PROVIDER MANUAL

UNICARE SECURITYCHOICE℠

A Medicare Advantage Private Fee For Service Plan

UniCare®
A Healthy Dose of Innovation℠

2005

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SECTION 1 – INTRODUCTION

UniCare SecurityChoice Overview

UniCare has entered into a contract with the Centers for Medicare and Medicaid Services (CMS) authorizing it to provide Medicare covered services to Medicare beneficiaries through the UniCare SecurityChoice Plan.

The Balanced Budget Act of 1997 (BBA) established a new Medicare+Choice Program that significantly expands the healthcare options available to Medicare beneficiaries. The introduction of this program represents the most significant change in the Medicare program since its inception in 1965. In 2003, the Medicare+Choice Program was renamed Medicare Advantage.

Section 4001 of the BBA (Public Law 105-33), enacted August 5, 1997, added sections 1851 through 1859 to the Social Security Act establishing a new Part C of the Medicare program, which is the Medicare Advantage Program. The new provisions address a wide range of areas, including eligibility, enrollment, benefits, beneficiary protections, quality assurance, participating healthcare professionals, payments to Medicare Advantage Organizations, premiums, contracting rules, appeals, and grievances. These new provisions are incorporated into the appropriate sections of the UniCare SecurityChoice Provider Manual.

UniCare is committed to providing our medical partners with an accurate and up-to-date UniCare SecurityChoice Provider Manual. However, there may be instances where new procedures or processes are not immediately reflected in the manual. In such cases, UniCare makes every effort to publish updated documentation as efficiently as possible.

Important Information for Providers

SecurityChoice from UniCare is an innovative new plan that is easy to participate in. SecurityChoice is available to Medicare beneficiaries in selected areas.

The SecurityChoice Plan works much the same way original Medicare does. There are no referrals for you to process. You simply agree to the Terms and Conditions of the Plan as defined below under Provider Disclosure.

With SecurityChoice, our members are free to go to any hospital or to see any health care provider they choose, as long as the provider is eligible to receive payment by Medicare and agrees to the SecurityChoice Plan's Terms and Conditions. This results in greater flexibility for both health care professionals and our members.

Providers automatically agree to accept the Terms and Conditions under the plan when they are aware their patient is a SecurityChoice member and they choose to extend services to our member. Reimbursement is the same as what you would receive if you were providing services or supplies to any Medicare beneficiary, just submit your bill to UniCare instead of Medicare. When you provide Medicare Covered services to SecurityChoice members, you will be reimbursed by UniCare, less any copayment amounts that are the responsibility of the SecurityChoice Member, based on the current Medicare Allowable Fee Schedule for your area.

Provider Terms and Conditions

Providers are "deemed" participants of the SecurityChoice plan when they have reasonable access to the following Terms and Conditions and knowingly extend services to a SecurityChoice member:

PROVIDER DISCLOSURE – SECURITYCHOICE℠ BENEFIT YEAR 2005

SecurityChoice is a Medicare Advantage Private Fee For Service(PFFS) Plan offered by UniCare Life & Health Insurance Company (UL&H). Prior to providing services to a SecurityChoice member, Providers must agree to the Terms and Conditions of the Plan. When Providers choose to extend services to a SecurityChoice member, they are acknowledging their agreement and are "deemed" to have a contract with UL&H.

Providers who are aware they are treating a SecurityChoice Enrollee and decline to accept the Terms and Conditions of the Plan must only do so if the services are extended on an urgent or emergency basis. Under any other circumstances, Providers who do not agree to accept these Terms and Conditions must not provide services to SecurityChoice Enrollees and they may not bill our Enrollee if they accept Medicare assignment.* If a Provider is unwilling to accept the SecurityChoice Terms and Conditions but renders services for urgent or emergency care, the Provider may collect the applicable copayment from the Enrollee and should submit the remainder of the claim for these services to UL&H at the address provided in this document.

Providers are considered to be deemed when they know in advance of providing services to an Enrollee that the Enrollee is a SecurityChoice Member, and they have reasonable access to the Terms and Conditions of the SecurityChoice Plan.

Federal healthcare providers, including the Veterans Administration, are not eligible for reimbursement under the SecurityChoice Plan, unless the services extended are for urgent or emergency care.

*Providers who do not accept Medicare assignment may balance bill our enrollees up to the Medicare limiting rate of 115%.

Terms and Conditions for Health Care Practitioners and Suppliers

Under the UL&H SecurityChoice Plan, Providers are reimbursed at the equivalent of the current Medicare Allowable amount for all Medicare Covered services. Other than applicable Member cost sharing amounts, reimbursement will be made directly by UL&H. Providers may collect only applicable copayment amounts from SecurityChoice Enrollees and may not otherwise charge or bill the Enrollee. Enrollee balance billing is prohibited by providers who accept Medicare assignment.* Copayments should be collected from the Member at the time of service. If a Provider (either deemed or un-deemed) mistakenly collects more from the Enrollee than the designated copayment amount, the Provider must refund the difference to the Member.

Providers must abide by the UL&H appeal and grievance procedures. Copies of the procedures and the provider manual are available on the internet at www.unicare.com/pffs or upon request by contacting Customer Service at 1-888-445-8916.

UniCare PFFS SecurityChoice Providers are delegated the responsibility to issue Notice of Medicare Non-Coverage (NOMNCs), Detailed Explanation of Non-coverage (DENCs) and Notices of Discharge and Medicare Appeal Rights. Providers that seek deemed status with PFFS plans will thereby be obligated to comply with all notice and case submission requirements effective 1/1/2004. Please visit our Website to download the NOMNC and DENC letter templates.

Providers must also:

- be licensed or certified by the State for the services being provided
- not have opted out of Medicare or be debarred from participation in the Medicare program
- abide by Medicare or other Federal healthcare program laws applicable to the services being provided
- have a Medicare billing number or be eligible to obtain one
- be certified to treat Medicare beneficiaries (if the provider is an institutional provider)
- follow the standards for confidentiality and patient privacy rights outlined in HIPAA regulations
- and, if the provider is a hospital, an advance good faith estimate of the out-of-pocket patient expenses must be provided to our member

In the Event Provider Renders Hospice Services

Providers who render hospice services to Medicare beneficiaries, including SecurityChoice members, should submit claims directly to Medicare through the Regional Home Health Intermediary.

Occasionally, a Provider may inadvertently submit a hospice claim to UL&H for payment and, unaware that the member has enrolled in hospice or that the services rendered were hospice services, UL&H may process and pay the claim. Should this situation occur, and UL&H later determines the claim was paid in error, UL&H will notify Provider that a refund is due and that Provider must bill Medicare for claim(s) payment.

Under the above circumstances, UL&H will expect Provider to issue a full refund within 30 days of notification. Instructions for refund will be included with notification.

If Provider fails to refund the amount due within 60 days of notification, UL&H will withhold all future claim(s) payments due Provider for any and all subsequent services rendered to SecurityChoice members until the refund amount due to UL&H has been satisfied in full.

To determine the appropriate Member copayment for the type of service being rendered, refer to the copayment schedule at right or contact a UL&H Customer Service representative at 1-888-445-8916.

2005 COPAYMENT SCHEDULE

Basic **patient copayment amounts** for Medicare Covered services are as follows:

Physician Services	***Michigan***	***All Other States***
Office Visits	$10	$10

Hospital Services		
Emergency Room Visits (if not admitted)	$25	$50
Inpatient Hospital (per 365 day benefit period)	$50 per stay	$150 per day (days 1-5)
IMPORTANT! If UL&H is not notified in advance of a planned inpatient hospital stay, the Member will be responsible for paying this additional amount ($50 per day, 10-day maximum)	$50	$50

Worldwide Travel Services		
Emergency Services (if not admitted)	$25	$50
Urgently Needed Services	$10	$10

Ancillary Services		
Skilled Nursing Facility (SNF) per day, days 1-20, each benefit period	$0	$0
per day days 21-100, each benefit period (100 day limit each benefit period)	$0	$50
IMPORTANT! If UL&H is not notified in advance of a planned SNF admission, the Member will be responsible for paying this additional amount ($50 per day, 10-day maximum)	$50	$50
Durable Medical Equipment (DME)	20%	35%
IMPORTANT! If UL&H is not notified in advance of a DME equipment or device purchase over $750, the Member will be responsible for this increased percentage (70% of the charge rather than the usual 35% of the charge)	70%	70%
Prosthetic Devices and Medical Supplies	20%	35%
IMPORTANT! If UL&H is not notified in advance of a prosthetic device or medical supply purchase over $750, the Member will be responsible for this increased percentage (70% of the charge rather than the usual 35% of the charge)	70%	70%
Outpatient Mental Health Services (individual or group visit)	$25	50%
Home Health Care Services	$0	15%

Claim Submission

Submit bills directly to UL&H at P.O. Box 3897, Scranton, PA 18505. Bills must be submitted within 365 days of providing services to a UL&H SecurityChoice member.

All Medicare billing guidelines must be followed when submitting your bill to UL&H. Physicians and others with Unique Physician Identification Numbers (UPIN) must include this information on all claims and, if applicable, the Clinical Laboratory Improvement Amendments (CLIA) number must also be included. All other types of providers must include their appropriate Medicare number or sub-provider number for the service rendered on each claim. If you have questions about submitting your claim, contact UL&H at 1-888-445-8916 between the hours of 8 am and 6 pm Central Time, Monday through Friday.

If you have any questions or concerns about your payment, UL&H's Terms and Conditions, or, if you would like more information on UL&H's SecurityChoice Plan, please contact the UL&H Customer Service Department at 1-888-445-8916. Representatives are available to assist you Monday through Friday from 8 am to 6 pm Central Time.

Provider Manual Overview

UniCare is committed to working with both the physician community and members to provide a high level of satisfaction in delivering quality care. The UniCare SecurityChoice Provider Manual is an integral part of this commitment. The manual provides comprehensive benefit information and communicates administrative policies and procedures to the medical community ensuring available and accessible medical care for every UniCare SecurityChoice member.

How to Use this Manual

The UniCare SecurityChoice Provider Manual is divided into sections, covering all aspects of UniCare SecurityChoice administration:

Introduction - This section describes the UniCare SecurityChoice plan's background and function, and it includes important terms and conditions for UniCare providers. In addition, it explains the fundamentals of the UniCare SecurityChoice Provider Manual.

Benefit Explanations & Limitations - This section provides in-depth information on the benefits and limitations to benefits offered by UniCare SecurityChoice.

Eligibility - Eligibility information, including enrollment and disenrollment criteria, appears in this section.

Benefit Administration - Procedures, guidelines, and processes for administering the UniCare SecurityChoice Plan are described in this section, including providing care, emergency care, and coordination of benefits.

Benefit Payment - Aspects of UniCare SecurityChoice payment methodologies are covered in this section.

Provider Administration - This section provides guidelines for various administrative functions.

Member Issues - Procedures for addressing and resolving quality of care, utilization, and administrative issues are described in this section. Also included are member responsibilities and formal Medicare appeals and grievance procedures.

Directory of Services - Provides point-of-contact personnel who are available to address inquiries.

