



MERCY MANAGED CARE BULLETIN

Affiliate Providers

plan updates/reminders/other important information

IMPORTANT CONTACTS

SPRGMMC@Mercy.Net

contact to join Mercy Network LLC.

MercyMCenrollment@Mercy.Net

contact for provider Managed Care enrollment, provider health plan effective dates, and provider load questions.

Mercy_MC_Network_Operations@Mercy.Net

contact for prior auth/denials, health plan contract/rate related inquiries, network management support, acquisitions, contract updates, and panel/ member attribution.

Mercy_MC_Contract_Operations@Mercy.Net

contact for contract questions, claims escalation, and health plan query requests.



IMPORTANT SITES

MANAGED CARE CONTRACT NEWS

Review health plan updates including administrative, reimbursement, clinical, pharmacy and/or authorization policy changes, and provider newsletters.

FRIENDLY REMINDERS

All Regions:

Managed Care Realignment:

As part of our ongoing efforts to streamline operations and improve cross-functional efficiency, managed care enrollment functions will be assumed by the Credentialing and Data Center department. This move is intended to better align core processes related to provider onboarding, provider enrollment and data integrity, reduce duplication of efforts, and enhance overall workflow efficiency.

In accordance with this transition:

- The Managed Care Enrollment team will officially move under the Credentialing and Data Center department on **July 21, 2025**.
- Credentialing will assume full functional ownership of Managed Care enrollment operations effective **September 1, 2025**.

To ensure your inquiries are directed appropriately, please use the following contacts effective immediately:

- Provider Enrollment and provider load questions (i.e., OON inquires) contact: MercyMCenrollment@Mercy.Net
- Credentialing related questions:
Email mercycredentialingcustomerservice@mercy.net

East MO Region

One Mercy Hospice

We are excited to announce that the East community hospice teams will officially consolidate on **October 1, 2025**, marking a major milestone in our journey toward a unified One Mercy Hospice model.

This transformation is more than operational—it's deeply personal. By bringing our teams together under one aligned structure, we're strengthening our commitment to caregiver connection, mission-driven service, and strategic excellence.



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Why One Mercy Hospice Matters

- Consistency in Care: Standardized practices across communities ensure every patient receives the same high-quality, compassionate care.
- Empowered Caregivers: Unified teams foster trust, belonging, and shared ownership—creating a culture where caregivers thrive.
- Operational Strength: Streamlined workflows and shared resources improve efficiency and accelerate innovation.

The One Mercy Hospice model embodies these goals by creating a seamless experience for caregivers and patients alike—one that is predictive, proactive, and personalized.

Mercy Hospice East will continue to serve patients across the full East Community, with a regional approach to managing operations we will be positioned to serve more patients and families.

As we move forward, we celebrate the dedication of our hospice teams and leaders who have made this vision a reality. Together, we are building a future where more people choose Mercy for more of their care.

Please direct any questions regarding this exciting change to our hospice leader email box: MercyHospice_Leadership@Mercy.Net

PAYOR COMMUNICATIONS

MO Healthnet:

- **East MO, Southeast MO, and Southwest MO Regions:** Missouri Department of Social Services is reaching out to every uninsured child in the state of Missouri and is requesting the MO Healthnet for Kids flyer to be distributed to patients on pages 6-8 and can also be found here: <https://dssmanuals.mo.gov/forms-manual/> This program provides healthcare coverage for children under age 19 whose family income falls within certain guidelines.

Medica:

- **East MO, Southeast MO, Southwest MO Regions:** Please see attached September Medica Connections news



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bulletin regarding clinical, pharmacy, administrative news, and self-service helpful tips on pages 9-18.

PAYOR CONTRACT UPDATES

Managed Care Contracts

Healthy Blue:

- **East MO Region:** The newest issue of Healthy Blue's Provider News is now available here: <https://providernews.healthybluemo.com> or scan the QR code on the attached flyer on page 19.

TriWest:

- **East MO Region:** TriWest Waiver ended June 30, 2025.
 - Managed Care provided TriWest with the latest roster of our providers and facilities for reconciliation. We will continue to monitor process and share updates as they become available.
 - Please see attached Tricare West Region Referral Waiver Approval Letter attached on page 20 for more details.

Claritev/ PHCS:

- **East MO, Southeast MO Regions:** Expanded access in these regions for health plan members enrolled in Dual Choice PPO plans through Kaiser Permanente. Kaiser Permanente Dual Choice PPO offers a variety of health plans that allow members to access a broad range of providers through Claritev's (formally Multiplan) PHCS Network for their medical care. Please see attached flyer on page 21 for more details.

Cigna Healthcare Medicare Advantage:

- **East MO, Southeast MO, Joplin Regions:** The Cigna Healthcare Medicare Advantage brand, which includes Medicare Advantage, Supplemental Benefits and Medicare Part D, is changing to HealthSpring effective January 1, 2026. Please reference [HealthSpring.com](https://www.healthspring.com) for more information.



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Humana:

- **East MO, Southeast MO, Southwest MO: Update on Humana Utilization Management (UM) Operations**
 - Effective October 1, 2025, Humana is transitioning from a regionally based UM model to a centralized national structure for inpatient and post-acute Medicare services. Centralizing UM operations will streamline processes and enhance consistency in supporting providers across all markets.
 - Your local provider engagement and contracting teams remain unchanged. They will continue to support your practice as they do today.
 - No changes are being made to how you submit clinical information or prior authorization requests.
 - **Starting October 1, the peer-to-peer preview process will be managed differently:**
 - A pre-determination peer-to-peer review will still be available prior to a medical necessity decision.
 - If requested, a Humana physician reviewer will attempt direct outreach.
 - If an adverse determination is made, you may request a pre-claim provider dispute (PCPD) within seven days of the denial date—or at any time while the member is still in-house.
 - You can request a PCPD clinical re-review or a peer-to-peer review (if one wasn't completed prior to the determination) by calling 800-901-1973 or emailing CentralizedPCPD@humana.com.

Shine Solar:

- **Arkansas Region:** DTE Contract for Shine Solar termed effective March 17, 2025.

Tall Tree:

- **East MO and Central MO Regions:** DTE Contract for Tall Tree went into effect April 1, 2025. Tall Tree insurance cards are attached on pages 22-49.



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Laclede Chain:

- [East MO Region](#): DTE Contract for Laclede Chain went into effect July 1, 2025. Aither is the TPA with cards attached on page 51-57.

Crader Distributing:

- [Southeast MO Region](#): DTE Contract for Crader Distributing went into effect September 1, 2025. EBMS is the TPA with cards attached on page 59.

MERS Goodwill:

- [East MO and Central MO](#): DTE Contract for MERS Goodwill will be terming effective January 1, 2026.
 - MERS Goodwill has asked that claims repricing runs through 12/31/26 to make sure they capture all claims from 2025 that might not get billed/processed until 2026.

Managed Medicaid Supplemental Patient Benefits Highlights

Home State:

- [East MO, Southeast MO, Southwest MO Regions](#): Home State Health is offering a "Shoes for Shots" program which incentivizes HPV vaccination by offering eligible members a free pair of shoes for completing the full vaccine series by age 13 during Measurement Year 2025. See attached flyer for more details on how the program works on page 60.

ATTENTION

LICENSED CHILDCARE PROVIDERS

THE DEPARTMENT OF SOCIAL SERVICES, FAMILY SUPPORT DIVISION, IS REACHING OUT TO CHILDREN ATTENDING LICENSED CHILDCARE FACILITIES.

THE GOAL IS TO REACH EVERY UNINSURED CHILD IN THE STATE OF MISSOURI.

ENCLOSED ARE MO HEALTHNET FOR KIDS (MHK) FLYERS.

THERE ARE ENOUGH FLYERS TO EQUAL YOUR FACILITY'S MAXIMUM CAPACITY (AS DOCUMENTED WITH DEPARTMENT OF ELEMENTARY & SECONDARY EDUCATION). THE FLYER IS AVAILABLE IN SPANISH AND CAN BE FOUND AT:

<https://dssmanuals.mo.gov/forms-manual/>

PLEASE DISTRIBUTE THESE FLYERS TO PARENTS OF CHILDREN IN YOUR FACILITY.



Does your child need health care coverage?

MO HealthNet for Kids may be the answer.

