MEDICAL NECESSITY, PRIOR AUTHORIZATION TIMEFRAMES AND ENROLLEE RESPONSIBILITIES

Definitions:

- "Medical necessity" or "medically necessary" is used to describe care that is reasonable, necessary and/or appropriate, based on clinical evidence and generally accepted standards of care.
- "Prior authorization" is a process through which your health insurance company reviews a request for a covered benefit before you, the enrollee, receive it. Prior authorization requests may be approved or denied.

Question and Answers:

Q. Why do some services require prior authorization and/or need to be reviewed for medical necessity?

A. Certain services require prior authorization in order to be covered under your health plan. We review requests to determine whether the services are medically necessary according to generally accepted standards of care. The services that require prior authorization are usually ones that have a high likelihood of excessive or inappropriate use.

We must receive the request for prior authorization before the services are provided, except in emergency situations. Emergency services, whether provided by a **preferred (in-network) provider** or a **non-preferred (out-of-network) provider**, do not require prior authorization.

Q. Who is responsible for obtaining prior authorization?

A. When you receive care from **preferred (in-network) providers**, the provider is responsible for obtaining prior authorization. If you choose to receive your care from **non-preferred (out-of-network) providers**, you are responsible for obtaining the necessary prior authorization for the services.

Q. How do I get prior authorization?

A. To request prior authorization, call the number on the back of your SummaCare Identification Card. You can ask for the prior authorization list for services by calling the SummaCare Member Service at **330-996-8671** (for TTY call **833-443-0818**). You may also view the list on **www.summacare.com** under Members/Resources & Self Service/Prior Authorization List for Services or click here.

Q. What happens if I do not get prior authorization?

A. When you receive care from a **preferred (in-network) provider**, the provider is responsible for obtaining prior authorization, when necessary. If the **preferred (in-network) provider** fails to get prior authorization, we will not pay for the services and the provider cannot bill you for them. Emergency services, whether provided by a **preferred (in-network) provider** or a **non-preferred (out-of-network) provider**, do not require prior authorization.

When you receive care from a **non-preferred (out-of-network) provider**, you are responsible for guaranteeing your non-preferred (out-of-network) provider completes all prior authorizations. If the proper prior authorization is not completed, the service will be reviewed for medical necessity and to determine if it is a covered service. If the service is determined to be not medically necessary or not a covered service, the claim will be denied. You have the right to appeal the decision if you do not agree with the decision. You will be responsible for meeting the **non- preferred (out-of-network) provider** deductible and for all copayments and coinsurance and any balance billing from the **non-preferred (out-of-network) provider**. Your level of coinsurance is a lower reimbursement level than if you would use a **preferred (in-network) provider**. Emergency services, whether provided by a **preferred (in-network) provider** or a **non-preferred (out-of-network) provider**, do not require prior authorization.

Q. How quickly will we respond to requests for prior authorization?

A. The below are required timeframes SummaCare adheres to once we receive ALL the clinical information needed to render a decision. We do our best to respond in the shortest time possible while ensuring we have all necessary clinical information from your provider.

- For non-urgent situations, we will make a decision within 7 calendar days
- For urgent situations, we will make a decision within 72 hours
- Determinations for requests or claims received after a service has already been performed will be made within 30 calendar days after the request is received