Exhibits - Examples of forms and letters, approved by the Centers for Medicare and Medicaid Services (CMS), used to communicate with UniCare SecurityChoice members, are included.

SECTION 2 – BENEFIT EXPLANATIONS & LIMITATIONS

Introduction

As a Private Fee-for-Service Medicare Advantage Plan, UniCare SecurityChoice covers the same benefits as Medicare. The following is a description of the services covered in this program.

Authorized Services

Authorized Services are those services covered by Medicare. This section provides you with general information on Medicare covered benefits. Please consult Medicare guidelines for additional information.

Abortion - Elective abortions are not covered.

Ambulance - Medicare covers limited ambulance service. Ambulance is covered only if transportation in any other vehicle would endanger your patient's life. Air ambulance is paid only in emergency situations. If land ambulance would not seriously endanger your patient's health Medicare will only reimburse land ambulance rates.

Anesthetics - Anesthetic administration in conjunction with surgical services in a hospital, outpatient surgical center, or at the medical group, is covered.

Bone Density Measurement - Measuring bone density for screening and managing female members at high risk for osteoporosis is a covered benefit. These patients must meet Medicare requirements.

Chiropractic Services - Chiropractic services are covered in accordance with Medicare guidelines, and are limited to services performed by a chiropractor licensed by the State. This benefit covers the manual manipulation of the spine to correct a subluxation. (A subluxation is defined as a complete dislocation, off centering, misalignment, fixation, or abnormal spacing of the vertebrae.)

Colorectal Screening - Effective January 1, 1998, colorectal cancer screening is a covered service. The test may consist of any of the following procedures: 1) screening fecal-occult blood test, 2) screening flexible sigmoidoscopy, and 3) screening colonoscopy for high-risk individuals.

Cosmetic Surgery - Cosmetic surgery is also known as aesthetic surgery and is intended only to improve the appearance of the body (for beautification purposes). Benefits are not provided for cosmetic surgery and related services. Reconstructive surgery is a covered benefit as it is intended primarily to improve bodily function, relieve symptomatology, or improve appearance that is altered by disease, trauma, or previous therapeutic processes (e.g., when surgery is performed to effect breast reconstruction after a mastectomy), or exists because of congenital or developmental abnormality. Cosmetic services do not become reconstructive services because of psychiatric reasons.

Diabetes Education and Home Monitoring - Effective January 1, 1998, diabetes outpatient self-management training services are a covered benefit. These services include educational and training services furnished to an individual with diabetes by a certified healthcare professional in an outpatient setting meeting certain quality standards. Blood glucose monitors and testing strips are now covered for Type II diabetics and without regard to a person's insulin use.

Diagnostic Procedures (Outpatient) - Medically necessary outpatient diagnostic radiology and laboratory procedures, services, and materials are covered.

Dialysis - Hemodialysis, renal dialysis, and peritoneal dialysis are covered services.

Durable Medical Equipment - Durable medical equipment (DME) includes appliances, devices, and equipment that are prescribed by a physician for the treatment of an illness, disease, or injury. Medicare coverage guidelines should be used to determine coverage. The supplier must have a

Medicare supplier number. Suppliers need to meet Medicare standards. UniCare will not pay claims without a supplier number even if supplies are provided by a large chain or department store.

Eye Exams - Routine eye exams are for the purpose of prescribing, fitting, changing eye glasses (and contact lenses), or determining the refractive state of the eyes. While routine eye exams are not covered by Medicare, SecurityChoice members are covered for one routine eye exam each year. SecurityChoice members are responsible for 50% of billed charges for one routine exam each year. SecurityChoice will pay the other 50%.

Foot Care - Medicare generally does not cover routine foot care.

Hearing Exams/Aids - Routine hearing exams are performed without relationship to treatment or diagnosis for specific illness, symptom, complaint, or injury and are NOT required by third parties (i.e., insurance companies, business establishments, governmental agencies). While Medicare generally does not cover hearing exams or hearing aids, SecurityChoice members are covered for one routine exam every 24 months with a $10 copay.

Home Health Care - Medicare coverage guidelines should be used to determine coverage. Skilled nursing services are services ordered and included in the written treatment plan established by the patient's physician. The services must be performed by, or under the direct supervision of, a licensed nurse (RN, LVN) to ensure the patient's safety.

In determining whether a service requires the skill of a nurse, consideration must be given to both the service's inherent complexity and the condition of the patient. A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a licensed nurse. When the nature of the service is such that it can be safely and effectively performed (or self-administered) by the average layperson without the direct supervision of a licensed nurse, the service cannot be regarded as a skilled nursing service even though a licensed nurse actually provides the services.

Hospice - In order to be eligible to elect hospice care, a patient must be entitled to Part A and Part B of Medicare, and must be certified as terminally ill by an attending physician and Hospice Medical Director. To be considered terminally ill, the individual must have a medical prognosis that life expectancy is 6 months or less. Once the member's attending physician has diagnosed the terminal illness and determines the need for hospice care, the member must be advised of the availability of the hospice care. Such services must be provided by Medicare-certified hospice centers. The hospice obtains, from the attending physician, a certification statement that the individual is terminally ill. The hospice also obtains an election of hospice benefits from the patient. The election statement may vary.

Lab Services - Medicare covers medically necessary diagnostic lab services when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare.

Mammography - Medicare covers screening mammography on an annual basis for women aged 40 and over. No deductible or copayment applies for this service.

Mental Health Visits - Physician mental health visits to a hospital or skilled nursing facility are covered based on Medicare guidelines.

Nursing Home Care - Medicare coverage guidelines should be used to determine coverage. Most nursing home care is custodial. Generally Medicare does not cover custodial care.

Outpatient Hospital Services - Medicare Part B covers medically necessary outpatient services from a Medicare-participating hospital for diagnosis or treatment of an illness or injury.

Pap Smear and Pelvic Exam - A screening pelvic exam, including a clinical breast examination, is now covered every 24 months. Coverage for both Pap smears and screening pelvic examinations is covered annually for women who are at high risk of developing cervical or vaginal cancer.

Physical Exams - Routine physical exams are performed without relationship to treatment or diagnosis for specific illness, symptom, complaint, or injury and are NOT required by third parties (i.e., insurance companies, business establishments, governmental agencies). While routine physical exams (baseline health assessments) are not covered by Medicare, SecurityChoice members are covered for one routine physical exam each year with a $10 copay (not including lab services).

Prostate Cancer Screenings - Prostate Specific Antigen (PSA) blood tests and digital rectal examinations are covered. Prostate cancer screening tests/procedures for the early detection of prostate cancer are covered for men ages 50 and older.

Radiation Therapy - Radiation services are covered in a hospital inpatient or outpatient setting.

Surgical Services - Surgical services in the hospital, at an ambulatory surgical center, or at the medical group, including the surgeon or specialist, assistant, and anesthetist's services, together with the appropriate postoperative care, are covered using Medicare guidelines.

Authorized Hospital Services

Inpatient Services - Inpatient services in a hospital are a covered benefit based on Medicare guidelines. Medicare coverage includes: semiprivate room, or in special treatment units licensed by the State, such as cardiovascular surgery or coronary care. All inpatient services and supplies (including those for nervous and mental care) that are medically necessary and not specifically excluded for the condition requiring confinement are provided.

Mental and Nervous Disorders - Mental or nervous disorders (psychiatric care) admissions are covered benefits. Psychiatric confinement to a general hospital is covered in the same manner as inpatient services provided for any other condition. Admission to psychiatric hospitals is limited to a 190-day lifetime maximum.

Skilled Nursing Facility (SNF) Care - Medicare covers skilled care in a skilled nursing facility under certain conditions for a limited time.

Skilled nursing services are services ordered and included in the written treatment plan established by the patient's physician. The services must be performed by, or under the direct supervision of, a licensed nurse (RN, LVN) to ensure the patient's safety.

In determining whether a service requires the skill of a nurse, consideration must be given to both the service's inherent complexity and the condition of the patient. A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a licensed nurse. When the nature of the service is such that it can be safely and effectively performed (or self-administered) by the average layperson without the direct supervision of a licensed nurse, the service cannot be regarded as a skilled nursing service even though a licensed nurse actually provides the services.

Limitations

The following are general limitations to the UniCare SecurityChoice plan. This list is designed to allow a physician general guidelines for coverage determinations for which UniCare SecurityChoice is not required to furnish benefits or services except as noted. Please call UniCare customer service for any clarifications.

Acupuncture

Benefit Limit Reached - Services received after the benefit limit under the member's benefit agreement is reached.

Chiropractic Services - Chiropractic services, except for manual manipulation for subluxation of the spine as specifically stated in the member's Evidence of Coverage (EOC).

Contraceptive Device - Contraceptive devices prescribed for birth control.

Cosmetic Surgery - Cosmetic surgery or other services for beautification, including any complications arising from or as the result of

cosmetic surgery. However, medically necessary prosthetic devices and reconstructive surgery provided to restore symmetry following a medically necessary mastectomy are covered.

Custodial Care or Rest Cures - Inpatient room and board charges in connection with a hospital stay primarily for environmental change, personal or comfort items, physical therapy, chronic pain treatment, or for diagnostic tests that could be performed safely on an outpatient basis.

Services provided by a rest home, a home for the aged, a nursing home, or any similar facility. Services provided by a skilled nursing facility, except as specifically stated in the member's EOC. Custodial care includes, but is not limited to:

1. Getting in and out of bed/repositioning
2. Feeding (not tube feeding)
3. Supervising medications that are ordinarily self-administered
4. Personal care
   a. Help in walking
   b. Dressing
   c. Bathing
   d. Hair care
   e. Skin care
   f. Oral hygiene
   g. Shaving
   h. Fingernail care
   i. Bedpan/urinal use
   j. Assistance in dressing
   k. Colostomy care
   l. Urinary catheter care
5. Assistance with ambulation; range of motion/position; walker, cane, or wheelchair use
6. Simple nonsterile dressing changes
7. Simple deciliter nondraining wound dressing care
8. Nonmedical enemas
9. Application of warm/cold packs

Dental Services or Supplies - Dental care, except surgery of the jaw or related structures, setting fractures of the jaw or facial bones, or services that would be covered when provided by a physician except as specifically stated in the member's EOC. Dental plates, bridges, crowns, caps or other dental prostheses, dental services, teeth extraction, or teeth or gum treatment. Cosmetic dental surgery or other services for beautification.

Durable Medical Equipment and Medical Supplies - Durable medical equipment that does not meet Medicare coverage criteria is excluded.

Examinations (Routine) - Routine physical or psychological examinations or tests that do not directly treat an actual illness, injury, or condition, including those required by employment or government authority, or at the request of a third party such as a school, camp, or sport-affiliated organization. Exception: one annual routine physical exam (not including labs services) with a $10 copay.

Experimental or Investigative Procedures

Eye Surgery for Refractive Defects - Any eye surgery solely for the purpose of correcting refractive eye defects such as nearsightedness (myopia) or astigmatism.

Government Treatment - Any services provided by a local, state, or federal government agency, except Medi-Cal. Veterans Administration hospitals and military treatment facilities are considered for payment according to current legislation.

Hearing Aids

Homemaker Services

Maximum Limiting Charge Excess - Any amounts in excess of the Medicare maximum limiting charge for care rendered by a noncontracting UniCare SecurityChoice provider.

