

Medicare Provider Manual

Overview

PERSONALCARE ADVANTRA PPO **PersonalCare Insurance of Illinois, Inc.'s** **Medicare Advantage Plans**

A. WHAT IS MEDICARE?

Medicare is a Federal Health Insurance Program established in 1965 as an amendment to the Social Security Act. It provides hospital (Part A) and supplemental medical (Part B) coverage for people 65 years of age and older, certain disabled people, and those of any age with End Stage Renal Disease (ESRD).

The Medicare Program is administered by The Center for Medicare and Medicaid Services (CMS), formerly Health Care Financial Administration (HCFA), of the U.S. Department of Health and Human Services (DHHS).

B. PERSONALCARE INSURANCE OF ILLINOIS INC.'S MEDICARE ADVANTAGE PLANS

PersonalCare Insurance of Illinois, Inc. (PersonalCare) has entered into a contract with the CMS that authorizes PersonalCare to provide comprehensive health services to persons who are entitled to Medicare benefits and who choose to enroll in Medicare Advantage (MA) plans, called Advantra Gold and Advantra Silver, respectively.

Advantra Gold and Advantra Silver are not Medigap policies or Medicare Supplement Plans.

Advantra Gold and Advantra Silver are MA Plans that include Medicare Part A and B benefits and enhanced benefits not covered by traditional Fee for Service Medicare. Enhanced benefits may include preventive care, and under some benefit plan options, vision and limited pharmacy coverage.

C. WHAT IS ADVANTRA?

Advantra Gold and Advantra Silver are MA plans offered by PersonalCare Insurance of Illinois, Inc. and administered by PersonalCare. Advantra includes all the benefits of

original Medicare coverage, plus many extra benefits offered to PPO members, such as preventive care and prescription drug coverage.

PersonalCare has entered into a MA Contract with CMS. This contract authorizes PersonalCare to provide comprehensive health services to people who are eligible for Medicare benefits and who choose to enroll with PersonalCare's Advantra PPO. PersonalCare assumes full financial risk for the continuing health care of the Medicare member in return for a prepaid monthly payment from CMS. In receipt of these Federal funds, PersonalCare and its contracted entities are obligated to comply with certain laws applicable to the Medicare Program.

D. HOW DOES THE PROGRAM WORK?

The Advantra PPO plans offer a new approach, with greater flexibility, freedom and savings. When your patient becomes a member of our Plan, they may choose a plan provider to be their Primary Care Physician. However, as a PPO member, they are not required to choose a PCP; however, Advantra encourages our members to develop a relationship with their provider, so he/she may better monitor their health or assist in coordinating the rest of the covered services they need. Members can choose to visit any Medicare participating doctor, any specialist or any hospital at any time. Members can use network physicians and specialists who have agreed to accept our payment to them as payment in full and members are responsible for only a co-payment for a doctor or specialist visit. If members choose providers outside the network, they are still eligible for benefits, but their cost share will be higher.

PersonalCare **Advantra Gold** PPO members pay monthly premiums to PersonalCare for their PPO coverage, must be eligible for Medicare Part A and are required to continue paying their Medicare Part B premium.

PersonalCare **Advantra Silver** PPO members are not required to pay monthly premiums to PersonalCare for their PPO coverage, however, they must be eligible for Medicare Part A and are required to continue paying their Medicare Part B premium.

E. Interpreter Services

Non-English speaking Advantra PPO members can request Interpreter Services through the Customer Service Department at 1-866-784-4916. Upon receipt of a call, the Customer Service Department will contact the designated vendor who can assist the member with their customer service needs.

F. WHO TO CONTACT?

Customer Service:

Monday – Friday 8am – 5pm
Telephone #: 866-784-4916
TTY #: 866-784-4931

Health Services:

Monday – Friday 8am – 5pm

Telephone #: 866-557-8748 or 217-373-3998

- Pre-authorization for hospital and appropriate outpatient services

After Hours Emergency Number for Health Services: 866-557-8748

Fax Number (Health Services) 217-366-5564 or 800-224-2009

Provider Relations (for Providers)

Monday – Friday 8am – 5pm

Telephone #: 1-866-784-4916

Fax #: 217-373-3995 or 800-698-2043

MH Net (for all mental health and substance abuse referrals and services)

Telephone: 800-423-8070

Medco (Part D) Available 24/7

Telephone: 800-707-9372 TTY# 800-716-3231

Coventry Dental:

Telephone: 1-866-690-4910 TDD# 1-866-690-4912

Sales/Marketing:

Monday – Friday 8am – 5pm

Telephone #: 217-373-3940

Claims

Mail PersonalCare Advantra medical claims to:

PersonalCare Advantra

P.O. Box 7141

London, KY 40742

Electronic Payor ID: 25146

Mail Coventry Dental claims to:

Coventry Dental

P.O. Box 6228

Rockville, MD 20849

Payor ID – CX049

www.cvtydental.com

Mail MH Net behavioral health claims to:

MHNet

P.O. Box 209010

Austin, TX 78720







Electronic Payor ID: MHNET BH

G. Member Identification Card

PersonalCare provides every Advantra PPO member with a white identification card shortly after joining the Plan. The identification card contains the following information:

- Member name
- PersonalCare Health Care ID Number (11 digit number starting with 9)
- Office Visit Copay
- Customer Service, Claims and Pharmacy Contact Information

ADVANTRA SILVER ID CARD

<p>Thank you for your membership. We have enclosed your new ID card(s) that will make it easy for you to receive your health care and prescription drug services. You should begin using this card on January 1, 2009. Simply show this new card to your doctors and pharmacists when receiving health care and prescription drug services. Please review the card(s) carefully and call Customer Service if corrections are needed.</p> <p>We are pleased to announce that we have selected Medco as our new Pharmacy Benefit Manager effective January 1, 2009. Medco will assist us in coordinating and managing your prescription drug needs. If you have questions regarding your prescription drug benefits, formulary, or how to transfer your prescription drugs from one pharmacy to another please call our Pharmacy Customer Service at the telephone number on the back of your ID card.</p>	<p style="text-align: right;">000001</p> <p style="text-align: right;">Personal Care Advantra 3721 TecPort Drive PO Box 67103 Harrisburg PA 17106-7103</p> <p style="text-align: center;">1 of 1</p> <p style="text-align: center;">XXXXXXXXXXXXXXXXXXXX 123 MAIN STREET USA</p>
<p style="text-align: center;"> PERSONALCARE <i>A Coventry Health Care Plan</i> Advantra</p> <p style="text-align: center;">PPO</p> <p>Plan Type: Medicare Advantage Advantra Silver Name: xxxxxxxxxxxxxxxx ID#: xxxxxxxx-xx RxBIN: 610014 Issuer: 80840 RxPCN: MEDDPRIME Group#: xxxxxxxx RxGrp: CVTYMED PCP Visit: OUTXX Specialist Office Visit: SPX ER:ERX UC:UCX CMS-IDXXX-PBP</p> <p style="text-align: center;">  Part B RxGrp: CVTYMEB</p>	<p>Customer Service: 1-866-784-4916, (TDD: 866-784-4931), 8 am-6 pm, CST, M-F Pre-Certification: 1-888-366-6730 Medical Claim Mailing Address: PO Box 7141, London, KY 40742 Mental Health Line: Call MHNet 1-800-423-8070 (TDD 1-800-955-8771), 24 Hrs per day, 7 days per week EMERGENCY: Go to the nearest emergency room or call 911. Send Pharmacy Claims to: Medco PO Box 14724 Lexington, Kentucky 40512 Pharmacy Customer Service: 1-800-707-9372 (TDD: 1-800-716-3231), 24 hours/7 days a week Pharmacy Provider Line: 1-800-922-1557 DO NOT bill Original Medicare. www.pcadvantra.com</p>
<p style="text-align: center;"> </p> <p>Name: xxxxxxxxxxxxxxxx ID: xxxxxxxx-xx Group #: xxxxxxxx Group: xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx</p> <p style="text-align: center;">Coventry Dental strongly suggests pre-authorization for all procedures over \$300. Scaling & root planning (4341 & 4342) MUST be pre-authorized. CMS-IDXXX-PBP</p>	<p>Customer Service: (866) 690-4910 8am -8pm M-F, (TDD 1-866-690-4912)</p> <p>PAYOR ID: CX049</p> <p style="text-align: right;"></p> <p>Mail Dental Claims to: Coventry Dental P.O. Box 7402 London, KY 40742</p>

ADVANTRA GOLD ID CARD

Thank you for your membership. We have enclosed your new ID card(s) that will make it easy for you to receive your health care and prescription drug services. You should begin using this card on January 1, 2009. Simply show this new card to your doctors and pharmacists when receiving health care and prescription drug services. Please review the card(s) carefully and call Customer Service if corrections are needed.

We are pleased to announce that we have selected Medco as our new Pharmacy Benefit Manager effective January 1, 2009. Medco will assist us in coordinating and managing your prescription drug needs. If you have questions regarding your prescription drug benefits, formulary, or how to transfer your prescription drugs from one pharmacy to another please call our Pharmacy Customer Service at the telephone number on the back of your ID card.

1 of 1



PPO
 Plan Type: Medicare Advantage Advantra Gold
 Name: xxxxxxxxxxxxxxxxx
 ID#: xxxxxxxx-xx RxBIN: 610014
 Issuer: 80640 RxPCN: MEDDPRIME
 Group#: xxxxxxxx RxGrp: CVTYMED
 PCP Visit: OUTXX
 Specialist Office Visit: SPX ER:ERX UC:UCX
 CMS-IDXXX-PBP



000001



Name: xxxxxxxxxxxxxxxxx
 ID: xxxxxxxx-xx
 Group #: xxxxxxxx
 Group: xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Coventry Dental strongly suggests pre-authorization for all procedures over \$300. Scaling & root planning (4341 & 4342) MUST be pre-authorized.