MO HealthNet for Kids is a program that provides healthcare coverage for children under age 19 whose family income falls within certain guidelines. (See back for income guidelines)

Who Is Eligible?

A child:

- who is under age 19;
- who has or applies for a social security number;
- who lives in Missouri and intends to remain;
- who is a United States citizen or an eligible qualified non-citizen (NOTE: receipt of MO HealthNet benefits does NOT subject qualified non-citizens to public charge consideration);
- the parent must cooperate with Child Support Enforcement (CSE) in the pursuit of medical support; and
- who has countable family income which meets the income guidelines.

MO HealthNet for Kids Non-CHIP

- 196% Federal Poverty Level (FPL) for children under age 1
- 148% FPL for ages 1-18

MO HealthNet for Kids (CHIP) Non-Premium

- Family gross income over 148% FPL up to 150% FPL; and
- Child is uninsured

MO HealthNet for Kids (CHIP) Premium

- Family gross income over 150% FPL up to 300% FPL;
- Child is uninsured; and
- Children in families with gross income over 150% FPL without access to affordable health insurance (from \$100 to \$250 per month, based on family size and income) and the family must pay a monthly premium. Premium amounts change in July of each year. The premium is based on family size and income to ensure that no family pays more than 5% of their income for coverage.

To Apply:

- **On line** at mydss.mo.gov/healthcare. Please send an email to Cole.MHNPolicy@dss.mo.gov with subject line "School" to let us know to watch for your application.
- **By telephone** at 1-855-373-9994. When speaking with a representative please tell them this is a "School Application".
- **Request an application** from 1-855-FSD-INFO (1-855-373-4636). Please write "SCHOOL" at the top of the application.
- **Print an application** online at dssmanuals.mo.gov/wp-content/uploads/2020/09/IM-1SSL-Fillable-Secured-6-24-21.pdf. Please write "SCHOOL" at the top of the application.

INCOME GUIDELINES EFFECTIVE APRIL 1, 2025

Children under age 1 at 196% of the federal poverty level:	
Family Size	Income Limit*
1	\$2557
2	\$3455
3	\$4353
4	\$5252
5	\$6150

Children ages 1-18 at 148% of the federal poverty level:	
Family Size	Income Limit*
1	\$1931
2	\$2609
3	\$3287
4	\$3966
5	\$4644

150% of the federal poverty level:	
Family Size	Income Limit*
1	\$1957
2	\$2644
3	\$3332
4	\$4019
5	\$4707

300% of the federal poverty level:	
Family Size	Income Limit*
1	\$3913
2	\$5288
3	\$6663
4	\$8038
5	\$9413

*The Federal Poverty level changes in April.

September 2025



NEWS FOR MEDICA NETWORK PROVIDERS

General News

- **Annual notice: Medica encourages its members to get flu vaccinations**
- **Medica MHCP service areas to expand, eff. Sept. 1**
- **Providers will soon see claims impact if not enrolled in DHS MPSE system**
- **Routing prior authorization requests appropriately + online**
- **Reminder: Provider offices need to make regular demographic updates**
- **Clarifying the premium grace period for IFB members**

Clinical News

- **Medical policies and clinical guidelines to be updated, eff. Dec. 1**

Pharmacy News

- **Medica adds 3 new UM policies for medical pharmacy drugs**
- **Medica removes prior authorization requirement on drug for Mayo Medical Plan**
- **Time to revise bookmarks linking to Prime Therapeutics website**
- **Upcoming changes to Medica Part D drug formularies, eff. Sept. 1**

Administrative News

- **Medica to implement new reimbursement policy, eff. Nov. 1**
- **Medica to implement new facility reimbursement policy, eff. Nov. 1**
- **Medica to update MPPR reimbursement policy, eff. Nov. 1**
- **Updates to Medica Provider Administrative Manual**

Tips & Training

- **Self-service resources, featuring: Keeping demographics up-to-date**



General News

Annual notice:

Medica encourages its members to get flu vaccinations

(This applies to Medica leased-network providers as well as direct-contracted providers.)



Each year, Medica encourages its members to get seasonal influenza vaccinations, and will do so again by promoting them through direct member outreach and worksite flu-shot clinics this fall.

Vaccine priorities

According to the Centers for Disease Control and Prevention (CDC), annual influenza vaccination is recommended for everyone 6 months of age and older. Health care personnel should consult current influenza vaccine recommendations for guidance around the timing of administration and use of specific vaccines, using every opportunity during the influenza season to administer influenza vaccines to all eligible people, including:

- **Essential workers:** Health care personnel, including staff in post-acute and long-term care facilities, as well as pharmacy staff, and other critical infrastructure workforce
- **Those at high risk for influenza complications:** Including infants 6 months of age and older and young children less than 5 years of age, children with neurologic conditions, pregnant people, adults 65 years of age and older, and other people with certain underlying medical conditions

Pharmacist-administered vaccination

Medica members may be able to receive their flu vaccination through a Medica network pharmacy. Inquiries can be directed to a member's local pharmacy.

Billing for vaccinations

Clinics should use their regular billing methods for flu vaccinations. To ensure full coverage, Medica members must receive them from a Medica network provider. When submitting claims for flu vaccinations, providers should use applicable codes of the International Classification of Diseases (ICD-10-CM), Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS). Medica will accept codes for reimbursement as outlined by the CDC.

More information

More details on the seasonal flu vaccine are available online:

- [Visit the CDC website.](#)
- [See Medicare flu resources.](#)
- In the event of a vaccine shortage, providers are encouraged to [refer to the CDC](#).

Effective Sept. 1, 2025:

Medica MHCP service areas to expand

(This applies to Medica network providers in Minnesota.)

Medica's Minnesota Health Care Programs (MHCP) Families and Children products will soon make the following changes in service areas, as of Sept. 1, 2025:

- Medica Choice CareSM Prepaid Medical Assistance Program (PMAP): Adding Benton and Kanabec counties
- Medica MinnesotaCare: Adding Anoka, Benton, Carver, Dakota, Olmsted, Ramsey, Rice, Scott, Stearns and Washington counties



These service area expansions will result in these two Medica MHCP Families and Children products having aligned service areas of 30 counties each. [Find more details in a recent Minnesota Department of Human Services \(DHS\) bulletin.](#)

Medica continues to offer additional services to MHCP Families and Children-eligible members that include a One Pass \$0 fitness center membership (with premium fitness partners Life Time and YMCA) and a subscription to GEDWorks to obtain a high-school equivalency diploma.

Providers will soon see claims impact if not enrolled in DHS MPSE system

(This applies to Medica network providers in Minnesota.)

We've previously noted that Minnesota providers are required to enroll with Minnesota Health Care Programs (MHCP) to serve MHCP members and submit claims for payment. We've communicated that all Medica network providers [needed to enroll by the end of 2024](#).

As a result of this requirement from the Minnesota Department of Human Services (DHS) to enroll in [the Minnesota Provider Screening and Enrollment \(MPSE\) system](#), Medica is implementing a front-end claims edit for MHCP claims to verify that providers — both billing and rendering, as required — are MPSE-enrolled. *Claims will be rejected upon submission for lack of MPSE enrollment.*

Note: Medica's network personal care assistance (PCA) agencies must submit claims with their billing national provider identifier (NPI) or their Unique Minnesota Provider Identifier (UMPI), as well as with the rendering direct-support worker's UMPI, in order for Medica to pay claims for services provided to MHCP members.

Routing prior authorization requests appropriately + online

(This applies to Medica leased-network providers as well as direct-contracted providers.)



We've published recently that Availity Essentials is the go-to portal for submitting most prior authorization requests. While that is true, there are a few notable exceptions.

Prior authorizations *should not be submitted* using Availity Essentials for medications or for radiology, cardiology or musculoskeletal services.

- Submit **prescription drug** prior authorization requests through the **Evernorth portal**. (Evernorth is the new name for Express Scripts, our pharmacy benefit manager.)
- Submit **medical drug** prior authorization requests via the **Prime Therapeutics portal**.
- For **radiology, cardiology and musculoskeletal services**, submit prior authorization requests using the **Carelon portal**.

As a helpful tip, whenever possible, please submit prior authorization requests electronically using the appropriate portal, whether Availity Essentials or one of the portals noted above. This is preferred over faxing of prior authorization forms since doing so expedites the processing of requests. Electronic requests also provide an authorization number upon submission, which can be used to easily check the authorization status online.