Naturopath Services - The therapeutic system that does not use drugs but employs natural forces such as light, heat, air, water, and massage.

Not Covered - Services received before the member's effective date or during an inpatient stay that began before the member's effective date. Services received after the member's coverage ends, except as specifically stated in the member's EOC.

Not Medically Necessary - Services or supplies that are not medically necessary.

Not Specifically Listed - Services not specifically listed in the member's EOC or not covered by Medicare.

Nutritional Counseling - Nutritional counseling, food supplements, and meals delivered to the member's home.

Obesity - Services primarily for weight reduction or obesity treatment. This exclusion will not apply to surgical obesity treatment if:

1. Surgical obesity treatment is necessary to treat another life-threatening condition involving obesity
2. It is documented that nonsurgical obesity treatments have failed.

Optometric Services or Supplies - Optometric services, vision/eye exercises, and orthoptics except for eye examinations determining the need for vision correction. Eyeglasses or contact lenses, except an implanted lens that replaces the organic eye lens as specifically stated in the member's EOC. Contact lenses or eyeglasses are covered after cataract surgery.

Orthodontia - Braces, other orthodontic appliances, or orthodontic services.

Orthopedic Shoes - Orthopedic shoes, unless they are part of a leg brace and are included in the orthopedist's charge; except for one pair of therapeutic shoes and inserts per year for those suffering from diabetic foot disease.

Personal Comfort Items - Personal comfort items that are furnished primarily for personal comfort or convenience. Air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators, and supplies for hygiene or beautification.

Prescription Drugs - Outpatient prescription drugs and medications unless prescribed to a registered bed patient in a hospital or skilled nursing facility, or administered in an authorized home health agency program, except as specifically covered by Medicare.

Private Duty Nursing - Inpatient or outpatient services of a private duty nurse unless UniCare SecurityChoice determines that such services are medically necessary in advance of services being rendered.

Services Provided by Family - Professional services received from a person who usually lives with the member or is related to the member by blood, marriage, or adoption.

Sex Transformation - Procedures or treatments to change characteristics of the body to those of the opposite sex.

Smoking Cessation - Smoking cessation programs for treating nicotine or tobacco use.

Telephone Consultations

Voluntary Payment - Services that the member is not legally obligated to pay. Services for which no charge is made to the member in the absence of insurance coverage, except services received at a nongovernmental charitable research hospital. Such a hospital must meet the following guidelines:

1. It must be internationally known as being devoted mainly to medical research
2. At least 10% of its yearly budget must be spent on research not directly related to patient care
3. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care
4. It must accept patients who are unable to pay
5. Two-thirds of its patients must have conditions directly related to the hospital's research

Work-Related Conditions - Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement, or otherwise, under any workers' compensation, employers' liability law, or occupational disease law, even if the member does not claim those benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, benefits are provided subject to UniCare SecurityChoice's right of recovery and reimbursement.

SECTION 3 – ELIGIBILITY/CONTRACT CHANGES/TERMINATIONS

Introduction

A wide variety of criteria are used to determine who is eligible for benefits and when a member's eligibility begins and when it terminates. This section provides guidelines on who is eligible for benefits, when benefits become effective, and when they terminate.

Eligibility Criteria

UniCare uses the following criteria to determine eligibility for UniCare SecurityChoice members:

1. A subscriber must be entitled to Medicare under Part A and enrolled in Part B.
2. A subscriber must reside within the UniCare SecurityChoice service area. The UniCare SecurityChoice service area is the area in which UniCare is given approval to provide services to Medicare beneficiaries by CMS.
3. A subscriber must not be diagnosed as having end-stage renal disease (permanent kidney failure requiring regular kidney dialysis or a transplant to maintain life). An individual who receives a transplant that restores kidney function should not be considered to have ESRD for purposes of Medicare eligibility.

A member cannot lose eligibility in UniCare SecurityChoice solely because the member develops end-stage renal disease while enrolled in UniCare SecurityChoice. If a subscriber meets the above conditions, the member cannot be denied membership in UniCare SecurityChoice on the basis of the member's health.

Enrollment

If the Medicare beneficiary is eligible as outlined above, the member may submit a completed enrollment application form to UniCare at any time during the year. A properly completed enrollment application form must be submitted for each Medicare beneficiary wishing to enroll in UniCare SecurityChoice. All enrollment applications are processed in the order in which they are received.

If the Medicare beneficiary is already a member of another Medicare Advantage plan, membership in that Medicare Advantage plan automatically ends on the effective date of his or her enrollment in UniCare SecurityChoice.

When Coverage Becomes Effective

UniCare SecurityChoice allows for five different periods in which beneficiaries may enroll in a Medicare Advantage plan. These include the following:

1. Initial coverage election period - This election period is the 3 months prior to the entitlement effective date to both Part A and Part B.
2. Annual election periods - For an election or change of election made in November, coverage is effective on the 1st day of the following calendar year.
3. Open enrollment periods - For complete applications received by UniCare SecurityChoice by the end of the month, coverage is effective the 1st day following the month in which the election is made.
4. Special election periods governed by special circumstances - The effective date of coverage is determined by CMS.
5. Special election period for individuals age 65 electing to return to original Medicare - Coverage is effective the 1st day of the 1st calendar month following the month in which the election is made.

If the member pays the required premiums to UniCare when they are due, the effective coverage date for that person is the date indicated on the letter sent to the new member to confirming CMS approval of the member's enrollment in UniCare SecurityChoice.

From the effective date forward, the member must receive all health care from UniCare SecurityChoice healthcare professionals and facilities, with the exception of the following:

Emergency Services

UniCare SecurityChoice members are instructed, as specified in their Evidence of Coverage, to go to the nearest medical facility. The Evidence of Coverage defines emergency services as services that may be furnished by a healthcare professional due to the immediacy of an injury, condition, or sudden serious illness. Coverage for emergency services is not limited to deemed providers.

Termination of Coverage

The following guidelines must be followed by UniCare for disenrollment:

1. Optional disenrollment
    a. Monthly premiums are not paid on a timely basis, subject to the grace period for late payment. A written notice of nonpayment is sent to the member within 20 days after the date the delinquent charges were due. It alerts the member that the premiums are delinquent and provides the member with an explanation of the disenrollment procedures. It further advises that failure to pay the premiums within the 90-day grace period will result in termination of Medicare Advantage coverage.
    b. The member's behavior is disruptive, unruly, abusive, or uncooperative to the extent that his or her continued enrollment in the plan seriously impairs the Medicare Advantage Organization's ability to furnish services to the member or to other individuals enrolled in the plan.

       UniCare will make an effort to resolve the problem(s) presented, including the use of grievance procedures. The beneficiary has the right to submit any information or explanation to UniCare. UniCare must establish that the member's behavior is not related to using medical services or to diminished mental capacity.

       UniCare documents the member's behavior, its own efforts to resolve the problem(s), and any extenuating circumstances. CMS reviews the proposed disenrollment and makes a decision within 20 working days after receipt of the documentation and notifies UniCare within 5 working days after making its decision. If CMS permits UniCare to disenroll an individual for disruptive behavior, the termination is effective the 1st day of the calendar month after the month in which UniCare gives the individual written notice of the disenrollment.
    c. The member commits fraud or permits abuse of enrollment card.

       The member knowingly provides, on the election form, fraudulent information that materially affects the member's eligibility to enroll in UniCare SecurityChoice. The member intentionally permits others to use his or her enrollment card to obtain services under UniCare SecurityChoice. UniCare must give the member a written notice of the disenrollment and report to CMS any disenrollment based on fraud or abuse.

2 Required Disenrollment.
    a. The member no longer resides in the plan's service area. UniCare must disenroll the member, on the basis of a confirmation from the member or other evidence acceptable to CMS, that he or she moved out of a plan's service area for more than 6 months.

b. The member loses entitlement to Part A or Part B benefits. The disenrollment is effective the 1st day of the calendar month following the last month of entitlement to Part A or Part B benefits.

c. Death of the member. If the member dies, disenrollment is effective the 1st day of the calendar month following the month of death.

3. Medicare Advantage Organization termination or service area reduction. If the Medicare Advantage Organization terminates or is terminated or the service area is reduced with respect to all members in the area in which they reside, UniCare must give each member a written notice of the effective date of the Medicare Advantage Organization termination or area reduction. Also included must be a description of alternatives for obtaining benefits under the Medicare Advantage program. This notice must be sent before the effective date of the Medicare Advantage Organization termination or area reduction.

A member's coverage may not be terminated because of the member's health status or requirements for health care services.

Effective/Termination Date Coincides with a Hospital Stay

If a member's effective date occurs during an inpatient stay in a hospital, UniCare SecurityChoice is not responsible for any services under Medicare Part A during the inpatient stay. (This provision applies to acute hospital stays only, not to stays in a skilled nursing facility.)

UniCare is responsible for inpatient hospital service under Part A on the day after the day of discharge from the inpatient stay. All other services, other than inpatient hospital services under Part A, are covered under the UniCare SecurityChoice plan beginning on the effective date of enrollment.

If the member's UniCare SecurityChoice coverage terminates while the member is hospitalized, UniCare is responsible for the hospitalization until discharge regardless of the reason for the termination.

SECTION 4 – BENEFIT ADMINISTRATION

Introduction

This section explains the method by which benefits offered in the UniCare SecurityChoice Plan are to be administered. Eligibility, copayment collection, and denial of services are discussed.

Professional Services Administration

When an individual seeks medical attention at a physician's office, it is important that the member's eligibility status be verified. Only after eligibility is verified will UniCare assume liability for professional care if a person is later determined to be ineligible. Use the following methods to determine eligibility status before providing services.

UniCare SecurityChoice Identification Card

All UniCare SecurityChoice subscribers are issued a UniCare SecurityChoice ID card displaying the following information.

1. UniCare SecurityChoice group number
2. Subscriber's Health Care indentification number
3. Subscriber name
4. Benefit information
5. Phone number for UniCare SecurityChoice's Customer Service Department

The ID card should be carried by the member at all times and presented when seeking medical services. If a member loses an ID card, the member should be advised to call UniCare SecurityChoice Customer Service.

Release of Medical Records Authorization

All new members are required to fill out an enrollment form containing the Authorization for Release of Medical Records.

Medical Records Confidentiality and Accuracy

For any medical records or other health or enrollment information the physician maintains for UniCare SecurityChoice members, the following procedures must be incorporated:

1. Safeguard the privacy of any information that identifies a particular member. Information from, or copies of, records may be released only to authorized individuals. Be sure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released only in accordance with federal or state laws, court orders, or subpoenas.
2. Maintain the records and information in an accurate and timely manner.
3. The member must have timely access to his or her records and information that pertains to them in accordance with federal and state regulations.
4. Abide by all federal and state laws regarding confidentiality and disclosure for mental health records, medical records, and other health and member information.

Determining Covered Benefits

After eligibility is established, the member should complete all the forms required by the physician's office. All treatment must be provided in accordance with the subscriber's UniCare SecurityChoice Evidence of Coverage.