CMS-IDXXX-PBP

000001

XXXXXXXXXXXXXXXXXX
 123 MAIN STREET
 USA

Personal Care Advantra
 3721 TecPort Drive
 PO Box 67103
 Harrisburg PA 17106-7103
 1 of 1

Customer Service: 1-866-784-4916, (TDD: 866-784-4931), 8 am-6 pm, CST, M-F
Pre-Certification: 1-866-366-6730
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www.pcadvantra.com

Customer Service: (866) 690-4910 8am -8pm M-F, (TDD 1-866-690-4912)

PAYOR ID: CX049



Mail Dental Claims to:
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 P.O. Box 7402
 London, KY 40742

H. MEMBER INPUT IN TREATMENT PLAN

Physicians should always consider member input in the proposed treatment plan. It is the right of enrollees to be represented by parents, guardians, family members or other conservators for those who are unable to fully participate in their treatment decisions. Physician is expected to educate members regarding their health needs, share findings of history and physician examinations, discuss potential options (without regard to plan coverage), side effects of treatment and management of symptoms; and recognize the member has the final course of action among clinically accepted choices.

I. EMERGENT/URGENT CARE/RENAL DIALYSIS SERVICES

◆ Emergency Care

Emergency services for both inpatient and outpatient services are covered if: (1) furnished by a qualified provider and; (2) needed to evaluate or stabilize an emergency condition. Emergency care requires no prior authorization.

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate attention to result in (1) serious jeopardy to the health of the individual (or an unborn child); (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Medically needed emergency services and post-stabilization care are covered no matter where members are, even if they are provided by a doctor or facility that is not contracted to participate in the PersonalCare Advantra PPO plans.

Post-Stabilization Care is medically necessary, non-emergency services needed to ensure that the enrollee remains stabilized from the time that the treating hospital requests authorization from PersonalCare until (1) the member is discharged, (2) a contracted physician arrives and assumes responsibility for the enrollee's care, or (3) the treating physician and PersonalCare agree to another arrangement.

Members receiving emergency services are requested to notify their Physician for follow-up care by calling the phone number listed on their card within 48 hours, or as soon as possible.

◆ Coverage for Renal Dialysis Services

Renal dialysis services are covered from qualified dialysis providers when the member is temporarily absent from the Plan's service area. The member's physician should coordinate these services; however, no authorization is required.

◆ Urgent Care

In-Area: Members must call their Physician or Customer Services at 866-784-4916.

Out-of-Area: If possible, members are instructed to call their Physician before seeking care. However, if this is not an option, members may seek care from a hospital emergency room and should inform their Physician of urgent services they have received within 48 hours, or as soon as possible.

A temporary absence is an absence from the PersonalCare Advantra Service Area lasting for 6 months or less.

J. Provider Appeals

Purpose:

To ensure Providers of a systematic, timely, and objective process for expressing their appeals regarding related administrative decisions made by PersonalCare.

Definitions:

Provider: a physician, hospital, skilled nursing facility, durable medical equipment entity, home health agency or any duly licensed institution or health professional.

Appeal: A request for reconsideration of an initial determination made by PersonalCare.

Provider Appeal: A Provider Appeal is a request by the Provider for consideration of a Health Plan issued denial for service(s) that were provided. PersonalCare is authorized to make benefit determinations in accordance with Medicare guidelines for Medicare-covered services. PersonalCare is obligated to ensure that services are provided in a culturally competent manner consistent with professionally recognized standards of health care.

Member Appeal: The provider is appealing on the member's behalf for a claim that the member is financially responsible for or for a denied service that the provider believes is medically necessary. Please refer to *Reconsideration of an Organization Determination, Including Transplants Policy MA100.01; Reconsideration by an Independent Entity MA100.05; and The Center for Health Dispute Resolution Reconsideration Format MA100.10* on how to appeal on behalf of a member.

Policy/Procedure:

Administrative Appeals are received by the Provider Relations Department, which are investigated and reviewed in conjunction with other departments as needed. Issues include but are not limited to decisions regarding medical claims coding, administrative policies and procedures, utilization management policies and procedures, timely filing and services provided without a referral.

To appeal a decision, the provider is required to complete a Request for Review form (attached) along with the supporting documentation as outlined below. The provider has 180 days from the date of denial or payment of claim to appeal.

Medical Claims Coding

First Level: The Provider initiates a call to the Provider Relations Department and questions payment justification outlined on the remittance advice received with his/her claims payment. The Provider Relations representative or technician responds to the provider and no further action is required.

Second Level: The provider disagrees with the decision at the first level on how a claim was processed. The Request for Review form (see attachment) is completed with a written statement describing his/her concerns along with the supporting documentation. PersonalCare will review the appeal and respond to the Provider with the final decision.

Policies and Procedures

Utilization Management Policies and Procedures: The Provider wants to express his/her general dissatisfaction with a specific utilization management policy and procedure. The Provider needs to submit in writing his/her dissatisfaction with such policy to the Medical Director. The Medical Director will review the Provider's request for review. The Medical Director will respond in writing to the Provider with PersonalCare's final decision. If the concern is related to a specific member or referral, please refer to *Reconsideration of an Organization Determination, Including Transplants Policy MA100.01*; *Reconsideration by an Independent Entity MA100.05*; and *The Center for Health Dispute Resolution Reconsideration Format MA100.10* on how to appeal on behalf of a member.

Administrative Policies and Procedures: If a Provider wants to express his/her dissatisfaction with an administrative policy, which includes issues regarding non-healthcare related decisions, i.e., claims payment policies and operational issues, the Provider will submit in writing his/her disagreement with the policy to the Director of Provider Relations. Following internal review by the appropriate person(s), a response will be sent to the Provider in writing of PersonalCare's final decision.