Reminder:

Provider offices need to make regular demographic updates

(This applies to Medica leased-network providers as well as direct-contracted providers.)

On a regular basis, providers should be submitting demographic changes such as location changes, additions, and terminations to Medica. As a courtesy, Medica's Credentialing team was performing these location updates when needed as part of the recredentialing process. However, due to a consistently high credentialing volume, Credentialing cannot continue to perform demographic updates for providers and will be re-directing them to use Medica's standard processes for making demographic updates.



To update your demographics data

- Whenever possible, make your demographic updates through the Provider Demographic-update Online Tool (PDOT) **in the Medica secure portal**.
- As needed, submit demographic changes using **the Uniform Practitioner Change Form**.
- **See full details at Medica.com on how to make demographic changes**.

(We echo this in our Self-Service Resources feature below, on "Keeping demographics up-to-date.")

Clarifying the premium grace period for IFB members

(This applies to Medica leased-network providers as well as direct-contracted providers.)



When Individual and Family Business (IFB) members fail to pay their premium in a timely manner, they enter a premium grace period. Depending on eligibility, the member's policy may have a 31-day grace period or a 93-day grace period. Members with a 93-day grace period, and in their second or third month, will have a claims hold placed on their account until premiums are paid. This prevents us, the health plan, from needing to recoup claims payment if the member were to fail to pay their premium and be retrospectively terminated.

If you receive a claim denial indicating your patient with an IFB plan is not eligible for the date of service, but you've confirmed the member is active based on our eligibility and benefits transaction on the Availity Essentials provider portal (or by calling us), it is likely your patient is in a premium grace period. The Availity eligibility transaction also indicates a grace period, if one is applicable: "HIX Grace Period" would show up under the Health Benefit Plan Coverage section.

CARC + RARC codes indicating grace period

When claims are received during months two and three of the grace period, the following informational codes will be displayed on the Provider Remittance Advice (PRA) or Explanation of Payment (EOP):

- **N617 (RARC code):** This enrollee is in the second or third month of the advance premium tax credit grace period.
- **OA 257 (CARC code):** The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance Exchange requirements. This claim/service will be reversed and corrected when the grace period ends.

These Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) adjustment codes indicate neither member nor provider liability. Once the grace period expires, claims will be reprocessed to be either paid or denied.

Appealing on behalf of the member

Until the member pays their overdue premium, we will not provide payment for the member's claims if they are in months 2 or 3 of their grace period. An appeal to our health plan will not resolve this issue, as we would be waiting for member action. Providers should only bill our IFB members if the "PR" code (for patient responsibility) shows up on PRAs or EOPs. This would also indicate when providers can contact our health plan to discuss how to resolve any claim denials, which may include beginning an appeal process for the member.

Our members have the right to appoint representatives, such as their providers, to initiate member appeals. Providers may initiate an appeal on behalf of a member by calling the Provider Service Center.

Questions? Contact our Provider Service Center at **1 (800) 458-5512**.



Clinical News

Effective Dec. 1, 2025:

Medical policies and clinical guidelines to be updated

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medica will soon update one or more utilization management (UM) policies, coverage policies and clinical guidelines. These upcoming policy changes will be effective Dec. 1, 2025, unless otherwise noted.

Monthly update notifications for Medica's UM policies, coverage policies and clinical guidelines are available on an ongoing basis. **Update notifications are posted on Medica.com** at least 90 days prior to their effective date. The medical policy update notification for changes effective Dec. 1, 2025, is already posted. Changes to policies are effective as of that date unless otherwise noted. ("Medical policy updates" notifications are available at Medica.com under For Providers, "Policies and Guidelines," then "Updates to Medical Policies.")

The medical policies themselves will be available online or as a hard copy:

- **View medical policies and clinical guidelines at Medica.com** as of their effective date; or
- Call the Medica Provider Literature Request Line for printed copies of documents, toll-free at **1 (800) 458-5512**, option 1, then option 8, ext. 2-2355.

These policies apply to all Medica products including commercial, government, and individual and family plan (IFB) products unless other requirements apply due to state or federal mandated coverage, for example, or coverage criteria from the Centers for Medicare and Medicaid Services (CMS).

Note: The next policy update notification will be posted in September 2025 for policies that will be changing effective Jan. 1, 2026. These upcoming policy changes will be effective as of Jan. 1 unless otherwise noted. The affected policies will then be available as noted above.



Pharmacy News

Medica adds 3 new UM policies for medical pharmacy drugs

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medica recently implemented the following new medical pharmacy drug utilization management (UM) policies — Their effective dates are noted below. Medica implements such policies as soon as possible after conducting a clinical review of new-to-market drugs and approving them for coverage with UM policies. Prior authorization is required for the corresponding medical pharmacy drugs.

Medical pharmacy drug UM policies — New

Prior authorization required.

Drug code	Drug brand name	Drug generic name	Effective date
J9999	Emrelis	telisotuzumab vedotin-tlrv	July 17
J3590	Zevaskyn	prademagene zamikeracel	July 17
J9999	Zusduri	mitomycin	Aug. 1

Member impact

These policies apply to Medica commercial, Individual and Family Business (IFB), Minnesota Health Care Programs (MHCP) and Medica Health Plan SolutionsSM (MHPS) members and to Medica Medicare members in Medica DUAL Solution[®] (Minnesota Senior Health Options, or MSHO) and all Medicare Advantage plans. They *do not apply* to Medica Prime Solution[®] (Medicare Cost), Medica Signature SolutionSM (Medicare Supplement), Medica Select Solution[®] (Medigap) or Mayo Medical Plan members, unless noted below. The drugs will be subject to pre-payment claims edit policies as well.

The updated medical pharmacy drug UM policies above are available online or on hard copy:

- **View drug management policies**; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

Effective Aug. 15, 2025:

Medica removes prior authorization requirement on drug for Mayo Medical Plan

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medica has removed the prior authorization requirement on Ocrevus Zunovo for Mayo Medical Plan members. This change was effective with Aug. 15, 2025, dates of service.

Medical pharmacy drug utilization management (UM) policies for Mayo Medical Plan members are available online or on hard copy:

- **View drug management policies**; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

Administrative update:

Time to revise bookmarks linking to Prime Therapeutics website

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Prime Therapeutics changed its medical pharmacy website URL to **gatewaypa.com**, and for some time, the former **mrxgateway.com** URL would redirect to the new web address. However, this redirecting has ceased, no longer redirecting users and instead generating an error message.



As a result, providers should update any outdated **mrxgateway.com** bookmarks and replace them with **gatewaypa.com**. This update to the Prime Therapeutics website domain name pertains to its medical drug prior authorization portal *as well as all Prime Therapeutics drug utilization management (UM) policy pages*, which are linked under “Clinical Guidelines” at the left side of the gatewaypa.com portal landing page.

Note: Providers do not need to register again to access the Prime Therapeutics prior authorization portal. Current usernames (e-mail addresses) and passwords remain valid.

Questions? Contact Prime Therapeutics at **ProviderInquiry@PrimeTherapeutics.com**.

Effective Sept. 1, 2025:

Upcoming changes to Medica Part D drug formularies

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medica periodically makes changes to its Medicare Part D drug formularies and posts updated formularies on Medica.com by the effective date of change. The updated formularies may include negative formulary changes, such as drug removals or tier increases. The latest updates are effective Sept. 1, 2025.

In accordance with Centers for Medicare and Medicaid Services (CMS) requirements, Medica provides advance notice to affected members at least 60 days prior to the effective date regarding any negative formulary changes. Medica also notifies affected Medica members in their Medicare Part D Explanation of Benefits (EOB) statements mailed out monthly.

Medica’s Medicare Part D drug formularies are the Medicare Part D Closed Formulary and the Medica DUAL Solution®

and Medica AccessAbility Solution[®] Enhanced List of Covered Drugs. Medica's Medicare Part D drug formularies are available online or on paper:

- [View Medica formularies.](#)
- [Download formularies for free at **epocrates.com**.](#)
- Call the Medica Provider Literature Request Line for printed copies of documents.

Medication request forms

A medication request form should be used when requesting a formulary exception. It is important to fill out the form as completely as possible and to cite which medications have been tried and failed. This includes the dosages used and the identified reason for failure (e.g., side effects or lack of efficacy). The more complete the information provided, the quicker the review, with less likelihood of Medica needing to request more information. To request formulary exceptions, providers can submit an exception form or call Express Scripts.