The UniCare SecurityChoice Group number, which is listed on the member's ID card, indicates the benefits to which the member is entitled. The member is liable for payment of any medical services not covered in the member's Evidence of Coverage, provided the member is informed in advance that services are not covered.

The only charges for which a member may be liable and billed are the following:

1. Services not covered under the member's benefit agreement

2. Copayments, deductibles, or coinsurance under the terms of the member's benefit agreement

Copayment Collection

For professional, urgent care, outpatient, or inpatient services, a copayment or co-insurance should be collected from the member. The physician's office must advise the member of the responsibility to pay a copayment prior to rendering any service that requires a copayment. Since copayments vary, check the benefit schedules before the copayment is collected. Copayments/co-insurance for services are collected at the time services are rendered. However, if immediate copayment collection is not possible, then a billing may be established and sent to the member for payment at a later date.

In lieu of the specified Plan copayment or coinsurance amount, enrollees pay 20% coinsurance when they choose to receive services from a Rural Health Clinic (RHC), Community Health Clinic or Federally Qualified Health Clinic (FQHC).

Rural/Community Health Clinics and Federally Qualified Health Clinics are located in designated "shortage areas." Shortage areas are defined geographic areas designated by the Department of Health and Human Services as having either a shortage of personal health services or shortage of primary medical care manpower. Rural health clinic services in shortage areas are reimbursable when furnished to a patient at the clinic, at a hospital or other medical facility, or at the patient's place of residence. Community health clinic services are covered only in outpatient settings, including the patient's place of residence.

COPAYMENT/COINSURANCE SCHEDULE

Type of Service	*Member Copay Michigan*	*Member Copay All Other States*
Outpatient Services		
Office Visit	$10	$10
Outpatient surgery (provided in an outpatient hospital facility)	$25	$75
Outpatient surgery (provided in an ambulatory surgical center)	$25	$75
Emergency Room Visits (if not admitted)	$25	$50
Emergency Room Visits (if admitted within 72 hours)	$0	$0
Outpatient Substance Abuse (Medicare-covered individual or group visit)	$10	$10
Chiropractic (Medicare-covered visit)	$10	$10
Podiatry (Medicare-covered visit)	$10	$10
Outpatient Rehabilitation Services (Medicare-covered visit)	$10	$10
Inpatient Services		
Inpatient Hospital when UL&H is notified in advance of a planned stay	$50 per admission	$150 per day (days 1-5)
Inpatient Hospital (additional per day up to 10 days when UL&H is not notified in advance of a planned stay)	$50	$50
Skilled Nursing Facility (SNF) if UL&H is notified in advance of a planned stay:		
Per day, days 1-20, each benefit period	$0	$0
Per day days 21-100, each benefit period *(Note: there is a 100 day limit each benefit period)*	$0	$50
Skilled Nursing Facility (SNF) (additional per day up to 10 days when UL&H is not notified in advance of a planned stay)	$50	$50
Inpatient Mental Health Care (each Medicare-covered stay) if UL&H is notified prior to admission	$50	$300
Inpatient Mental Health Care (additional per day up to 10 days if UL&H is not notified prior to admission)	$50	$50
Ambulance Services		
Each medically necessary trip	$25	$75
Worldwide Travel Services		
Emergency Services (if not admitted)	$25	$50
Emergency Services (if admitted within 72 hours)	$0	$0
Urgently Needed Services	$10	$10
Ancillary Services		
Durable Medical Equipment (DME) (unless purchase amount is over $750 and UL&H is not notified in advance of purchase)	20%	35%
Durable Medical Equipment (DME) (if purchase amount is over $750 and UL&H is not notified in advance of purchase)	70%	70%
Prosthetic Devices and Medical Supplies (unless purchase amount is over $750 and UL&H is not notified in advance of purchase)	20%	35%

COPAYMENT/COINSURANCE SCHEDULE (CONTINUED)

Type of Service	*Member Copay Michigan*	*Member Copay All Other States*
Ancillary Services (continued)		
Prosthetic Devices and Medical Supplies (if purchase amount is over $750 and UL&H is not notified in advance of purchase)	70%	70%
Outpatient Mental Health Services (individual or group visit)	$25	50%
Home Health Care Services	$0	15%
Preventive Services		
Baseline Health Assessment (one routine health examination per year)	$10	$10
Hearing Services (one routine hearing exam every 24 months)	$10	$10
Vision Care		
Medicare-covered visit	$10	$10
Routine exam (one per year)	50%	50%
(Note: UL&H provides a $75 allowance for eyeglass frames and lenses every 24 months)		
Prostate Cancer Screening (Medicare-covered visit for men age 50 and older)	$10	$10
Immunizations (Medicare-covered Pneumococcal pneumonia vaccine, Flu shot, Hepatitis B vaccine (if at risk of contracting the disease), Other vaccines for those at risk (e.g., anti-rabies vaccine for those possibly exposed to rabies) (Note: $10 office visit copayment may apply)	$0	$0
Bone Mass Measurements (Medicare-covered visit)	$10	$10
Colorectal Screening (Medicare-covered visit)	$10	$10
Other Services		
Diabetes Monitoring (Medicare-covered visit)	$10	$10
Medical Nutrition Therapy (Medicare-covered visit)	$10	$10

UniCare Health Risk Assessment

UniCare conducts a new enrollee health risk assessment using the University of Minnesota Pra+® survey instrument within 90 days of a new member's effective enrollment.

General Service Guildelines

Emergency Services

UniCare SecurityChoice members are instructed, as specified in their Evidence of Coverage, to go to the nearest medical facility. The Evidence of Coverage defines emergency services as services that may be furnished healthcare professional due to the immediacy of an injury, condition, or sudden serious illness.

Emergency Services Denial

In determining whether emergency services are covered, UniCare will review the symptoms present at the time services were obtained and must consider the frame of mind and reasonable belief of the member, regardless of the medical outcome of the services.

Denial of Other Services

UniCare complies with all CMS regulatory requirements in regard to denials and denial notices accuracy and timeliness. Medicare law regulates claim payment and service authorization processes for Medicare Advantage Organizations ensure beneficiaries receive the benefits to which they are entitled and beneficiaries understand their rights to appeal any adverse coverage determination. Members have the right to appeal to their health plan.

Medicare law and regulations require that Medicare Advantage Organizations process claims promptly and provide beneficiaries with written notices of noncoverage when they deny requests for payment or services. The law and regulations also require that Medicare Advantage Organizations ensure those written notices contain clear reasons for denial and that they provide a complete description of the appeal process.

1. The initial decision: If services are denied UniCare will review all issues to determine if care meets coverage guidelines. We will inform the member of the member's rights to reconsideration.
2. If the member disagrees with the decision, they can ask to have the decision 'reconsidered' or appealed. After reviewing the appeal UniCare will decide to stay with the original decision or overturn the decision and give the patient some or all of the care they want.
3. If we turn down the request in step 2 we are required to send the request to an independent review organization that is appointed by the Federal government and not part of UniCare.
4. If the patient is unhappy with that decision they may request an Administrative Law Judge consider the case and render a decision.
5. This decision can be reviewed by a Departmental Appeals Board. This Board is part of CMS.
6. Finally Federal Court can be requested to review the case if it is greater than $1,000 of medical services. The court will make the final determination.

The reason for these requirements is that the right to appeal denials is one of the most basic and important beneficiary protections in the Medicare Advantage program. If Medicare Advantage fails to clearly advise beneficiaries of this right in an intelligible and complete manner, beneficiaries will fail to execute this basic right due to lack of information.

Expedited Organization Determination Review Process

The following procedures and time frames were developed to comply with CMS regulations that require establishing an expedited review process for requests for service, care reductions, and care termination in time-sensitive situations.

Specifically, CMS indicated that an expedited organization determination must be granted if the member's life, health, or ability to regain maximum function could be jeopardized by waiting for a decision under the standard 14-day organization determination process. Situations that might warrant an expedited review include the following:

1. Physical therapy termination
2. Skilled nursing facility services or courses of treatment
3. Pre-service requests
   a. Specialist referrals
   b. Therapies
   c. Course of treatment
   d. Diagnostic tests

Determining whether a case is expedited will be made by UniCare SecurityChoice. Refer all requests for expedited organization determination to UniCare SecurityChoice Customer Service. The UniCare Case Management Department determines if the criteria is met. Decisions pertaining to denying claim payments do not qualify for expedited review.

Notice of Discharge and Medicare Appeal Rights (NODMAR)

The Center for Medicare and Medicaid Services requires the hospital to issue notices of non-coverage to members who are about to be discharged from the hospital due to the decision that their hospital stay is no longer medically necessary. The main responsibility for administering the notice of non-coverage requirement lies with the hospital.

Hospitals are responsible for the following:

1. Issuing a written notice of non-coverage to a patient when a stay is determined to be no longer medically necessary.
2. Informing patients of their right to appeal the discharge decision. This information must be given to the member on admission. Members must also be made aware of the 72-hour expedited appeals process.

A member cannot be held liable for the cost of hospital care until advance notification of non-coverage is made.

Appealing a NODMAR

The Center for Medicare and Medicaid Services (CMS) has a rule: *Appeal Rights and Procedures for Beneficiaries Enrolled in Prepaid Health Care Plans* (Regulations 42 CFR 417.440 (f), 417.454 (b), and 417.605). Contracting hospitals are required to comply with the requirements of this rule.

The appeal rights give Medicare enrollees the right to an immediate review by a PROQuality Improvement Organization (QIO). QIO reviews are initiated by the patient when a decision is made to discharge the patient from a hospital stay that is no longer medically necessary.

In order to meet the intent and purpose of the beneficiary right to a QIO review, hospitals are responsible for the following:

1. Informing UniCare SecurityChoice members of their appeal rights on admission
2. Issuing the NODMAR to a patient when a stay is determined to be no longer medically necessary

If the member misses the deadline for immediate review, the member may still request a review through the procedures delineated in the notice of non-coverage. The member must appeal to the QIO first.

Notice of Medicare Non-Coverage (NOMNC)/Detailed Explanation of Non-Coverage (DENC)

Beginning on January 1, 2004, enrollees of Medicare Advantage plans, such as UniCare SecurityChoice, will have the right to an expedited review by a Quality Improvement Organization (QIO) when they disagree with their Medicare Advantage plan's decision that Medicare coverage of their services from a skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) should end. This new right stems originally from the Grijalva lawsuit and was established in regulation in a final rule published on April 4, 2003 (68 FR 16652). It is similar to the longstanding right of a Medicare beneficiary to request a QIO review of a discharge from an inpatient hospital.

Based on the provisions of the April 2003 final rule, SNFs, HHAs, and CORFs must provide an advance notice of Medicare coverage termination to MA enrollees no later than 2 days before coverage of their services will end. If the patient does not agree that covered services should end, the enrollee may request an expedited review of the case by the QIO in that state. Please see the chart on the next page of the QIOs in each state SecurityChoice offers coverage. SecurityChoice has delegated the responsibility to deemed SNFs, HHAs, and CORFs to furnish a Detailed Explanation of Non-Coverage (DENC), which explains why services are no longer necessary or covered. The review process generally will be complete within less than 48 hours of the enrollee's request for a review.