Claims Denied Due to Filing Time

The Provider disagrees with PersonalCare's decision to deny payment of a claim due to filing past the contractual filing time. The Review for Request form (see attachment) with appropriate documentation needs to be completed by the provider and sent to PersonalCare. The claim will be researched and the provider will be notified of PersonalCare's final decision. Acceptable proof of timely filing include:

- A date in box 31 of a HCFA, or box 86 of a UB.
- A computerized print-out of all the dates the claim was submitted.

- For electronically filed claims, the provider must submit a first level acceptance report.
- A copy of the provider's EOB denial from the incorrect insurance company.
- A copy of the incorrect insurance card the member gave to the provider on the DOS.

Services Provided Without a Referral

The provider wants to express his/her dissatisfaction with a claim being denied due to no referral. The provider completes the Request for Review form (see attachment) and attaches the supporting documentation. The provider will be notified in writing of PersonalCare's final decision. See page 13 – QIO Review section of the Provider Manual for more information.

Denial of Hospital Services

If the provider wants to appeal a denied hospital service or bed day, the provider must submit in writing his/her appeal reason along with any supportive medical information. The provider completes the Request for Review form (see attachment) and sends to PersonalCare. PersonalCare's Provider Relations department will notify you in writing with the final decision.

Claims Denied due to “Never Event” and Hospital-Acquired Condition (HAC)

Consistent with CMS policy, PersonalCare will not reimburse providers for the extra care resulting from HACs listed in the CMS website. In addition, PersonalCare prohibits passing these charges on to patients.

POA/HAC: <http://www.cms.hhs.gov/HospitalAcqCond/>

L. MEMBER GRIEVANCE OR MEDICARE APPEAL PROCESS

The provider shall cooperate and comply with all PersonalCare and Medicare requirements regarding the processing of member appeals and grievances, including the obligation to provide information within the timeframe reasonably requested for such purpose. PersonalCare has established a separate Customer Services Department dedicated to PersonalCare Advantra PPO members.

The first step of the member appeal process begins after PersonalCare processes an Organization Determination on behalf of one of its members. An Organization Determination is any determination made by a provider of health care or the plan regarding the receipt of treatment or payment of services. A member must receive this determination, whether favorable or a denial, within 14 days of a service request, or 60 days of a claim payment request, unless an

expedited determination is necessary. Other levels of the member's appeal process are addressed in the attached Appeal Policies - *Reconsideration of an Organization Determination, Including Transplants Policy MA100.01; Reconsideration by an Independent Entity MA100.05; and The Center for Health Dispute Resolution Reconsideration Format MA100.10* on how to appeal on behalf of a member.

M. PERSONALCARE ADVANTRA MEMBER RIGHTS AND RESPONSIBILITIES

PersonalCare Advantra Members have the right to:

Be treated with dignity, respect and fairness

You have the right to be treated with dignity, respect, and fairness at all times. Our Plan must obey laws that protect you from discrimination or unfair treatment. We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. If you need help with communication, such as help from a language interpreter, please call Member Services. Member Services can also help if you need to file a complaint about access (such as wheel chair access). You may also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or your local Office for Civil Rights.

The right to the privacy of your medical records and personal health information

There are federal and state laws that protect the privacy of your medical records and personal health information. We protect your personal health information under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people don't see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who isn't providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at medical records held at the Plan, and to get a copy of your records (there may be a fee charged for making copies). You also have the right to ask us to make additions or corrections to your medical records (if you ask us to do this, we will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Member Services. "The Plan will release your information, including your

prescription drug event data, to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations."

Your right to see plan providers, get covered services, and get your prescriptions filled within a reasonable period of time

As explained in the Evidence of coverage, you will get most or all of your care from plan providers, that is, from doctors and other health providers who are part of our Plan. You have the right to choose a plan provider (we will tell you which doctors are accepting new patients). You have the right to go to a women's health specialist (such as a gynecologist) without a referral. You have the right to timely access to your providers and to see specialists when care from a specialist is needed. "Timely access" means that you can get appointments and services within a reasonable amount of time. The Evidence of coverage explains how to use plan providers to get the care and services you need. You have the right to timely access to your prescriptions at any network pharmacy.

Your right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our Plan. Note: This includes the right to know about the different Medication Management Treatment Programs we offer and in which you may participate. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a provider has denied care that you believe you were entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision called an organization determination or a coverage determination. Organization determinations and Coverage determinations are discussed in the Evidence of Coverage.

You have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of your refusing treatment. This includes the right to know about the different Medication Management Treatment Programs we offer and in which you may participate.

Your right to use advance directives (such as a living will or a power of attorney)

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called “**advance directives**.” There are different types of advance directives and different names for them. Documents called “**living will**” and “**power of attorney for health care**” are examples of advance directives.

If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores.

You can sometimes get advance directive forms from organizations that give people information about Medicare. Section 1 of the Evidence of Coverage tells how to contact your SHIP, which stands for State Health Insurance Assistance Program. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have *not* signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is *your choice* whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you *have* signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with:

The Illinois Department of Public Health
535 West Jefferson Ave.
Springfield, IL 62761
Telephone: 1-800-782-7861 (toll free)
Telephone: 217-782-7861 (outside of Illinois)
Hours of Operation: Monday – Friday- 8:30 AM to 5:00 PM
www.idph.state.il.us

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. A complaint can be called a grievance, an organization determination, or a coverage determination depending on the situation.