Administrative News

Effective Nov. 1, 2025:

Medica to implement new reimbursement policy

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medica will soon implement the new reimbursement policy indicated below, effective on or after Nov. 1, 2025, dates of service. Such policies define when specific services are reimbursable based on the reported codes.

Replacement Codes

This policy will address codes assigned status code "I" where the Centers for Medicare and Medicaid Services (CMS) has indicated a replacement code is available and has assigned a relative value unit (RVU) to the replacement code. All codes published on the National Physician Fee Schedule (NPFS) by CMS are assigned a status code.

- Status code "I" = Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. This code isn't subject to a 90-day grace period.

This policy applies to services reported on the CMS-1500 claim form or its electronic equivalent. Providers must report the replacement code with an assigned RVU that best describes the procedure or service. This policy does not include codes with status code "I" that are not assigned with replacement codes or whose replacement codes are not assigned an RVU.

This new policy will apply to claims for our commercial and Individual and Family Business (IFB) members. It will be available online or on hard copy:

- [View reimbursement policies](#) as of Nov. 1; or
- Call the Provider Literature Request Line for printed copies of documents.

Effective Nov. 1, 2025:

Medica to implement new facility reimbursement policy

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medica will soon implement the new reimbursement policy indicated below, effective on or after Nov. 1, 2025, dates of service. Such policies define when specific services are reimbursable based on the reported codes.

Device, Implant, and Skin Substitute

This policy addresses billing guidelines for all outpatient hospital services associated with devices, implants and skin substitutes and billed on a UB-04 claim form for facilities, or its electronic equivalent. Following criteria from the Centers for Medicare and Medicaid Services (CMS), Medica will utilize the Integrated Outpatient Claims Editor (OCE) for this policy.

Using CMS criteria for devices and implants, our new policy will address billing guidelines to report devices or implant-dependent procedures. When a device or implant is submitted on a claim, it must be submitted on the same day and same claim as the procedure. If the procedure is not submitted on the same day and same claim, *the procedure will be denied*. The procedure would only be considered for payment, when the device or implant code is missing, if appended with modifier 73 or 74, representing a discontinuation of the procedure.

For related coding guidelines, refer to CMS:

- **Medicare Claims Processing Manual**
- **HCPSC Codes for Drugs, Biologicals, and Radiopharmaceuticals with Substantial Descriptor Changes as of July 1, 2025** (see p. 31)

This new policy will apply to claims for our commercial, Medicare, Minnesota Health Care Programs (MHCP) and Individual and Family Business (IFB) members. It will be available online or on hard copy:

- **View reimbursement policies** as of Nov. 1; or
- Call the Provider Literature Request Line for printed copies of documents.

Effective Nov. 1, 2025:

Medica to update MPPR reimbursement policy

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medica will soon implement revisions to the following reimbursement policy, effective on or after Nov. 1, 2025, dates of service. Such policies define when specific services are reimbursable based on the reported codes.

Multiple Procedure Payment Reduction (MPPR) for Diagnostic Imaging

This policy describes reimbursement for multiple diagnostic imaging services performed on the same date of service by providers who report the same federal tax identification number (TIN).

Medica aligns with the Centers for Medicare and Medicaid Services (CMS). Medica will consider codes in the National Physician Fee Schedule (NPFS) with Multiple Procedure Indicator (MPI) of 4 performed in a single session as eligible for multiple procedure payment reductions for diagnostic imaging. Different MPPR for diagnostic imaging percentages apply to the professional component (PC) and technical component (TC) portion of global services.

As early as Nov. 1, 2025, Medica will apply a reduction to certain ultrasound Current Procedural Terminology (CPT®) codes that do not have an MPI indicator of 4 but are similar to other ultrasound CPT codes with an indicator of 4 to claims for our commercial, Minnesota Health Care Programs (MHCP) and Individual and Family Business (IFB) members. Our Medicare products will continue to follow CMS guidelines as outlined in the NPFS.

The revised Medica policy will be available online or on hard copy.

- **View reimbursement policies** as of Nov. 1; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

Updates to Medica Provider Administrative Manual

To ensure that providers receive information in a timely manner, changes are often announced in *Medica Connections* that are not yet reflected in the Medica Provider Administrative Manual. Every effort is made to keep the manual as current as possible. The table below highlights updated information and when the updates were (or will be) posted online in the Medica Provider Administrative Manual.

Information updated	Location in manual	When posted
---------------------	--------------------	-------------

Updated Minnesota state-specific contracting and regulatory requirements to add language about Minnesota's new timely filing extension requirements.

"Supplementary Contracting and Regulatory Requirements" section under State-Specific Contract Requirements subsection, in "Minnesota Specific Requirements" ([found here](#))

July
2025

For the current version, providers may [view the Medica Provider Administrative Manual online](#).



Tips & Training



SELF-SERVICE RESOURCES

Featured this month: Keeping demographics up-to-date

Keeping demographic data up-to-date means your details will be accurate for referrals, provider directories and more. It is also critical for accurate and timely claims payment! Set aside time this month to confirm your information with Medica. If any changes are needed, follow the steps to make updates through the Provider Demographic-update Online Tool (PDOT) [in the secure portal](#) or take steps [outlined on Medica.com](#). For reference, [here's the PDOT User Guide](#).

Getting Connections?

Sign up for regular updates, if you haven't already.

[Subscribe](#)

Looking for past issues?

Access the archive on our website.

[View archive](#)

Colleagues not receiving Connections?

Forward this month's newsletter.

[Forward to Colleagues](#)

What do you think of our newsletter?

Let us know!

[Take survey](#)

Leadership in Provider Support Areas

Jennifer Alm, Vice President of Provider Partnerships and Solutions

Adam Hjerpe, Chief Operations Officer and Senior Vice President

David Webster, MD, MBA, Chief Clinical and Provider Strategy Officer

Nick Rogers, PharmD, Vice President and Chief Pharmacy Officer

Kathryn Kading, Vice President of Health Services

Kristen Kopski, MD, Senior Medical Director

Angela Porter, MD, Senior Medical Director

'Medica Connections' editor

Hugh Curtler III, Communications

Email: Hugh.Curtler@Medica.com

Distributed: 8/20/25



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Healthy Blue

The newest issue of our *Provider News* is now available



Missouri | Healthy Blue | MO HealthNet Managed Care (Medicaid) • Medicare Advantage

The newest issue of *Provider News* is now available online.

Check out the August 2025 issue of *Provider News* online at

<https://providernews.healthybluemo.com>

or

scan the QR code below to access it directly.



Provider News contains important information for you and your office staff, such as information about policy updates, new programs, and training opportunities.

Please take a moment to share the information with your staff.

<https://provider.healthybluemo.com>

Healthy Blue is a Medicaid product offered by Missouri Care, Incorporated, a MO HealthNet Managed Care health plan contracting with the Missouri Department of Social Services. Healthy Blue is administered statewide by Missouri Care, Incorporated and administered in the Kansas City service region by Missouri Care, Incorporated in cooperation with Blue Cross and Blue Shield of Kansas City. Missouri Care, Incorporated and Blue Cross and Blue Shield of Kansas City are both independent licensees of the Blue Cross Blue Shield Association.

MOHB-CDCR-088415-25-CPN87911 August 2025

TRICARE WEST REGION REFERRAL WAIVER APPROVAL LETTER

Dear Provider,

The TRICARE West Region Referral Waiver has been extended through June 30, 2025.

This letter serves as approval for TRICARE Prime patients to seek outpatient TRICARE-covered services that would otherwise require approval from TriWest Healthcare Alliance (TriWest), including those referrals submitted to TriWest on or after January 1, 2025.

The Defense Health Agency implemented a temporary waiver of outpatient referral requirements for eligible TRICARE West Region beneficiaries enrolled in a TRICARE Prime plan.