Please visit our Website to download the NOMNC and DENC letter templates at www.unicare.com/pffs.

For additional information or education on the Grijalva final rule please visit www.cms.hhs.gov/healthplans/appeals

Quality Improvement Organization

State	Organization and Website Link	Telephone Number
Illinois	Illinois Foundation for Quality Health Care (www.ifghc.org)	630-571-5540
Indiana	Health Care Excel (www.hce.org)	317-347-4500
Iowa	Iowa Foundation for Medical Care (www.ifmc.org)	515-223-2900
Kentucky	Health Care Excel (www.hce.org)	812-234-1499
Michigan	Michigan Peer Review Organization (www.mpro.org)	248-465-7300
Minnesota	Stratis Health (www.stratishealth.org)	952-854-3306
Nebraska	CIMRO of Nebraska (www.cimronebraska.org)	402-476-1399
North Carolina	Medical Review of North Carolina (www.mrnc.org)	919-851-2955
Utah	HealthInsight (www.healthinsight.org)	801-892-0155
Virginia	Virginia Health Quality Center (www.vhqc.org)	804-289-5320
Wisconsin	MetaStar (www.metastar.com)	608-274-1940

Workers' Compensation

Workers' compensation coverage is founded on the philosophy that industry should provide employees with injury protection as a cost of doing business, and that benefits should be provided without regard to whom is at fault when an injury occurs in the course of employment.

The UniCare SecurityChoice Plan excludes coverage for work-related conditions. However, there are many cases in which an industrial injury is in dispute, and the employer refuses to accept liability for the illness or injury. When these types of cases occur, the UniCare SecurityChoice Plan will provide coverage subject to the following guidelines:

1. Once a work-related injury or illness is accepted by an employer, UniCare denies claims for that illness or injury.
2. However, if UniCare is advised that the employer's workers' compensation carrier denied payment of the claim, UniCare will pay the related claims, and file a reimbursement lien if the carrier's decision is appealed.
3. When reimbursement is paid, claims are adjusted to reflect the amount collected.

A physician should question a member seeking medical treatment when the nature of the illness or injury appears to be work-related. Some employers insist that all workers' compensation cases be handled through their private worker's compensation physicians, and only when authorized; these employers will not reimburse any other healthcare professional or facility.

PAYMENT METHODOLOGY

Acute Care Hospital ***Inpatient Services***	UniCare will calculate the Medicare Base Payment Rate, any Outlier amount, Operating Expense, Capital Expense, Disproportionate Share, Organ Acquisition costs and Transfer payments.
Acute Care Hospital ***Outpatient Services***	UniCare will utilize the Outpatient National Medicare Provider Rate File (ONMPRF) to group/price APC claims for ANY Medicare-approved provider. When processing an APC claim, components that comprise the total reimbursement amount (i.e., accounting for outliers, drugs and devices paid as passthroughs) will be included.
Ambulance ***Independent and Provider Based***	Blended method between reasonable charge for ambulance supplier and national fee schedule. Reasonable charge for provider is added to the correct percentage of the national fee schedule for that year to arrive at payment. If necessary, ambulance company can submit Medicare RA showing correct amount.
Anesthesia/Physician Performed	UniCare will calculate according to Medicare's methodology: Medicare anesthesia conversion factor by locality x sum of uniform base units + time units.
Anesthesia ***Physician Medical Direction of 2 or more Nurse Anesthetists concurrently***	UniCare will calculate according to Medicare's methodology: Medicare anesthesia conversion factor by locality x sum of uniform base units + time units.
Ambulatory Surgical Center	Utilize fee schedules via CMS or intermediary website.
Assistant at surgery ***(Physicians)***	If physician is assistant, payment is 16% MFS. If physician assistant is assistant, payment is 85% times 16% MFS.
Blood	Reimbursed under OPPS for hospital outpatient services.
Braces	100% of the Medicare Durable Medical Equipment Prosthetic, Orthotic and Supplies Fee Schedule. Covered when furnished incident to physicians' services or on a physicians' order.
Cancer Hospitals ***Inpatient Services***	UniCare will contact facility for their pricing information. Facility can submit copy of Medicare RA showing correct pricing.
Cancer Hospitals ***Outpatient Services***	UniCare will utilize the Outpatient National Medicare Provider Rate File (ONMPRF) to group/price APC claims for ANY Medicare-approved provider.

PAYMENT METHODOLOGY (CONTINUED)

Certified Registered Nurse Anesthetist (CRNA)	UniCare will calculate according to Medicare's methodology: Medicare anesthesia conversion factor by locality x sum of uniform base units + time units. Payment is made on an assignment basis only. The above allowance is divided equally between the anesthesiologist and the anesthetist (50% each).
Clinical Nurse Specialist	85% Medicare Fee Schedule
Clinical Psychologist	100% Medicare Fee Schedule
Clinical Social Workers	75% of Medicare Fee Schedule
Clinical Trial Services	Medicare directly reimburses all approved clinical trial services provided to a Medicare Advantage enrollee according to the appropriate fee for service methodology.
Community Mental Health Centers	UniCare will utilize the Outpatient National Medicare Provider Rate File (ONMPRF) to group/price APC claims for ANY Medicare-approved provider.
CORF	Reimbursement based on the Medicare physician fee schedule. Vaccines reimbursed under the OPPS.
Co-Surgeons	For each co-surgeon, the payment amount is 62.5% of the global surgery under the Medicare fee schedule.
Co-Surgeons ***Team Surgery***	Team surgery reimbursement is "by report".
Critical Access Hospital (CAH)	UniCare will contact facility for pricing information. Providers can submit copy of Medicare RA showing correct pricing.
Diabetic Shoes	Only covered for certain conditions with annual limit. Reasonable charge subject to payment limits.
Drugs	Reimbursement calculated using CMS fee schedules. Medicare covered out-patient drugs/biologicals that qualify for pass-through payments will be processed.
Durable Medical Equipment	Reimbursement calculated using CMS fee schedules.
Epoetin (EPO)	EPO is paid $10 per 1,000 units when administered by an ESRD facility or provider. Otherwise, it is paid 95% AWP.

PAYMENT METHODOLOGY (CONTINUED)

ESRD Facility	UniCare will contact facility for pricing information, including exception payments. If necessary, facility can submit copy of Medicare RA showing correct pricing.
FQHC ***Independent and Provider Based***	UniCare will contact facility for pricing information. If necessary, facility can submit copy of Medicare RA showing correct pricing.
Hemophilia clotting factors billed by provider (eg. Hosp, SNF, HHA)	Add on payment for beneficiaries in an inpatient setting. Outpatient setting paid on a cost basis. All other settings (SNF, HHA) paid under the Single Drug Pricer.
Hemophilia clotting factors billed by supplier (eg DME, supplier, indep pharmacy, Red Cross)	Reimbursed under the Single Drug Pricer.
Home Dialysis Supplies & Equipment	Method I or II per Medicare.
Home Health Agencies ***Independent and Provider Based***	Reimbursement calculated using pricer via CMS website.
Home Infusion	Reimbursement per Medicare Durable Medical Equipment Prosthetic, Orthotic and Supplies Fee schedule for applicable services.
Hospital Transfer ***Acute to Acute***	Transferring hospitals are reimbursed a per diem rate. The per diem rate is the full DRG amount divided by the geometric mean length of stay for the DRG. Twice the per diem is paid on the first day and the per diem for every following day up to the transfer or the full DRG amount. Transfer cases classified into DRG 385 are paid at the full DRG instead of the per diem methodology.
Hospital Transfer ***Acute to Postacute***	Expanded Transfer Definition: A qualified discharge from one of 10 DRGs to a postacute care provider will be treated as a transfer case and reimbursed the per diem methodology stated above, with the following exception. DRGs 209, 210 and 211 are paid under a methodology where 50% of the DRG plus the per diem is paid on the first day of the stay. For each subsequent day, 50% of the per diem is paid up to the full DRG amount.
Immunosuppressive Drugs, transplant	Paid under OPPS if beneficiary is in the outpatient dept of a Medicare participating hospital. In all other settings, 95% average wholesale price.

PAYMENT METHODOLOGY (CONTINUED)

Indian Health Service Facility (IHS) ***Inpatient Services***	UniCare will utilize the National Medicare Provider Rate File (NMPRF) to group/price DRG claims for ANY Medicare-approved provider.
Indian Health Service Facility (IHS) ***Outpatient Services***	All-inclusive rate. Excluded from OPPS. Fee schedule for outpatient professional services.
Injections	Specific injection services are paid separately if physician does not render other services at the time of the injection. Chemotherapy injections are paid in addition to the visit for same day of service.
Laboratory	Reimbursement calculated using CMS fee schedules.
Mammography Screening	100% of Medicare Fee Schedule
Maryland Hospitals	HSCRC mandated rate thresholds. Reimbursed 94% of approved charges for IP and OP services.
Medical Nutrition Therapy	85% Medicare Fee Schedule
Medicare Dependent Hospital ***Inpatient Services***	UniCare will utilize the National Medicare Provider Rate File (NMPRF) to group/price DRG claims for ANY Medicare approved provider.
Medicare Dependent Hospital ***Outpatient Services***	UniCare will utilize the Outpatient National Medicare Provider Rate File (ONMPRF) to group/price APC claims for ANY Medicare approved provider.
Nurse Practitioner	85% Medicare Fee Schedule
Oral Anti-Cancer Drugs	95% of the average wholesale price as identified in Drug Topics Red Book.
Oral Anti-Nausea	Furnished by physician/supplier, reimbursed at 95% of the median average wholesale price.
Parenteral and Enteral Nutrition	PEN Fee Schedule
Physical Therapy Occupational Therapy Speech Therapy	100% Medicare Fee Schedule

PAYMENT METHODOLOGY (CONTINUED)

Physician (MD)	Reimbursement calculated using CMS fee schedules. Physician Services are priced according to the Correct Coding Initiative (CCI) edits and payment rules are configured to follow Local Medical Review Policies.
Physician (DO)	Reimbursement calculated using CMS fee schedules. Physician Services are priced according to the Correct Coding Initiative (CCI) edits and payment rules are configured to follow Local Medical Review Policies.
Physician (Podiatrist)	100% Medicare Fee Schedule
Physician (Chiropractor)	100% Medicare Fee Schedule
Physician (Optometrist)	100% Medicare Fee Schedule
Physician (Dentist)	100% Medicare Fee Schedule
Physician (Oral and Maxilofacial Surgeon)	100% Medicare Fee Schedule
Physician Assistant	85% Medicare Fee Schedule
Prosthetic Devices	100% of the Medicare Durable Medical Equipment Prosthetic, Orthotic and Supplies Fee Schedule.
Psych Hospital ***Inpatient & Outpatient Services***	UniCare will contact facility for pricing information. If necessary, facility can submit copy of Medicare RA showing correct pricing
Registered Dietition	85% Medicare Fee Schedule
Rehab Hospital ***Inpatient Services***	Reimbursement calculated using pricer via CMS website.
Rehab Hospital ***Outpatient Services***	UniCare will utilize the Outpatient National Medicare Provider Rate File (ONMPRF) to group/price APC claims for ANY Medicare approved provide.
Religious Non-Medical Health Care Institutions	UniCare will contact facility for pricing information. If necessary, facility can submit copy of Medicare RA showing correct pricing.