If you make a complaint, we must treat you fairly (i.e., not retaliate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed against our Plan in the past. To get this information, call Member Services.

Your right to get information about our Plan, plan providers, drugs, health care coverage, and costs

The Evidence of Coverage tells you what medical services are covered for you as a plan member and what you have to pay.

If you need more information, please call Member Services. You have the right to an explanation from us about any bills you may get for services not covered by our Plan. *We must tell you in writing why we will not pay for or approve a service, and how you can file an appeal to ask us to change this decision..* See Section 9 and Section 10 of the Evidence of Coverage for more information about filing an appeal.

You also have the right to get information from us about our Plan. This includes information about our financial condition, about our Plan health care providers and their qualifications, about information on our network pharmacies, and how our Plan compares to other health plans. You have the right to find out from us how we pay our doctors. To get any of this information, call Member Services. You have the right under law to have a written/binding advance coverage determination made for the service, even if you obtain this service from a provider not affiliated with our organization.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call Member Services. You can also get free help and information from your SHIP. You can also visit www.medicare.gov on the Web to view or download the publication “Your Medicare Rights & Protections.” Under “Search Tools,” select “Find a Medicare Publication.” Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

What you do if you think you have been treated unfairly or your rights are not being respected?

If you think you have been treated unfairly or your rights have not been respected, you may call Member Services or:

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, you can call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or call your local Office for Civil Rights.
- If you have any other kind of concern or problem related to your Medicare rights and protections described in this section, you can also get help from your SHIP.

Your responsibilities as a member of our Plan

Your responsibilities include the following:

- Getting familiar with your coverage and the rules you must follow to get care as a member. You can use the Evidence of Coverage to learn about your coverage, what you have to pay, and the rules you need to follow. Please call Member Services if you have any questions.
- Letting us know if you have additional health insurance coverage.
- Notifying providers when seeking care (unless it is an emergency) that you are enrolled in our Plan and you must present your plan enrollment card to the provider.
- Giving your doctor and other providers the information they need to care for you, and following the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions and have them explain your treatment in a way you can understand.
- Acting in a way that supports the care given to other patients and helps the smooth running of your doctor's office, hospitals, and other offices.
- Paying your plan premiums your co-payments and coinsurance for your covered services. You must pay for services that aren't covered.
- Letting us know if you have any questions, concerns, problems, or suggestions. If you do, please call Member Services.

Your right to get information about your drug coverage and costs

The Evidence of coverage tells you what you have to pay for prescription drugs as a member of our Plan. If you need more information, please call our Member Services. You have the right to an explanation from us about any bills you may get for drugs not covered by our Plan. We must tell you in writing why we will not pay for a drug, and how you can file an appeal to ask us to change this decision. See Section 10 of the Evidence of Coverage for more information about filing an appeal. You also have the right to receive an explanation from us of any utilization-management requirements, such as step therapy or prior authorization that may apply to your plan. If you have any questions please review your formulary Web site or call Member Services.

Your right to get information about our Plan and our network pharmacies

You have the right to get information from us about our Plan. This includes information about our financial condition and about our network pharmacies. To get any of this information, call Member Services.

What can you do if you think you have been treated unfairly or your rights aren't being respected?

For concerns or problems related to your Medicare rights and protections described in this section, you may call our Member Services Department. You can also get help from your State Health Insurance Assistance Program, or SHIP.

N. Quality Improvement Organization QIO-review

The Quality Improvement Organization (QIO), an independent agency, has contracted with the Secretary of the Department Health and Human Services (DHHS) to review records of the medical care provided to PersonalCare Advantra PPO members when they register complaints concerning quality of access or to care.

Members also have the right to an Immediate Review by the QIO if the member believes that they are being discharged from the hospital Skilled Nursing Services, Home Health Services or Rehabilitation Services too soon. When a Notice of Discharge is given to the member, the notice is subject to QIO Review.

PersonalCare will contact your office to obtain medical records upon Quality Improvement Organization's request. All reviews will be performed by a board-certified physicians of like specialty not involved in the original determination and having no relationship to PersonalCare. Please direct any questions regarding the Quality Improvement Organization and the Review Process to our Medicare Appeals Department.

O. Independent Quality Review

PersonalCare maintains an agreement with the Illinois Foundation of Quality for Health Care, a Quality Improvement Organization approved by CMS. The purpose of this agreement is to focus on the development and implementation of cooperative projects as a method to improve the quality of care in the State and to help Medicare risk beneficiaries make informed health care choices. Quality of care includes access, appropriateness and desired outcomes to care and consumer satisfaction.

P. Unique Services

PersonalCare Advantra PPO offers a more comprehensive benefit package for its members compared to Fee-For-Service Medicare, Medigap or Medicare Supplement Plans. Examples of these service enhancements are described below. Please note that PersonalCare Advantra PPO products have coverage limitations that are different from the PersonalCare commercial HMO & PPO products. In most cases, the coverage limitations follow Medicare Fee for Service coverage guidelines.

Please note: Members are subject to the copayment indicated on their identification card for certain services.