WAIVER DETAILS	Referrals from military or civilian primary care manager (PCM) or other TRICARE-authorized provider do not require separate approval from TriWest during the waiver period. Outpatient TRICARE-covered procedures, services, and equipment ordered or initiated during the waiver period do not require separate approval from TriWest. Beneficiaries are encouraged to take their PCM referral with them to their specialty appointment.
EFFECTIVE DATES	Referrals and orders for service issued to TRICARE Prime beneficiaries January 1, 2025, through June 30, 2025, are valid for services rendered through September 30, 2025.
INCLUDED SERVICES	TRICARE-covered office visits and outpatient procedures/services/equipment that otherwise require TriWest approval, when a PCM or other TRICARE-authorized provider issued the referral between January 1 and June 30, 2025.
AUTHORIZED PROVIDER	Any TRICARE-authorized provider. Network and non-network provider directories are available at https://tricare.triwest.com under "Find a Provider."
EXCEPTIONS	Inpatient care, applied behavior analysis (ABA)/Autism Care Demonstration (ACD) services, laboratory developed test (LDT), Extended Care Health Option (ECHO) services and other services that require pre-authorization.
LIMITATIONS	This waiver only applies to TRICARE-covered services. Refer to "Is a Referral/Auth Required?" on Availity in the TRICARE West payer space under Applications to search specific services that may require pre-authorization.
AFTER WAIVER ENDS	Referrals and orders issued after June 30, 2025, must follow TRICARE referral and authorization requirements. Point of service charges and authorization penalties may apply if TriWest approval is not obtained.
CLAIMS DOCUMENTATION	A copy of this TRICARE West Region Referral Waiver Approval Letter is not required with a claim submission.

NOTE: This TRICARE West Region Referral Waiver Approval Letter is your verification of approval.

Sincerely,

TriWest Healthcare Alliance

Please share this notice with your scheduling and administrative staff.

Announcing Access by Health Plan Members through Kaiser Permanente Dual Choice PPO



We are pleased to announce expanded access in your area for health plan members enrolled in Dual Choice PPO plans through Kaiser Permanente. Kaiser Permanente Dual Choice PPO offers a variety of health plans that allow members to access a broad range of providers through Claritev's (formally Multiplan) PHCS Network for their medical care.

- The Dual Choice PPO plan may channel additional patients to your practice.
- Your services provided to Dual Choice PPO members will be reimbursed based on your Claritev (formally Multiplan) PHCS Network agreement. However, if you hold a direct contract with Kaiser Permanente, reimbursement will be based on your Kaiser Permanente agreement.
- No referrals required when plan members seek care through their POS and PPO benefit.

Identifying members - The Dual Choice PPO identification card will clearly display Claritev's (formally Multiplan) PHCS Network logo.

Precertification - Medical Services: 800-221-2412, Pharmacy Services: 800-788-2949.

In accordance with GA SB 80, Ensuring Transparency in Prior Authorization Act, Kaiser Permanente posts its Pre-Certification list on the Georgia Community Provider Portal. The list will be updated and posted annually to the portal. Access the list at: https://providers.kaiserpermanente.org/info_assets/cpp_ga/pdfs/GA_KPIC_Precert_List_2022.pdf. Please continue to follow the pre-certification guidelines and use the list in reference as needed.

Claims Submission - Kaiser Permanente Claims Administration, P.O. Box 370010, Denver CO, 80237-9998. EDI Payer ID: 21313.

Benefits and eligibility - Refer to the phone number on the back of the member's ID card.

Questions about your Claritev (formally Multiplan) contract - Visit www.claritev.com/provider or call 866-675-7427.

Thank you for your continued participation with Claritev (formally Multiplan). We appreciate your commitment to providing quality health care to Kaiser Permanente Dual Choice PPO plan members.

You are receiving this fax transmission because our records show that you participate in one or more of our provider network products. We may use this method to inform you about issues that affect your participation, such as new client announcements and requests for practice information updates. If you have questions about your participation with Claritev (formally Multiplan), please contact us at 866-675-7427.

NOTICE OF CONFIDENTIALITY: Information included in and/or attached to this fax transmission may be confidential. This fax transmission is intended for the addressee(s) only. Any unauthorized disclosure, reproduction, or distribution of and/or any unauthorized action taken in reliance on the information in this fax is prohibited. If you believe that you received this fax transmission in error, please notify the sender by reply transmission and destroy the fax without copying or disclosing it.



Group ID#: SBFSA

Name: JOHN SMITH

ID#: A3476BCF1

Non Prev. Office Co-pays: \$30 / \$55
Urgent Care Co-Pay: \$65
ER Co-pay: DED then 30%

Ntwk. Ded./Non-Ntwk. Ded.: \$1,000 / \$9,000
Ntwk. OOP/Non-Ntwk OOP: \$3,500 / \$14,000



TELEMEDICINE:

Lyric Health
<https://portal.getlyric.com>
866-223-8831



MEDICAL CLAIMS:

Tall Tree Administrators
Emdeon payor ID#: 88067
P.O. Box 1807
Draper, UT 84020



MERCY CLAIMS:

Mercy Benefit Administrator
P.O. Box 211197
Eagan, MN 55121
Payor ID#: 43185

PHARMACY PLAN:

RxBIN: 005285
RxPCN: ACB
RxGRP: 50003604-01
Customer Service: 800-311-3446
www.ehimrx.com



MEMBER BENEFIT:

Eligibility Benefits- Call 844-525-2387
Provider Network: To find a First Health
provider call 800-226-5116 or visit
www.firsthealthcomplementary.com



PRE CERTIFICATION:

Call Integrated Health Management
at 877-587-2700.

**All services requiring a Pre-Auth will
be denied if not obtained.**





HUNSAKER ENTERPRISES LLC



Group ID#: SBHUE
Name: JOHN SMITH

ID#: A3476BCF1



PCP Copay:	\$10 / \$25
Specialist Copay:	\$20 / \$45
Urgent Care Copay:	\$20 / \$45
ER Benefit:	Ded then 20%
RX Benefit:	\$0 / \$35 / \$75 / \$200
Ded Tier 1/Tier 2/Tier 3:	\$0/\$250/\$500
OOP Tier 1/Tier 2/Tier 3:	\$625/\$1,250/\$3,750

MEDICAL CLAIMS:
Tall Tree Administrators
Emdeon payor ID#: 88067
P.O. Box 1807
Draper, UT 84020

MEMBER BENEFIT:
Eligibility Benefits- Call 844-525-2387
Provider Network: To find a First Health
provider call 800-226-5116 or visit
www.firsthealthcomlementary.com

MERCY CLAIMS:
Mercy Benefit Administrator
P.O. Box 211197
Eagan, MN 55121
Payor ID#: 43185

PHARMACY PLAN:
RxBIN: 023385
RxPCN: CPT
RxGRP: CPRX
Customer Service: 945-260-2281
www.cerpassrx.com



TELEMEDICINE:
Lyric Health
<https://portal.getlyric.com>
866-223-8831

The lyric logo, featuring the word "lyric" in a stylized, lowercase, teal-colored font.

PRE CERTIFICATION:
Call Integrated Health Management
at 877-587-2700

**All services requiring a Pre-Auth will
be denied if not obtained.**



JESHORT INC



Group ID#: SBJES

Name: JOHN SMITH

ID#: A3476BCF1

PCP Copay:	\$10 / \$20
Specialist Copay:	\$30 / \$55
Urgent Care Copay:	\$30 / \$55
ER Benefit:	DED

Ntwk. Ded./Non-Ntwk. Ded.:	\$3,000 / \$9,000
Ntwk. OOP/Non-Ntwk OOP:	\$3,000 / \$14,000

TELEMEDICINE:

Lyric Health
<https://portal.getlyric.com>
866-223-8831



MEDICAL CLAIMS:

Tall Tree Administrators
Emdeon payor ID#: 88067
P.O. Box 1807
Draper, UT 84020



MERCY CLAIMS:

Mercy Benefit Administrator
P.O. Box 211197
Eagan, MN 55121
Payor ID#: 43185

PHARMACY PLAN:

RxBIN: 005285
RxPCN: ACB
RxGRP: 50003551-01
Customer Service: 800-311-3446
www.ehimrx.com



MEMBER BENEFIT:

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Provider Network: To find a First Health
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PRE CERTIFICATION:

Call Integrated Health Management
at 877-587-2700.