PAYMENT METHODOLOGY (CONTINUED)

Rural Health Clinic Independent and Provider Based	UniCare will contact facility for pricing information. If necessary, facility can submit copy of Medicare RA showing correct pricing.
Skilled Nursing Facilities (SNFs) ***Independent and Provider Based***	Reimbursement calculated using pricer via CMS website.
Surgical Dressings	The Medicare DMEPOS fee schedule applies to all surgical dressings except those applied incident to a physician's professional services, those furnished by an HHA and those applied while a patient is being treated in an outpatient hospital department or as an acute care inpatient. Hospital outpatient reimbursed under PPS (APCs) HHA's-payment is bundled into PPS (HHRGs). If a physician, certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist applies surgical dressings as part of a professional service that is billed to Medicare, the surgical dressings are considered incident to the professional services of the health care practitioner.
Swing Beds	Reimbursement calculated using pricer via CMS website.
VA Hospitals	Federal providers are excluded from participation in the Medicare program. However, Federal Hospitals, like other non participating hospitals may be paid for emergency inpatient and outpatient hospital services. Hospital filed claims: Inpatient: Lower of actual charges or rates published for Federal Hospitals in the Federal Register under OFFICE OF MANAGEMENT & BUDGET-Cost of Hospital & Medical Care & Treatment. Outpatient: 85% of the total covered charges.
X-Ray	100% Medicare Fee Schedule

SECTION 5 – PROVIDER ADMINISTRATION

Introduction

This section provides guidelines for various administrative functions in compliance with CMS regulations.

Compliance with CMS Regulations

UniCare must adhere to the terms and conditions of the CMS contract. All UniCare SecurityChoice healthcare professionals are required to accept the same terms and conditions, as appropriate.

Compliance with the following CMS regulations is required:

1. UniCare SecurityChoice has the ultimate responsibility and accountability for ensuring compliance with CMS guidelines.
2. Healthcare professionals are prohibited from holding a member liable for paying fees that are the obligation of UniCare SecurityChoice.
3. Healthcare professionals must safeguard the privacy of any information that identifies a particular member and must maintain records in an accurate and timely manner.
4. Healthcare professionals must submit to UniCare all data necessary to characterize content and purpose of each encounter with a member.
5. Healthcare professionals are prohibited from discriminating against members based on health status.
6. Healthcare professionals must provide access to benefits in a manner described by CMS.
7. Healthcare professionals must provide all covered benefits in a manner consistent with professionally recognized standards of healthcare.
8. Healthcare professionals must be subject to all laws applicable to individuals/entities receiving federal funds and must comply with all other laws and regulations including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, and the Americans with Disabilities Act.
9. Healthcare professionals must comply with Medicare appeals/expedited appeals procedures for members, including gathering/forwarding information on appeal to UniCare as necessary.
10. UniCare has the right to approve, suspend, or terminate arrangements pertaining to selecting healthcare professionals, contractors, or subcontractors.

Local Medicare Carrier Coverage Guidelines

UniCare SecurityChoice is in compliance with its Local Medicare Carrier Guidelines, and incorporated these guidelines into its internal coverage guidelines. Local Medical Review Policy (LMRP) addresses issues not specifically covered nationally by CMS.

Local Medical Review Policy is primarily a Medicare program integrity tool. It is developed by the local Medicare carrier to specify criteria that describe whether a service is covered and under what clinical circumstances it is considered to be reasonable, necessary, and appropriate. The local carrier solicits comments from the medical community through the Carrier Advisory Committee, which meets quarterly and includes the UniCare SecurityChoice plan.

Member Rights

BBA 422.112 applies existing regulations and policies to establish standards under the Medicare Advantage program. Recommendations from the President's Consumer Bill of Rights and Responsibilities (CBRR) and the Quality Improvement System for Managed Care (QISMC) standards were incorporated.

The physician ensures "cultural competency" in providing healthcare to members, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities.

Prohibiting Interference with Advice from Healthcare Professionals

UniCare is prohibited from interfering with a healthcare provider's ability to care for UniCare SecurityChoice members. A healthcare professional has the right to advise, or advocate on behalf of a patient regarding the following:

1. The patient's health status, medical care, and treatment options (including the risks, benefits, and consequences of treatment).
2. The member's right to refuse treatment and express preferences about future treatment decisions, in accordance with CMS regulations.

Prohibiting Indemnification by Healthcare Professionals or Facilities

UniCare may not contract or otherwise provide, directly or indirectly, for any of the following individuals, organizations, or entities to indemnify the organization against any civil liability for damage caused to a member as a result of the physician's denial of medically necessary care:

1. A physician or healthcare professional
2. A healthcare professional or facility
3. Another entity providing healthcare services
4. A group of such professionals, facilities, or entities

SECTION 6 – MEMBER ISSUES

Overview

UniCare SecurityChoice member issues are divided into two types: member grievances and appeals (or reconsiderations). Complaints are resolved through one of two distinct processes, depending on the type of complaint (as defined below). UniCare SecurityChoice procedures are designed to handle member issues expeditiously and equitably, and are administered by the Blue Cross of California Grievance and Appeal Management Department acting on behalf of UniCare SecurityChoice.

Grievance procedures apply when a member complains about services, quality of care, or involuntary disenrollment issues. The grievance process is not utilized to appeal claim or service denial. Grievance examples include complaints about the cleanliness of a physician's office, lack of follow-up by the office, no return phone calls or inability to reach the office, rude office staff, quality of care issues, or disputing involuntary disenrollment issues.

Appeal procedures apply when a member disagrees with a decision about payment for, or provision of, services. Reconsideration or appeal requests can be about either an initial denial for service authorization or claim denial.

It is possible to have issues that apply both to grievances and appeals. The procedures for grievances and appeals are mutually exclusive. If a member addresses two issues on one complaint, each issue is processed separately and simultaneously under the proper procedure.

Grievance Criteria:

1. Complaints regarding quality of service/quality of care received by the member
2. Does not involve an adverse initial determination (request for services or claims payment)
3. Involuntary disenrollment issues

Appeal Criteria:

1. Service denial issued by the Medicare Advantage Organization or the physician
2. Claims denied by the Medicare Advantage Organization or the physician
3. Reimbursement denied for emergency or urgently needed services
4. Discontinuing or reducing services

All appeals and quality of care grievances are handled directly by the Grievance and Appeal Management Department. Quality of service grievances are handled directly by UniCare Security Choice. All appeals and quality of care grievances should be forwarded to the following address:

UniCare SecurityChoice
Grievance and Appeal Unit
PO Box 9154
Oxnard, CA 93031-9154
Fax: (818) 234-4084

Member Grievance Resolution Procedure

If a member has a complaint regarding the quality of care/quality of service provided by a physician or a dispute pertaining to involuntary disenrollment issues, the member must request a review directly from UniCare. The member may complete a grievance form that can be obtained from UniCare SecurityChoice Member Services. The member may also request the member services representative to complete a grievance form over the telephone.

Grievances related to quality of care and certain disenrollment issues are forwarded directly to the Grievance and Appeal Management Department for review.

Grievances related to quality of service are handled by UniCare SecurityChoice.

The grievance process is implemented as follows in the Grievance and Appeal Management Department:

1. An acknowledgment letter is sent to the member within 5 working days of receipt of the grievance.
2. The documentation submitted is reviewed by the Grievance and Appeal Management associate. If it is determined that further information is required, a copy of the complaint along with a letter is sent to the physician/internal department requesting medical records and/or the physician/internal department response to the member's complaint.
3. If the requested information is not received timely, the Medical Director reviews the case based on the information available.
4. A letter is sent to the member at the review conclusion addressing all the issues and questions raised by the member in his or her grievance. A copy of the letter is sent to the physician if indicated.
5. If the member is not satisfied with the written response to the grievance, or if the grievance is not resolved within 30 days, the member may take the issue to binding arbitration or the State Department of Insurance.
6. All quality-of-care cases are reviewed by the Medical Director (or physician designee) and/or by the Grievance and Appeal Management Committee chaired by physicians.
7. Expedited grievances are resolved within 72 hours of receipt or extended 14-calendar day if beneficial to the member.
8. If a member disagrees with our decision to not give you a "fast appeal", or if we take an extension on our initial decision or appeal, they have the right to ask for a "fast grievance". SecurityChoice will respond to the "fast grievance" in 24 hours.
9. Physicians identified in quality-of-care grievances are assigned severity levels that have a designated number of points. Any healthcare professional who is assigned a severity level of seven or who reaches a total of 25 combined points in a 2-year period is immediately referred to the Credentialing Committee for peer review. The Credentialing Committee may also decide to take immediate corrective action against the physician based on the outcome of the peer review.
10. All grievances received by the Grievance and Appeal Management Department are logged into the senior grievance and appeal tracking system to document all correspondence and actions taken as a result of the grievance.

    A monthly grievance report is generated by the Grievance and Appeal Management Department. The report includes the following data:

    a. Number of grievances received
    b. Resolution turnaround time
    c. Status of cases received (open, closed)
    d. Grievance type
    e. Resolution/outcome

    Identified trends are reviewed by the Director of the Grievance and Appeal Management Department and reported to the Medical Director if applicable. Corrective actions are implemented as indicated.

    The monthly grievance report is forwarded to the Medical Director. A quarterly report is forwarded to the Provider Relations Committee, a subcommittee of the Board of Directors.

Medicare Standard Reconsideration and Appeals Procedures

UniCare provides, as required by CMS, a reconsideration/appeals procedure for all UniCare SecurityChoice members. This procedure pertains to disputes involving an initial claim payment denial or provision of services denial. The appeal must be submitted in writing by the member or by a representative appointed by the member. A standard appeal must be resolved as expeditiously as possible, but no later than 30 calendar days for service appeals and 60 calendar days for claim appeals from receipt of the appeal by UniCare. For service denial appeals, a 14-calendar-day extension may be granted if the extension will benefit the members (i.e., additional tests or consultations are needed in order to appropriately review the appeals).

When an initial determination is made by UniCare SecurityChoice, a written notification is sent to the member advising her or him of the determination and of the Medicare appeal procedure. If UniCare SecurityChoice fails to make an initial determination within 14 calendar days (or extended 14 calendar days if beneficial to the member) of the request, it is considered an adverse determination and the member/representative can appeal to UniCare SecurityChoice.

If the physician's office receives an appeal from the member or his or her representative, they must fax the appeal immediately to the Grievance and Appeal Management Department.

The initial determination from UniCare SecurityChoice is final and binding unless a reconsideration is requested by the member/representative in writing to UniCare SecurityChoice and received in UniCare SecurityChoice within 60 days from the date of the notice of the initial determination. An exception to the 60-day time frame may be made for good cause.