Preventive Care

Routine Physicals are covered once per year

Mammograms are covered annually. As required by CMS, members may self-refer to a contracted facility for the annual screening mammogram. PersonalCare does remind each member that they should also have a breast exam by their Physician or a contracted gynecologist in conjunction with obtaining a mammogram.

Gynecological Visit

Members are entitled to one office visit per year for a routine annual exam including a pap smear without a referral from the member's physician when using a PersonalCare Advantra PPO contracted gynecologist. A copayment may apply.

Mammography Screening

Members have direct access (through self-referral) to a mammography screening.

Immunizations and Vaccinations

Members have direct access (through self-referral) for influenza and pneumococcal vaccines and their administration and are covered in full.

For further information specific to benefits, please contact the Customer Service Department at 1-866-784-4916.

Q. Advance Directive

An Advance Directive is a written formal document, written by the member in advance of an incapacitating illness or injury. All PersonalCare Advantra PPO members receive an Advance Directive document as part of their membership materials. Extra copies can be obtained through PersonalCare Advantra PPO Customer Service Department at 1-866-784-4916.

When a PersonalCare Advantra PPO member visits your office, we ask that you discuss Advance Directives and document in the medical records whether or not the member has executed an Advance Directive.

<p style="text-align: center;">PERSONALCARE HEALTH CARE MEDICAL CARE ADVANCE DIRECTIVE POLICY</p>
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PersonalCare believes in the right of the patient to make the appropriate decisions concerning his/her care. We also understand that in some medical situations, that power may not be within the patient's realm of physical or mental capacities. As a Preferred Provider Organization, we believe in and support a patient's right to make advance arrangements for the direction of his/her medical care in these instances. The state of Illinois recognizes and enforces the provisions of the Patient Self-Determination Act of 1990. In response to this legislation the state of Illinois recognizes two forms of medical care advance directive.

- "Living Will"
- Health Care Power of Attorney (Durable Power of Attorney)

PersonalCare requires each of our network and contracted providers to notify and educate the member/patient about his/her rights and how to exercise them. The following is the policy followed by PersonalCare.

1. PersonalCare makes the provision in their Medicare provider contracts to require each provider to inform individuals about their rights.
 - under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to invoke medical care advance directives.
 - the provider's policy with respect to the implementation of medical care advance directives; and
 - any policy of the Preferred Provider Organization regarding these rights.
2. Any document of medical care advance directives executed by the member is included at least by copy in the individual's medical record. Documentation of declination to execute such right will also become a part of the permanent record.
3. The existence of a medical care advance directive will not cause or create a change in the provision of care provided or result in any discrimination against the individual because of this choice. This provision shall, not, however, be construed to require care in conflict with the medical care advance directives.
4. PersonalCare will monitor the compliance of its provider offices by reviewing advance directive processes at regular medical record reviews.
5. PersonalCare will conduct orientation and continuing education with providers, their staffs and the staff of PersonalCare which will include education about

advance directives. PersonalCare will provide written material on advance directive rights for the distribution through the medical offices.

6. PersonalCare will require each provider to inform each adult member about the medical care advance directions in the following situations:
 - for hospital provider, at the time of the patient's admission
 - for a SNF, at the time of admission
 - at the time of admission to a nursing facility as a resident
 - at the time of arranging for home health care, before the patient comes under the care of the home health provider or
 - at the time of the initial advice on hospice care

PersonalCare further believes in the rights of any provider to object to the implementation of medical care advance direction. Those providers are required to inform the patient of their objection, how that will impact the request for medical care advance directive and provisions for referral or reassignment to a new physician that has compatible beliefs with the patient.

R. Accessibility Standards

PersonalCare has developed standards for accessibility and availability of physicians for members. Although there may be exceptional circumstances, every effort must be made to adhere to these standards.

- Providers must be available for medically necessary services 24 hours a day, seven days a week.
- The hours of operation must be convenient and accessible to all members regardless of sex, race, or gender.
- Minimum of 20 hours each week of regularly scheduled office hours for treatment of patients for a one-physician practice and minimum of 30 hours for a two or more physician practice.
- Response time to urgent calls no greater than 30 minutes after notification.
- No more than an average of five patients scheduled and seen each hour for routine office visits for adult medicine, and five for pediatrics.
- Member waiting time for urgent care visits - within 24 hours.
- Member waiting time for a non-urgent/non-emergency, but symptomatic office visit - not more than one week.
- Member waiting time for a routine non-systematic office visit - not more than 2 weeks.
- Member requesting a routine physical exam - not more than 4 weeks.

S. Record Retention

As a requirement of Medicare, all providers must maintain for a period of 6 years books and in certain instances described in the Medicare Advantage regulation, periods in

excess of 6 years for more records, documents and other evidence of accounting procedures and practices, physical facilities and equipment and records related to Medicare enrollees and any additional relevant information CMS may require.

T. Claims and Encounter Submission

It is recommended that you submit Claims within 90 days from the date of service on a CMS 1500 Form. PersonalCare Advantra has adopted the standard billing guidelines so that completion of the CMS Form is consistent with Medicare Guidelines.