**All services requiring a Pre-Auth will
be denied if not obtained.**



HUNSAKER ENTERPRISES LLC



Group ID#: SBHUE
Name: JOHN SMITH

ID#: A3476BCF1



PCP Copay:	\$5 / \$15
Specialist Copay:	\$20 / \$40
Urgent Care Copay:	\$20 / \$40
ER Benefit:	Ded then 20%
RX Benefit:	\$0 / \$35 / \$75 / \$200
Ded Tier 1/Tier 2/Tier 3:	\$500/\$1,000/\$2,500
OOP Tier 1/Tier 2/Tier 3:	\$1,250/\$3,500/\$7,000

MEDICAL CLAIMS:
Tall Tree Administrators
Emdeon payor ID#: 88067
P.O. Box 1807
Draper, UT 84020

MERCY CLAIMS:
Mercy Benefit Administrator
P.O. Box 211197
Eagan, MN 55121
Payor ID#: 43185

PHARMACY PLAN:
RxBIN: 023385
RxPCN: CPT
RxGRP: CPRX
Customer Service: 945-260-2281
www.cerpassrx.com



MEMBER BENEFIT:
Eligibility Benefits- Call 844-525-2387
Provider Network: To find a First Health
provider call 800-226-5116 or visit
www.firsthealthcomlementary.com



TELEMEDICINE:
Lyric Health
<https://portal.getlyric.com>
866-223-8831



PRE CERTIFICATION:
Call Integrated Health Management
at 877-587-2700

**All services requiring a Pre-Auth will
be denied if not obtained.**



HUNSAKER ENTERPRISES LLC



Group ID#: SBHUE
Name: JOHN SMITH

ID#: A3476BCF1



PCP Copay:	\$20 / \$40
Specialist Copay:	\$40 / \$80
Urgent Care Copay:	\$30 / \$60
ER Benefit:	DED then 20%
RX Benefit:	\$0 / \$35 / \$75 / \$200
Ded Tier 1/Tier 2/Tier 3:	\$2,500/\$5,000/\$10,000
OOP Tier 1/Tier 2/Tier 3:	\$4,350/\$8,700/\$17,400

MEDICAL CLAIMS:
Tall Tree Administrators
Emdeon payor ID#: 88067
P.O. Box 1807
Draper, UT 84020

MERCY CLAIMS:
Mercy Benefit Administrator
P.O. Box 211197
Eagan, MN 55121
Payor ID#: 43185

PHARMACY PLAN:
RxBIN: 023385
RxPCN: CPT
RxGRP: CPRX
Customer Service: 945-260-2281
www.cerpassrx.com



MEMBER BENEFIT:
Eligibility Benefits- Call 844-525-2387
Provider Network: To find a First Health
provider call 800-226-5116 or visit
www.firsthealthcomlementary.com



TELEMEDICINE:
Lyric Health
<https://portal.getlyric.com>
866-223-8831



PRE CERTIFICATION:
Call Integrated Health Management
at 877-587-2700

**All services requiring a Pre-Auth will
be denied if not obtained.**



Group ID#: SBSBS

Name: JOHN SMITH

ID#: A3476BCF1



PCP Copay:	\$10 / \$25
Specialist Copay:	\$20 / \$45
Urgent Care Copay:	\$20 / \$45
ER Benefit:	10% /Ded then 20%
RX Benefit:	\$0 / \$35 / \$75 / \$200
Ded Tier 1/Tier 2/Tier 3:	\$0/\$250/\$500
OOP Tier 1/Tier 2/Tier 3:	\$625/\$1,250/ 3,750

MEDICAL CLAIMS:

Tall Tree Administrators
Emdeon payor ID#: 88067
P.O. Box 1807
Draper, UT 84020

MERCY CLAIMS:

Mercy Benefit Administrator
P.O. Box 211197
Eagan, MN 55121
Payor ID#: 43185

PHARMACY PLAN:

RxBIN: 023385
RxPCN: CPT
RxGRP: CPRX
Customer Service: 945-260-2281
www.cerpassrx.com



MEMBER BENEFIT:

Eligibility Benefits- Call 844-525-2387
Provider Network: To find a First Health
provider call 800-226-5116 or visit
www.firsthealthcomlementary.com



TELEMEDICINE:

Lyric Health
<https://portal.getlyric.com>
866-223-8831



PRE CERTIFICATION:

Please Contact MediReview at
800-850-0281 for Pre-Authorization.

**All services requiring a Pre-Auth will
be denied if not obtained.**



JESHORT INC



Group ID#: SBJES

Name: JOHN SMITH

ID#: A3476BCF1

PCP Copay:	\$10 / \$20
Specialist Copay:	\$20 / \$40
Urgent Care Copay:	\$25 / \$50
ER Benefit:	\$300

Ntwk. Ded./Non-Ntwk. Ded.:	\$5,000 / \$9,000
Ntwk. OOP/Non-Ntwk OOP:	\$5,000 / \$14,000



TELEMEDICINE:

Lyric Health
<https://portal.getlyric.com>
866-223-8831



MEDICAL CLAIMS:

Tall Tree Administrators
Emdeon payor ID#: 88067
P.O. Box 1807
Draper, UT 84020



MERCY CLAIMS:

Mercy Benefit Administrator
P.O. Box 211197
Eagan, MN 55121
Payor ID#: 43185

PHARMACY PLAN:

RxBIN: 005285
RxPCN: ACB
RxGRP: 50003551-01
Customer Service: 800-311-3446
www.ehimrx.com



MEMBER BENEFIT:

Eligibility Benefits- Call 844-525-2387
Provider Network: To find a First Health
provider call 800-226-5116 or visit
www.firsthealthcomplementary.com



PRE CERTIFICATION:

Call Integrated Health Management
at 877-587-2700.

**All services requiring a Pre-Auth will
be denied if not obtained.**



JESHORT INC



Group ID#: SBJES

Name: JOHN SMITH

ID#: A3476BCF1

PCP Copay:	\$10 / \$20
Specialist Copay:	\$20 / \$40
Urgent Care Copay:	\$25 / \$50
ER Benefit:	DED

Ntwk. Ded./Non-Ntwk. Ded.:	\$6,000 / \$9,000
Ntwk. OOP/Non-Ntwk OOP:	\$6,000 / \$14,000

TELEMEDICINE:

Lyric Health
<https://portal.getlyric.com>
866-223-8831



MEDICAL CLAIMS:

Tall Tree Administrators
Emdeon payor ID#: 88067
P.O. Box 1807
Draper, UT 84020



MERCY CLAIMS:

Mercy Benefit Administrator
P.O. Box 211197
Eagan, MN 55121
Payor ID#: 43185

PHARMACY PLAN:

RxBIN: 005285
RxPCN: ACB
RxGRP: 50003551-01
Customer Service: 800-311-3446
www.ehimrx.com



MEMBER BENEFIT:

Eligibility Benefits- Call 844-525-2387
Provider Network: To find a First Health
provider call 800-226-5116 or visit
www.firsthealthcomplementary.com



PRE CERTIFICATION:

Call Integrated Health Management
at 877-587-2700.

**All services requiring a Pre-Auth will
be denied if not obtained.**

Group ID#: SBJVH

Name: JOHN SMITH

ID#: A3476BCF1



PCP Copay:	\$20 / \$40
Specialist Copay:	\$40 / \$80
Urgent Care Copay:	\$30 / \$60
ER Benefit:	DED then Coins.
RX Benefit:	\$0 / \$35 / \$75 / \$200
Ded Tier 1/Tier 2/Tier 3:	\$2,500/\$5,000/\$10,000
OOP Tier 1/Tier 2/Tier 3:	\$4,350/\$8,700/\$17,400

MEDICAL CLAIMS:

Tall Tree Administrators
Emdeon payor ID#: 88067
P.O. Box 1807
Draper, UT 84020

MERCY CLAIMS:

Mercy Benefit Administrator
P.O. Box 211197
Eagan, MN 55121
Payor ID#: 43185

PHARMACY PLAN:

RxBIN: 023385
RxPCN: CPT
RxGRP: CPRX
Customer Service: 945-260-2281
www.cerpassrx.com



MEMBER BENEFIT:

Eligibility Benefits- Call 844-525-2387
Provider Network: To find a First Health
provider call 800-226-5116 or visit
www.firsthealthcomlementary.com



TELEMEDICINE:

Lyric Health
<https://portal.getlyric.com>
866-223-8831



PRE CERTIFICATION:

Call Integrated Health Management
at 877-587-2700

**All services requiring a Pre-Auth will
be denied if not obtained.**

Group ID#: SBJVH

Name: JOHN SMITH

ID#: A3476BCF1



PCP Copay:	\$15 / \$35
Specialist Copay:	\$25 / \$55
Urgent Care Copay:	\$25 / \$55
ER Benefit:	DED then Coins.
RX Benefit:	\$0 / \$35 / \$75 / \$200
Ded Tier 1/Tier 2/Tier 3:	\$1,500/\$3,000/\$6,000
OOP Tier 1/Tier 2/Tier 3:	\$3,000/\$12,000/\$24,000

MEDICAL CLAIMS:

Tall Tree Administrators
Emdeon payor ID#: 88067
P.O. Box 1807
Draper, UT 84020

MERCY CLAIMS:

Mercy Benefit Administrator
P.O. Box 211197
Eagan, MN 55121
Payor ID#: 43185

PHARMACY PLAN:

RxBIN: 023385
RxPCN: CPT
RxGRP: CPRX
Customer Service: 945-260-2281
www.cerpassrx.com



MEMBER BENEFIT:

Eligibility Benefits- Call 844-525-2387
Provider Network: To find a First Health
provider call 800-226-5116 or visit
www.firsthealthcomlementary.com



TELEMEDICINE:

Lyric Health
<https://portal.getlyric.com>
866-223-8831



PRE CERTIFICATION:

Call Integrated Health Management
at 877-587-2700

**All services requiring a Pre-Auth will
be denied if not obtained.**



Group ID#: SBMBC

Name: JOHN SMITH

ID#: A3476BCF1



PCP Copay:	\$10 / \$25
Specialist Copay:	\$20 / \$45
Urgent Care Copay:	\$20 / \$45
ER Benefit:	Ded then 20%
RX Benefit:	\$0 / \$35 / \$75 / \$200
Ded Tier 1/Tier 2/Tier 3:	\$0/\$250/\$500
OOP Tier 1/Tier 2/Tier 3:	\$625/\$1,250/\$3,750

MEDICAL CLAIMS:
Tall Tree Administrators
Emdeon payor ID#: 88067
P.O. Box 1807
Draper, UT 84020

MERCY CLAIMS:
Mercy Benefit Administrator
P.O. Box 211197
Eagan, MN 55121
Payor ID#: 43185

PHARMACY PLAN:
RxBIN: 023385
RxPCN: CPT
RxGRP: CPRX
Customer Service: 945-260-2281
www.cerpassrx.com



MEMBER BENEFIT:
Eligibility Benefits- Call 844-525-2387
Provider Network: To find a First Health
provider call 800-226-5116 or visit
www.firsthealthcomlementary.com



TELEMEDICINE:
Lyric Health
<https://portal.getlyric.com>
866-223-8831



PRE CERTIFICATION:
Call Integrated Health Management
at 877-587-2700

**All services requiring a Pre-Auth will
be denied if not obtained.**



Group ID#: SBMBC

Name: JOHN SMITH

ID#: A3476BCF1



PCP Copay:	\$15 / \$35
Specialist Copay:	\$25 / \$55
Urgent Care Copay:	\$25 / \$55
ER Benefit:	Ded then 20%
RX Benefit:	\$0 / \$35 / \$75 / \$200
Ded Tier 1/Tier 2/Tier 3:	\$1,500/\$3,000/\$6,000
OOP Tier 1/Tier 2/Tier 3:	\$3,000/\$12,000/\$24,000

MEDICAL CLAIMS:
Tall Tree Administrators
Emdeon payor ID#: 88067
P.O. Box 1807
Draper, UT 84020

MERCY CLAIMS:
Mercy Benefit Administrator
P.O. Box 211197
Eagan, MN 55121
Payor ID#: 43185

PHARMACY PLAN:
RxBIN: 023385
RxPCN: CPT
RxGRP: CPRX
Customer Service: 945-260-2281
www.cerpassrx.com



MEMBER BENEFIT:
Eligibility Benefits- Call 844-525-2387
Provider Network: To find a First Health
provider call 800-226-5116 or visit
www.firsthealthcomlementary.com



TELEMEDICINE:
Lyric Health
<https://portal.getlyric.com>
866-223-8831



PRE CERTIFICATION:
Call Integrated Health Management
at 877-587-2700

**All services requiring a Pre-Auth will
be denied if not obtained.**



THE OZARKS METHODIST MANOR



Group ID#: SBOMM
Name: JOHN SMITH
ID#: A3476BCF1

Non Prev. Office Co-pays: \$40 / \$80
Urgent Care Co-Pay: \$60
ER Co-pay: DED then 30%
RX Benefit: \$0/\$35/\$75/No Benefit
Ntwk. Ded./Non-Ntwk. Ded.: \$5,000 / \$10,000
Ntwk. OOP/Non-Ntwk OOP: \$8,700 / \$17,400



TELEMEDICINE:
Lyric Health
<https://portal.getlyric.com>
866-223-8831



MEDICAL CLAIMS:

Tall Tree Administrators
Emdeon payor ID#: 88067
P.O. Box 1807
Draper, UT 84020

MERCY CLAIMS:

Mercy Benefit Administrator
P.O. Box 211197
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Payor ID#: 43185

PHARMACY PLAN:

RxBIN: 023385
RxPCN: CPT
RxGRP: CPRX
Customer Service: 945-260-2281
www.cerpassrx.com



MEMBER BENEFIT:

Eligibility Benefits- Call 844-525-2387
Provider Network: To find a First Health
provider call 800-226-5116 or visit
www.firsthealthcomplimentary.com



PRE CERTIFICATION:

Call MedWatch at 888-673-7706 or online
at wp.urmedwatch.com/precertifications.
All services requiring a Pre-Certification
will be denied if not obtained.

Utilization Review/Inpatient Pre-Admission:
Pre-certification is required for any non-urgent
surgeries or procedures. Confinements must
submit PA within 48 hours of admittance.





THE OZARKS METHODIST MANOR



Group ID#: SBOMM

Name: JOHN SMITH

ID#: A3476BCF1

Non Prev. Office Co-pays:	\$35 / \$55
Urgent Care Co-Pay:	\$55
ER Co-pay:	\$500
RX Benefit:	\$0/\$35/\$75/No Benefit
Ntwk. Ded./Non-Ntwk. Ded.:	\$3,000 / \$6,000
Ntwk. OOP/Non-Ntwk OOP:	\$6,000 / \$12,000



TELEMEDICINE:
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<https://portal.getlyric.com>
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MEDICAL CLAIMS:

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Emdeon payor ID#: 88067
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Customer Service: 945-260-2281
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MEMBER BENEFIT:

Eligibility Benefits- Call 844-525-2387
Provider Network: To find a First Health
provider call 800-226-5116 or visit
www.firsthealthcomplimentary.com



PRE CERTIFICATION:

Call MedWatch at 888-673-7706 or online
at wp.urmedwatch.com/precertifications.
All services requiring a Pre-Certification
will be denied if not obtained.

Utilization Review/Inpatient Pre-Admission:
Pre-certification is required for any non-urgent
surgeries or procedures. Confinements must
submit PA within 48 hours of admittance.





Questions?
314.637.6756

concierge@simparahr.com

ah!

Member

Laclede Chain Manufacturing Company

Group #: SI003

Member ID: 0367477SI003

Member: Trisa L Chapman

Medical Plan

Effective: 07/01/2025

Coverage: Employee Only



Deductible / Out of Pocket Maximum

Mercy: Ind: \$1,500 / \$3,000 | Fam: \$3,000 / \$6,000

In-Net: Ind: \$3,000 / \$6,000 | Fam: \$6,000 / \$12,000

Non-Net: Ind: \$6,000 / \$12,000 | Fam: \$12,000 / \$24,000

Copays: PCP: \$25 Specialist: \$50

Urgent Care: \$75 ER: \$250

Pharmacy Plan

Rx Bin: 012528

PCN: VENTEG

Rx Group: VRX0215



www.ventegra.com

877.867.0943

8512-A1 7333 IC(Added) SI003-SI003 HLT Base-004--M(D)(V)

20250731T01 Sh: 0 Bin 1
J16C Env [4] Csets 1 of 1



Medical Claims Submission

EDI: Payer ID 64884

Mail: Aither Health
PO Box 211440
Eagan, MN 55121
833.894.4382
www.aitherhealth.com



For Provider Locator Assistance outside of the state of MO, please call 800.226.5116 or visit www.myfirsthealth.com

Out of Network claims are paid based on the Maximum Allowable Charge. See applicable Plan Document for details. Acceptance of this card and any subsequent payments received from the Plan will indicate acceptance of the Plan's benefits as payment in full for services rendered. This Plan will only consider an Assignment of Benefits (AOB) valid under the condition that the Provider accepts the payment received from the Plan as consideration in full for services, supplies, and/or treatment rendered.