STATE	BINDING ARBITRATION ALLOWED/DISALLOWED
Illinois	Allowed
Indiana	Allowed
Iowa	Not Allowed
Kentucky	Not Allowed
Michigan	Not Allowed
Minnesota	Allowed
Nebraska	Not Allowed
North Carolina	Allowed
Utah	Allowed
Virginia	Allowed
Wisconsin	Not Allowed

If a reconsideration request is submitted more than 60 days and less than 1 year from the date of the initial denial letter, the Grievance and Appeal Management Department requests that the member submit in writing the reason(s) for the submission delay. If the Grievance and Appeal associate cannot identify any good cause for the delay, the case is reviewed by the Medical Director or the Grievance and Appeal Management Committee. If the Medical Director or Committee agree that there is no good cause for the submission delay, a letter is sent to the member denying review of his or her appeal request and advising him or her of the grievance process.

Any appeal request submitted more than 1 year from the date of the initial denial letter will not be accepted for review. A letter is sent to the member advising him or her of the rejection of his appeal request for review and advising him or her of the grievance process.

All reconsidered determinations involving coverage denial based on lack of medical necessity must be made by a physician with expertise in the field of medicine that is appropriate for the service at issue.

A member may utilize the reconsideration and appeals procedure for any adverse initial determination rendered by UniCare that pertains to the following:

1. Any claims denied in full or partially by UniCare.
2. Services that UniCare refuses to provide that the member believes should be furnished.
3. Any discontinuation or reduction of services.

An initial organization determination is made by UniCare. On any adverse determination, a letter must be sent to the member to advise him or her of the Medicare reconsideration and appeals procedure.

The following is a summary of the appeal procedure:

1. The member's appeal request is received in writing and directed to the Grievance and Appeal Management Department.

   The member may appoint a representative to file the appeal on his or her behalf. This representative may be any individual, including a physician. Appeals submitted by a representative must be accompanied by an appointment of representation statement, dated and signed by both the member and the representative. If an attorney is the representative, he or she does not need to sign the statement of representation. A statement of appointment is not needed if the appeal is submitted by a court appointed guardian or an agent under a healthcare proxy to the extent provided under state law.

2. An appointment of representation statement must be provided in order for the Grievance and Appeal Management Department to document the appeal request validity. The Grievance and Appeal Management Department should commence the review even if the representative statement is not attached to the request. However, the Grievance and Appeal Management Department will not issue a determination prior to receiving the signed statement. If the appeal is submitted by a representative and not accompanied by a signed appointment of representation statement, the acknowledgement letter will include a request to submit the signed appointment of representation statement as required by CMS.

3. If, after reviewing the documentation submitted, it is determined that further information is required, the Grievance and Appeal Management associate sends a request for the necessary information to the appropriate parties. If the appeal is submitted without a copy of the denial letter, a copy is requested from UniCare SecurityChoice.

4. If the requested information related to the appeal is not received timely the appeal is reviewed by the Medical Director based on the information available.

5. If the claim appeal is not resolved within 30 calendar days of receipt, a follow-up letter is sent to the member advising him or her that the Grievance and Appeal Management Department is continuing to review the case.

6. All reconsideration requests including service provision and claims payment are resolved within the 30-day (+ 14 calendar days if indicated) requirement for service appeals and 60-day requirement for claim appeals.

7. Appeal cases are reviewed by the Medical Director, and/or by the Grievance and Appeal Management Committee chaired by physicians, if applicable.

8. The member has the right to appear in person and/or have a representative appear to present evidence in support of his or her appeal.

9. If the initial determination is reversed, a written notice of favorable determination is sent to the member and service provision/authorization or payment of the denied claim is made within 30 days (plus an additional 14 calendar days if extension is needed) and 60 days, respectively, of receipt of the appeal.

10. If the initial determination is upheld (in whole or in part), the Grievance and Appeal Management associate forwards the case to CMS's reconsideration contractor, the Center for Health Dispute Resolution (CHDR), with a completed Reconsideration Background Data form, Case Narrative form, and supporting medical documentation. All information is sent to CHDR by overnight mail, no later than 30 calendar days (plus an additional 14 calendar days if extension is applicable) for a service appeal and 60 calendar days for a claim appeal from receipt of the appeal. If the Grievance and Appeal Management Department fails to make a determination within the required time frame, it is considered an adverse determination and the case is forwarded to CHDR.
11. The Grievance and Appeal Management Department provides written notice to the member that his or her request for reconsideration has been forwarded to CMS's reconsideration contractor for further consideration.
12. CMS's reconsideration contractor, CHDR, reviews the information provided and requests any additional documentation needed from either the Grievance and Appeal Management Department or the member. The care management analyst forwards any additional information requested by CHDR within the timeframe requested by CHDR. CHDR will not send a second request for information. If the Grievance and Appeal Management Department receives additional information after submitting the case to CHDR, it may forward the additional information on its own to CHDR within 3 days of receipt of the appeal case file by CHDR. However, CHDR is under no obligation to use this additional information.
13. The reconsideration review result is mailed to the Grievance and Appeal Management Department and to the member by CHDR. If CHDR upholds the Grievance and Appeal Management Department's denial, the notice advises the member of his or her right to a hearing before an administrative law judge (ALJ) if the amount in controversy is $100 or more.
14. A reconsideration determination by CHDR is final and binding unless a request for a hearing before an administrative law judge (ALJ) is filed within 60 days of the date of the CHDR notification letter.
15. If the UniCare SecurityChoice member is dissatisfied with the ALJ hearing decision, they may request a review by the Departmental Appeals Board (board) within 60 days of the rendered decision.
16. If the amount in controversy is $1,000 or more, a final decision of the ALJ or the Board can be appealed to a Federal District Court within 60 days of the Board's decision.
17. If CHDR overturns the Grievance and Appeal Management's denial, UniCare SecurityChoice must (1) authorize the service within 72 hours from the date of receipt of the reversal or provide the service as expeditiously as the member's health condition requires, but no later than 14 calendar days from the date of receipt of the reversal or (2) pay for the service no later than 30 calendar days from the date of receipt of the reversal.
18. The reconsideration determination is final and binding on UniCare SecurityChoice.
19. On a monthly basis, the Grievance and Appeal Management Department generates a reconsideration report that includes the following elements:
    a. Number of reconsiderations received
    b. Status of cases (open, closed)
    c. Resolution turnaround time
    d. Number of cases forwarded to CHDR
    e. Timeliness of forwarding cases to CHDR, when applicable
    f. CHDR resolution (fully favorable, partially favorable, upheld)

Any identified trends are reviewed by the Director of Grievance and Appeal Management and reported to the Medical Director. Corrective actions are implemented as indicated.

The monthly reconsideration report is forwarded to the Medical Director. A quarterly report is forwarded to the Provider Relations Committee, a subcommittee of the Board of Directors.

Medicare Expedited Appeal Procedure

UniCare provides, as required by CMS, an expedited appeal procedure for all its members. The expedited appeal process only applies to service denials (pre-service or service discontinuation). It does not apply to the administrative law judge level and beyond. Claim denials may only be appealed under the standard 60-day appeal process.

Members of UniCare SecurityChoice or their representatives may request an expedited appeal, either orally or in writing. Expedited appeal requests must be resolved within 72 hours of receipt of the request (including weekends and holidays) + 14 calendar day extension if beneficial to the member.

Members may submit requests for an expedited appeal in one of the following ways:

1. Fax: (818) 234-4084
2. Phone: 1-888-445-8916
3. Mail:
   UniCare SecurityChoice
   Grievance and Appeal Unit
   P.O. Box 9154
   Oxnard, CA 93031-9154

All requests for expedited appeals must be faxed to the Grievance and Appeal Management Department immediately.

UniCare may not prohibit or otherwise restrict a healthcare provider from advising or advocating on behalf of the member in the area of medical care relating to treatment options, including risks, benefits, and consequences of treatment or non-treatment, or the member's right to refuse treatment and express preferences about future treatment decisions. UniCare may not take or threaten punitive action against a physician acting on behalf or in support of a member requesting an expedited determination or expedited reconsideration, in accordance with Section 422.570(f) of the Balanced Budget Act of 1997.

The expedited appeal procedure is implemented as follows:

1. The member's request for expedited review, received either orally or in writing, is immediately directed to the Grievance and Appeal Management Department. Any request received orally by a member services representative is documented in writing before it is forwarded to the Grievance and Appeal Management Department.

   An expedited appeal may also be requested by a physician without having to represent the member.

   An expedited appeal may be requested by the member or the member's representative. This representative may be any individual appointed by the member, including a physician. Should the member appoint someone to file the expedited appeal on the member's behalf, the member must submit a dated appointment statement signed by the member and the representative, with the appeal. The Grievance and Appeal Management Department commences the review process even if the signed appointment of representation statement is not attached to the request. However, the Grievance and Appeal Management Department will not issue a determination prior to receipt of the signed statement.

   The member or representative is notified of the need for the signed appointment of representation statement. They are also informed that if the signed representative statement is not received within 72 hours (plus 14 calendar days if applicable) from the

date of the request for expedited review, the case will be forwarded to CHDR for possible dismissal.

Without the signed appointment of representation statement, the request may be considered invalid.

2. The request is reviewed by the Grievance and Appeal Management associate to determine whether the request qualifies for expedited review. A request for expedited review must be expedited if any one of these requirements is met:
   a. The member's condition is such that the 30-day time frame of the standard appeal procedure could seriously jeopardize the life or health of the member or could jeopardize the member's ability to regain maximum function. See the CMS approved clinical guidelines criteria.
   b. The request is submitted by a physician or supported by a physician. If the Grievance and Appeal Management associate determines that the request does not meet the criteria for expedited review, the case is reviewed with the Medical Director before issuing a denial of the request for expedited review to the member or representative.
3. If the request does not meet the criteria for expedited review, it is immediately transferred to the standard 30-day process for review (refer to the Medicare standard appeal procedure section).

   The Grievance and Appeal Management associate immediately notifies the member or representative orally (within 72 hours of receipt of the request for expedited review) that the appeal will not be expedited. A letter of explanation is delivered to the member/representative within 3 calendar days of the oral notification. This letter includes information that (1) the member's request will be processed within 30 calendar days (2) that the member may file a grievance with UniCare SecurityChoice if the member disagrees with the determination (refer to the Member Grievance Resolution Procedure) not to expedite and (3) the member has the right to resubmit the request for expedited reconsideration with a physician support statement.
4. If the request meets the criteria for expedited review, the following process is implemented:
   a. The Grievance and Appeal Management associate immediately faxes a copy of the appeal along with a letter to the physician requesting medical records and a response to the member's appeal. The physician is requested to respond to the request for information within 24 hours or sooner, if necessary.
   b. The expedited appeal case is reviewed by the Medical Director and/or by the Grievance and Appeal Management Committee if applicable. A decision is rendered within 72 hours from the time of receipt of the request for expedited review (+ 14 calendar day extension if beneficial to the member).
   c. An extension of up to 14 calendar days is allowed if requested by the member or if the Grievance and Appeal Management Department determines that the extension is beneficial to the member. If the Grievance and Appeal Management Department extends the 72-hour time frame, a letter must be sent to the member/representative advising them of the reasons for the extension and of their right to file a grievance if they disagree with the decision to extend the 72-hour time frame. The member's request for extension is documented in the case file by the Grievance and Appeal Management Department associate.
   d. The member or appointed representative is notified of the appeal decision orally within the required time frame. An oral notification of a favorable decision within

72 hours (+ 14-calendar day extension if beneficial to the member) of the request is followed by a confirmation letter within 3 calendar days of the oral notification. If the case is to be forwarded to CMS's reconsideration contractor, CHDR, this is reflected in the notification letter to the member/representative. This notification letter of the denial decision must be sent concurrently to the member/enrollee with the case file to CHDR.

e. If the Grievance and Appeal Management Department upholds the denial, either in part or in whole, the case is forwarded to CHDR, with the appropriate forms, within 24 hours of making a determination. All information is sent to CHDR by overnight mail.