- You must include your **NPI** number on each Claim Form submitted.
- The mailing address for PersonalCare Advantra claims is:

Mail PersonalCare Advantra medical claims to:

PersonalCare Advantra
P.O. Box 7141
London, KY 40742
Electronic Payor ID: 25146

Mail Coventry Dental Claims to:

Coventry Dental
P.O. Box 6228
Rockville, MD 20849
Payor ID – CX049

Mail MH Net behavioral health claims to:

MHNet
P.O. Box 209010
Austin, TX 78720
Electronic Payor ID: MHNET BH

IMPORTANT PROVIDER ENCOUNTER INFORMATION REGARDING MEDICARE ADVANTAGE RISK ADJUSTMENT PAYMENT METHODOLOGY

The Balanced Budget Act of 1997 specifically required implementation of a Risk Adjustment Method Payment methodology. Starting 2004, Medicare Advantage Organizations will receive a portion of their payment from CMS based on the “health status” of the Medicare beneficiary. The payment model recognizes diagnoses from inpatient hospital data and ambulatory settings.

Based on the Balance Budget Act of 1997, Medicare Advantage Organizations must collect and submit all inpatient hospital, outpatient hospital and physician encounter data to the Center of Medicare and Medicaid Services (CMS) on all enrolled Medicare Advantage HMO & PPO members.

Effective July 1, 2002, all encounters submitted to CMS must contain all relevant diagnoses noted during hospital inpatient stays and hospital outpatient and physician visits.

All hospitals and physicians must use current valid International Classification of Diseases - 9th Edition - Clinical Modification (ICD-9-CM) Codes; report all diagnoses

related to service performed and justified by medical record documentation and following coding guidelines using the most specific code.

All providers who participate in the Medicare-Choice Program are required to submit complete and accurate claims data and maintain clear, concise and complete medical record documentation practices.

The following procedures have been identified to assist providers in complying with the regulatory requirements of submitting encounter information.

- (1) Provider should provide ongoing training to staff regarding appropriate use of ICD-9-CM code set for reporting diagnoses.
- (2) Submit **all** diagnosis that impact the patient evaluation, care and treatment:
 - Main reason for a visit or admission
 - Co-existing acute condition
 - Chronic conditions
 - Permanent past conditions.
- (3) Providers should periodically review their claim/encounter data submission to ensure that they are accurate, complete and truthful and are supported by the medical record or other relevant documentation.
- (4) Provider should fully communicate diagnosis details to coding staff, so that the visit or admission is coded to the highest level of specificity known.

U. Importance of Medical Record Documentation

- Accurate risk adjusted payment relies on complete medical record documentation and diagnostic coding.
- CMS annually conducts risk adjustment data validation by Medical Record Review.
- The medical record chronologically documents the care of the patient and is an important element contributing to high quality care.

Resources - ICD-9-CM Coding

1. www.hcfa.gov/medlearn/cbticd9.htm for a computer-based course on ICD-9-CM
2. www.cms.hhs.gov (Conduct a site search for ICD-9-CM)
3. www.mcoservice.com

V. Referral/Authorization

PersonalCare Advantra PPO

Certain PersonalCare Advantra PPO services must either be provided by network providers, be approved in advance by network providers, or be authorized by PersonalCare in advance to be covered. If members use non-plan providers for services that they must get from plan providers, they are still eligible for benefits, but their cost share will be higher.

Covered services that need prior authorization may be coordinated through the PersonalCare Health Services Department calling 1-866-557-8748 or 1-217-373-3998, Monday – Friday 8:00 a.m. to 5:00 p.m. Member’s can request prior authorization through the use of non-network providers by contacting Customer Service at 1-866-784-4916, Monday-Friday 8:00 a.m. to 6:00 p.m. If the service is approved, an approval letter is sent to the PersonalCare Advantra PPO member and the provider performing the service. If a review is required by a Medical Director, the provider may also be notified by telephone. Denial notices are sent if the services are not authorized.

PersonalCare Advantra PPO members do not need a referral for pap smears , pelvic exams and mammograms

Mental Health/Substance Abuse Referrals

Mental Health/Substance Abuse services are covered through Mental Health Network (MH Net). MH Net has a multidisciplinary team of mental health professionals available 24 hours a day, seven days a week. The phone number for MH Net is 1-800-423-8070 and is also listed in the PersonalCare Advantra Provider Directory.

Complex Case Management

Members may be referred to complex case management for multiple (two or more within the last 6 months) admissions or ER visits for the following:

System

Cardiovascular:

- Case
- Congestive Heart Failure
- Myocardial Infarction with complications
- Coronary Artery Disease
- Hypertension (uncontrolled)

Dehydration

Diabetes Mellitus with:

- Cellulitis
- Diabetic ketoacidosis
- Hyperosmolar coma
- Hypoglycemia/hyperglycemia (uncontrolled diabetes)
- New diagnosis with insulin dependence

End Stage Renal Disease

- Members on dialysis

Pain Management

Respiratory

- Asthma
- Chronic Obstructive Pulmonary Disorder (COPD)

**System
Seizures**

- Case

**Sepsis
Trauma/Medical
Surgical/Neuromuscular**

- Burns greater than 20% of body or 2nd or 3rd degree
- Coagulation defects
- Congenital anomalies (severe)
- Spinal cord injury
- Major trauma
- Organ failure
- Ventilator dependence

Scheduled, elective inpatient admission for hip replacement surgery

Complex discharge planning needs requiring greater than two services that are required for longer than one month.