Eligibility

To confirm eligibility, verify benefits or check the status of a claim, please call Aither Health **833.894.4382**.

This card does not guarantee eligibility or payment. Coverage may be subject to limitations and conditions.

Utilization

Providers:

All providers must call Aither Health for Precertification **833.894.4382**.

Precertification must be obtained for all hospital admissions, outpatient surgeries, imaging, outpatient chemotherapy and radiation in addition to other services as specified in the member's plan.

Notice: Failure to call may result in a penalty or reduction in benefits. Obtained precertification does not guarantee coverage or payment for the service or procedure.





Questions?
314.637.6756

concierge@simparahr.com

ah!

Member

Laclede Chain Manufacturing Company

Group #: SI003

Member ID: 0846442SI003

Member: Sheri Diffley

Medical Plan

Effective: 07/01/2025

Coverage: Employee Only



Deductible / Out of Pocket Maximum

Mercy: Ind: \$1,500 / \$3,000 | Fam: \$3,000 / \$6,000

In-Net: Ind: \$3,000 / \$6,000 | Fam: \$6,000 / \$12,000

Non-Net: Ind: \$6,000 / \$12,000 | Fam: \$12,000 / \$24,000

Copays: PCP: \$25 Specialist: \$50

Urgent Care: \$75 ER: \$250

Pharmacy Plan

Rx Bin: 012528

PCN: VENTEG

Rx Group: VRX0215



www.ventegra.com

877.867.0943

8512-A1 7333 IC(Added) SI003-SI003 HLT Base-004--M(D)(V)

20250731T01 Sh: 0 Bin 1
J16C Env [7] Csets 1 of 1



Medical Claims Submission

EDI: Payer ID 64884

Mail: Aither Health
PO Box 211440
Eagan, MN 55121
833.894.4382
www.aitherhealth.com



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Utilization

Providers:

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Questions?
314.637.6756

concierge@simparahr.com

ah!

Member

Laclede Chain Manufacturing Company

Group #: SI003

Member ID: 0369754SI003

Member: Maria E Hastings

Medical Plan

Effective: 07/01/2025

Coverage: Employee Only



Deductible / Out of Pocket Maximum

Mercy: Ind: \$1,500 / \$3,000 | Fam: \$3,000 / \$6,000

In-Net: Ind: \$3,000 / \$6,000 | Fam: \$6,000 / \$12,000

Non-Net: Ind: \$6,000 / \$12,000 | Fam: \$12,000 / \$24,000

Copays: PCP: \$25 Specialist: \$50

Urgent Care: \$75 ER: \$250

Pharmacy Plan

Rx Bin: 012528

PCN: VENTEG

Rx Group: VRX0215



www.ventegra.com

877.867.0943

8512-A1 7333 IC(Added) SI003-SI003 HLT Base-004--M(D)(V)

20250731T01 Sh: 0 Bin 1
J16C Env [9] CSets 1 of 1



Medical Claims Submission

EDI: Payer ID 64884

Mail: Aither Health
PO Box 211440
Eagan, MN 55121
833.894.4382
www.aitherhealth.com



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Eligibility

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Utilization

Providers:

All providers must call Aither Health for Precertification **833.894.4382**.

Precertification must be obtained for all hospital admissions, outpatient surgeries, imaging, outpatient chemotherapy and radiation in addition to other services as specified in the member's plan.

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Questions?
314.637.6756

concierge@simparahr.com

ah!

Member

Laclede Chain Manufacturing Company

Group #: SI003

Member ID: 0905380SI003

Member: Melissa E Searle

Medical Plan

Effective: 07/01/2025

Coverage: Employee Only



Deductible / Out of Pocket Maximum

Mercy: Ind: \$1,500 / \$3,000 | Fam: \$3,000 / \$6,000

In-Net: Ind: \$3,000 / \$6,000 | Fam: \$6,000 / \$12,000

Non-Net: Ind: \$6,000 / \$12,000 | Fam: \$12,000 / \$24,000

Copays: PCP: \$25 Specialist: \$50

Urgent Care: \$75 ER: \$250

Pharmacy Plan

Rx Bin: 012528

PCN: VENTEG

Rx Group: VRX0215



www.ventegra.com

877.867.0943

8512-A1 7333 IC(Added) SI003-SI003 HLT Base-004--M(D)VU

20250731T01 Sh: 0 Bin 1
J16C Env [10] CSets 1 of 1



Medical Claims Submission

EDI: Payer ID 64884

Mail: Aither Health
PO Box 211440
Eagan, MN 55121
833.894.4382
www.aitherhealth.com



For Provider Locator Assistance outside of the state of MO, please call 800.226.5116 or visit www.myfirsthealth.com

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Eligibility

To confirm eligibility, verify benefits or check the status of a claim, please call Aither Health **833.894.4382**.

This card does not guarantee eligibility or payment. Coverage may be subject to limitations and conditions.

Utilization

Providers:

All providers must call Aither Health for Precertification **833.894.4382**.

Precertification must be obtained for all hospital admissions, outpatient surgeries, imaging, outpatient chemotherapy and radiation in addition to other services as specified in the member's plan.

Notice: Failure to call may result in a penalty or reduction in benefits. Obtained precertification does not guarantee coverage or payment for the service or procedure.





Network Access:



Aetna Signature Administrators®
PPO

www.aetna.com/asa

To verify eligibility, please call EBMS at (866) 462-9051



Crader Distributing Company



Group: 00358

Employee: Stan Beel

ID: 980002503

Medical Coverage: Employee + Spouse

Dental Coverage: Employee + Spouse

EBMS Member Services:

For help finding providers, questions on claims, or information on your plan, please visit mibenefits.ebms.com or call (866) 326-7372

Information for Providers:

For questions regarding your patient's Health Plan, please call (866) 462-9051
For questions regarding your patient's Dental Plan, please call (406) 869-5555

CareLink* Pre-Notification: (866) 894-1505

*CareLink must be notified of all hospital admissions

Submit claims electronically with payer ID #81039 at ebms.com/services/providers

Mail: EBMS

P.O. Box 21367

Billings, MT 59104

Healthcare Provider: this card in no way guarantees benefits

Aetna participating doctors and hospitals are independent providers and are neither agents nor employees of Aetna.

For Out of Network Facility & Out of Network Professional Claims:

www.planlimit.com/crader-distributing-company

Member Applicable Ded/OOP Amounts

In Network Ded: \$3,500 Ind / \$7,000 Fam

In Network OOP: \$7,150 Ind / \$14,300 Fam

Non-Network Ded: \$10,500 Ind / \$21,000 Fam

Non-Network OOP: \$21,450 Ind / \$42,900 Fam

Pharmacy Plan:

Rx BIN: 015433

Rx PCN: SSN

Rx GRP: 00358



Liviniti.com

Member Support: (800) 710-9341

“Shoes for Shots” Incentive Program

The “Shoes for Shots” program is a targeted initiative designed to improve HPV immunization rates among eligible members. Members who have received their first HPV vaccine and complete the full series **by their 13th birthday** within Measurement Year (MY) 2025 will receive a free, brand-new pair of shoes as an incentive.



Why is it Important?

- HPV vaccination is a crucial step in protecting young individuals from HPV-related cancers and diseases.

How the Program Works:

- Members who have already received their first dose of the HPV vaccine will be notified about the program and provided with information on how to participate.
- The member will receive a letter by mail containing a physical form as well as a QR code linking to an online version. After submitting the completed form—either online or by mail—and completing both shots in the series the member will receive the pair of shoes they selected.
- Providers are encouraged to educate families about the importance of the HPV vaccine and inform them of this incentive during well-child visits.



**Shoe brands and style selection are subject to change. Member/member parent/guardian may provide their preference from available selection but is not a guarantee. Shoes are valued at up to \$50 per pair, per member.*