   Note: CHDR will not accept case files by fax; however, we must fax CHDR a notification of an impending expedited case file.

   If the Grievance and Appeal Management Department fails to make a determination within the required 72 hours or extended 14 calendar days, it is considered an adverse determination and the case must be forwarded to CHDR within 24 hours of the expired 72 hours or extended 14 calendar days.

f. If additional information is requested by CHDR, this information must be submitted to CHDR within 3 days from the date of the request or as indicated by CHDR.

g. CHDR notifies the member or appointed representative and the Grievance and Appeal Management Department of its determination within 72 hours (plus an additional 14 calendar days if additional information is needed) of receipt of the case file.

   Note: The expedited does not extend to the administrative law judge level.

h. Regarding continued hospital stay denial, the member must first request PRO review. If the member misses the noon deadline, the member can still request an expedited appeal. However, if PRO review is already being conducted on a case, the Grievance and Appeal Management Department should not process any request for expedited review. While the member is held harmless during the PRO review process, this financial protection does not apply to the expedited appeal process.

5. An expedited appeal determination by CHDR is final and binding unless a request for hearing with the administrative law judge is filed within 60 calendar days of the date of the CHDR notification letter by the member/representative.

6. Expedited appeals are included in the monthly reconsideration report generated by the Grievance and Appeal Management Department. They have a separate identification code to distinguish them from the standard 30-and 60-day appeals.

   Any identified trends are reviewed by the Director of Grievance and Appeal Management and reported to the Medical Director. Corrective actions are implemented as indicated.

   The monthly expedited appeal report is forwarded to the Medical Director. A quarterly report is forwarded to the Provider Relations Committee, a subcommittee of the Board of Directors.

Releasing Information to Members

UniCare is committed to maintaining the highest level of confidentiality for its members' medical records. To protect members' privacy and standardize the release of information, members' requests for release of information are processed as follows:

1. Members requesting medical information release or those who have questions concerning medical information are directed to call UniCare SecurityChoice's Customer Service Department.
2. Only questions involving verifying claim payments are answered over the telephone. No other information will be given out, including questions on claim type or other claims-related issues. A member requesting any other information is sent a Release of Information Request form.
3. The request must be filled out by the person whose medical information is being requested. A person will not be able to obtain information for a spouse, parent, or independent adult child.
4. Information requested in accordance with the above procedure is sent out within 10 days of receipt of the Release of Information Request form. The Customer Service Department keeps all requests in the member's file, and documents the date and nature of the information being released.
5. The customer service representative checks the signature on all Release of Information Request forms against the signature on file for the member, and the manager or supervisor of Customer Service then signs off on each request. This acts as a double-check system to prevent releasing any confidential information to the wrong party and prevents forgery.
6. Any Release of Information Request forms that are filled out incorrectly will be returned to the member with an explanation of why his or her request cannot be fulfilled and instructions for filling out the form correctly.
7. Any requests for information that are out of the ordinary, or those that appear to be happening on a frequent basis, will be turned over to the Customer Service manager for further follow-up.

Member Responsibility Policy

UniCare SecurityChoice, as a Medicare Advantage Organization, is entitled to review and respond to issues regarding its members and their medical care. The joint responsibilities of the Medicare Advantage Organization, its healthcare professionals and facilities, and its members, are defined in the Terms and Conditions executed between these parties.

Failure to uphold these responsibilities may jeopardize the ongoing relationships between the parties and interfere with providing proper medical care.

The remedial action available to UniCare is disenrollment, usually after progressive notification. In cases related to members' relationships with physicians requiring remedial actions, the Medical Director and/or the Grievance and Appeal Management Committee serve as a deliberative entity to review the positions of all parties. It is most important, in view of the significance of the issues involved, that there be substantial documentation for each case considered for remedial action.

Requests for disenrollment, progressive notification, will be considered for the following:

1. If the member moves out of UniCare SecurityChoice's service area.
2. If the member knowingly omits or misrepresents a material fact on the membership application.
3. If the member fraudulently applies for any benefits under the UniCare SecurityChoice contract.
4. If the member permits abuse of his or her membership card.

5. If the member fails to pay the required copayments.
6. If the member exhibits disruptive behavior in the course of seeking or receiving care.
7. If the member exhibits dangerous behavior (e.g., attempted physical abuse of personnel or other patients) in the course of seeking or receiving care.
8. If the member utilizes fraud or deception in using UniCare SecurityChoice.
9. If the member persists in conduct that interferes with the effective delivery of healthcare:
    a. Members may reasonably refuse to accept advice, procedures, or treatments by the physician. Such refusal, if within the bounds of proper behavior, does not constitute a breach of the physician/member relationship.
    b. Physicians shall use their best efforts to render all necessary and appropriate professional services in a manner compatible with the member's wishes. However, physicians must retain the right to exercise their own judgment as to the requirements of proper medical practice.

Causes of action related to #1 through #5 listed above are reviewed by UniCare SecurityChoice. Causes of action related to #6 through #9 listed above are reviewed by the Grievance and Appeal Management Department.

Member Remedial Actions

Member remedial actions may only be implemented on completing the due process outlined below. Notification of any due process activity or member remedial action must be by written notice, certified mail/return receipt, and delivered no less than 20 working days in advance of the effective date of due process activity or remedial action. Such written notification must also clearly explain the member's right of response/rebuttal and right to file a grievance with UniCare SecurityChoice. The member shall have the opportunity to respond to alleged causes of action #5-9 listed above directly to the Medical Director and/or the Grievance and Appeal Management Committee prior to determining or implementing any remedial action. The member remedial actions available to UniCare SecurityChoice are:

1. Disenrollment
   Member disenrollment constitutes a total loss of the member's benefits under UniCare SecurityChoice. In such a case, UniCare SecurityChoice will not have any further responsibility to provide care or any funding or reimbursement for care.
   CMS must be notified of all disenrollment actions taken or intended disenrollment actions.
2. Progressive Notification
   Progressive notification is a three-step process and consists of the following:
    a. The member is sent an initial letter detailing the cause of action and requesting that the member work with the physician to remedy the difficulty. The member is informed that failure to do so may jeopardize his or her UniCare SecurityChoice coverage. The member's behavior/actions are tracked by the Grievance and Appeal Management Department. The Medical Director and/or the Grievance and Appeal Management Committees may also intervene on the member's behalf through referral to case management, social service, government, community, or other appropriate agencies.
    b. If the member fails to remedy the cause of action after mailing the initial letter, the Medical Director and/or the Grievance and Appeal Management Committee direct the staff to mail a second letter. The second letter documents the member's failure to remedy the cause of action and warns the

member that failure to do so, within a specified time frame, will cause disenrollment. Agency referral, as above, may be initiated by the Medical Director and/or Committee. The member's behavior/actions are tracked by the Grievance and Appeal Management Department.

c. If the member fails to remedy the cause of action within the specified time frame after mailing the second letter, the case is reviewed with the Medical Director and/or the Grievance and Appeal Management Committee. If the decision is made to proceed with the disenrollment, the case is forwarded to the Director of Medicare Compliance for review before sending a letter to the member notifying him of his failure to remedy the cause of action and of our request to CMS for disenrollment. The member is advised of his/her right to file a grievance should he/she disagree with the decision. Following disenrollment approval by CMS, a letter is sent to the member advising him of the disenrollment approval by CMS and of the effective date of his disenrollment from UniCare SecurityChoice. The member is also advised that until the effective disenrollment date, he or she must continue to have all his or her care provided by UniCare.

Prohibition on Discrimination, Discouragement of Enrollment

UniCare SecurityChoice and its deemed contracted providers may not:

1. Promote discrimination
2. Discourage enrollment
3. Steer specific subsets of Medicare beneficiaries to particular Medicare Advantage plans
4. Inhibit access to services

Advance Directives

UniCare SecurityChoice expects physicians to honor advance directives, and assist and guide members with regard to these sensitive issues. UniCare SecurityChoice will not provide actual advance directive forms, and does not require the deemed providers to supply forms. Forms are available from hospitals, and various nonprofit organizations. Forms are also available in major stationery stores where legal forms are sold.

Introduction

This section assists the provider in reaching the appropriate resources at UniCare. It also identifies servicing units and UniCare personnel that have the particular expertise needed to address the providers' questions, issues, and concerns.

Customer Service

Customer Service representatives are available to members, providers and brokers to answer both written and telephone inquiries on a variety of topics, including:

1. Eligibility verification and research
2. Benefit questions and explanations
3. Professional services, bills, and claims
4. Hospital services, bills, and claims
5. Membership problems and inquiries
   a. Adding and deleting members
   b. Billing inquiries
   c. Address changes
   d. ID card requests
6. Conflict resolution regarding benefit interpretation
7. Reconsideration and appeals process
8. Disenrollment requests
9. Complaints about the provider's personnel, physician care, delivery of care, etc. Direct physician, hospital, and other ancillary provider inquiries to UniCare SecurityChoice's Customer Service Department: 1-888-445-8916.

Customer Service representatives assist providers with a variety of administrative issues, including:

1. Eligibility verification and effective dates
2. Benefit questions and explanations
3. Request for member removal for disciplinary actions

Claim Submission

Submit bills directly to UniCare SecurityChoice, P.O. Box 3897, Scranton, PA 18505. Bills must be submitted within 365 days of providing services to a UniCare SecurityChoice member.

All Medicare billing guidelines must be followed when submitting your bill to UniCare. Physicians and others with Unique Physician Identification Numbers (UPIN) must include this information on all claims and, if applicable, the Clinical Laboratory Improvement Amendments (CLIA) number must also be included. All other types of providers must include their appropriate Medicare number or sub-provider number for the service rendered on each claim.

Medical Services

The UniCare SecurityChoice Medical Department is responsible for all medical management functions, and is under the direction and supervision of the UniCare SecurityChoice medical director. Medical management functions include, but are not limited to, quality assurance, case management, member and healthcare professional or facility grievance resolution.

Medical Director

The medical director, a UniCare-licensed physician, reports to UniCare's vice president of Quality Management. The medical director reviews all activities of the UniCare SecurityChoice Quality Management Program. He or she assesses the UniCare SecurityChoice Quality Management Program to evaluate its efficiency and effectiveness, and makes modifications in organization, systems, staff activities, medical policy, and clinical practices where necessary to ensure a high level of performance. When necessary, the medical director is actively involved in the problem-resolution process and coordinates quality management activities.

Grievance and Appeal

The Grievance and Appeal Management Department is:

1. Processing grievances
2. Processing appeals

Forward all UniCare SecurityChoice grievance and appeal correspondence to:

UniCare SecurityChoice
Grievance and Appeal Unit
PO Box 9154
Oxnard, CA 93031-9154

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