Any transplant evaluation

**Newly enrolled members
requiring:**

- Greater than two homecare services for longer than one month
- Ongoing outpatient services such as chemotherapy, radiation, dialysis
- Current inpatient hospitalization in a skilled nursing or acute rehabilitation facility

Pharmacy

- Poly-pharmacy with ten (10) or more prescriptions in thirty days
- Member taking large quantities of pain medications or antidepressant medications

Repeated Falls

Ordering physicians will be informed for any interventions and any follow up needs identified through the complex case management assessment.

W. MEDICAL RECORDS

Providers should safeguard the privacy of the member's medical record. Original medical records should be released only in accordance with Federal or State laws, court orders or subpoenas.

All records should be kept confidential and maintained for ten (10) years and in certain instances described in the Medicare Advantage regulation, periods in excess of ten (10)

years or more. All member information should be available to be transferred upon request by the member, or authorized representative, to any organization with which the member may subsequently enroll, or to a provider to ensure continuity of care.

Ensure timely access by member to pertinent records and information upon request. Members can be charged a reasonable fee for copies of records.

The provider must abide by all Federal and State laws regarding confidentiality, documentation on whether or not a member has executed an Advance Directive and disclosure for mental health records and medical records.

X. CMS REQUIREMENTS

Please be advised that marketing material communications that promote, communicate or explain the Medicare health plan to PersonalCare Advantra PPO members require approval by the Center for Medicare and Medicaid Services (CMS). Health education materials are generally not under the purview of CMS marketing review.

The Plan can provide CMS-approved materials for you to announce your participation with the PersonalCare Advantra PPO program. Please contact the PersonalCare Advantra Marketing Department if you are interested in pursuing any communication to members of your practice regarding the PersonalCare Advantra PPO products.

PersonalCare Advantra PPO Personal Health Profiles

All new members are sent an Advantra Senior Health Questionnaire within the first 30 days of enrollment. The questionnaire is completed by the member and sent back to PersonalCare.

The form asks the member a number of questions specific to the member's medical history, as well as questions about lifestyle. The form is also used to educate members about the use of PersonalCare Advantra PPO contracted providers and to transition members into receiving services from contracted providers.

PersonalCare requests that the member discuss their Senior Health Questionnaire with their Physician. The information from the Senior Health Questionnaire will assist the Physician or Specialist in providing direction regarding the member's health needs and potential treatment options. This will allow the member to participate in the development of their own treatment plan. PersonalCare will also assist in the coordination of care for complex or serious disease cases with the member's physician or Specialist and will inform members of any follow-up care and provide training in self-care through the Case Management or Disease Management Program.

Y. LAWS AND REGULATIONS

All Plan providers must comply with applicable Medicare laws and regulations, including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975,

the Americans with Disabilities Act, the Rehabilitation Act of 1973, and other laws applicable to recipients of Federal funds.

Providers should provide services to PersonalCare members without regard to the race, color, religion, sex, ethnic origin, age or disability of such person, or any other classification prohibited by law.

PersonalCare's policy, as well as the Federal law, is that no form of discrimination prohibited by law will be permitted on the basis of sex, race, color, disability, age, religion or ethnic origin, and that all members will have access to their medical services at all contracted provider facilities.

Member Access to Care and Information from Plan Providers

PersonalCare Advantra PPO members have the right to get timely access to plan providers and to all covered services. "Timely access" means that members get appointments and services within a reasonable period of time. Members have the right to get full information from their doctors when they get medical care. Members have the right to participate fully in decisions about their health care, which includes the right to refuse care.

Disclosure of Information

At the request of the MA Organization or CMS, the provider shall disclose all information necessary to (1) administer and evaluate the program, to include quality performance indicators and information regarding members' satisfaction and (2) establish and facilitate a process for current and prospective beneficiaries to exercise their right to choose Medicare services.

Continuation of Benefits

Provider shall continue to provide covered services to PersonalCare Advantra PPO members who are hospitalized on the date the CMS contract terminates or expires or if PersonalCare becomes insolvent, through the date of each member's discharge or for the remainder of the period for which the member's Medicare premium has been paid.

External Review

Provider agrees to cooperate with all independent quality review and improvement organization activities required by CMS and/or PersonalCare pertaining to the provision of services for PersonalCare Advantra PPO members.

Plan Provider Termination Notice

The MA Organization must make a good faith effort to notify members of the termination of a provider's contract 30 days before the termination is effective. Providers must follow the termination provision as defined in their Physician Agreement, to ensure timely notification.

Termination without Cause

The MA Organization and the provider shall provide at least 60 days advance written notice in the event that the MA Organization or the provider seeks to terminate the Physician Agreement other than “for cause”.

Compliance with Medical Management

Providers must agree to comply with the Plan’s Medical policies, QI and Medical Management Programs.

Exclusion of Certain Persons

Provider shall not and shall ensure that no provider with which the provider contracts shall employ or contract for the provision of healthcare with individuals excluded from participation in Medicare. PersonalCare will not contract with any Provider for participation in the Medicare Advantra plan if the Provider has opted out of the traditional Medicare program. Health Plan will monitor the Opt-Out list and will terminate from participation in the Medicare Advantra plan any provider who appears on the list.