statements from the HMO. OCI also maintains files of HMO financial statements that may be inspected by the public.