TheHealthPlan

Chapter 6

Medicare Advantage (MA)

Provider Manual

SecureCare HMO Medicare Advantage Plan

THP has entered into a contract with the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Medicare program. Under this contract, CMS makes a monthly payment to THP for each Medicare beneficiary who enrolls in our plan. This contract requires THP to provide comprehensive health services to persons who are entitled to Medicare benefits and who choose to enroll in THP. THP receives a set rate for each member plus any enrollee premium.

Medicare Advantage benefit plans generally have copays for:

- Primary and specialty care physician office visits
- Inpatient admissions
- Skilled nursing home services
- Emergency room services
- Urgent care
- Outpatient mental health visits
- Physical, occupational, and speech therapy
- Biological drugs
- Durable medical equipment

The benefits for SecureCare Health Maintenance Organization (HMO) members are identical to traditional Medicare benefits along with additional enhanced benefits . rights and responsibilities as a participating provider with THP. You are expected to assist our members by making them aware of their rights and by supporting these within your practice.

Please refer to this section of the manual for important information regarding CMS quality standards that you are required to meet when caring for Medicare Advantage enrollees. The Customer Service Department is available to assist with any member issues that may arise at 1.877.847.7907.

Medicare Advantage Member ID Cards

The THP Medicare Advantage member ID cards are color-coded orange to more easily identify THP's Medicare Advantage population.

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SecureChoice PPO Medicare Advantage Plan

SecureChoice Preferred Provider Organization (PPO) is THP's Medicare Advantage preferred provider organization (PPO) option. SecureChoice PPO members are not required to select a primary care physician (PCP) and referrals to specialists are not required. THP prior authorization requirements do apply.

The SecureChoice PPO plan provides benefits at an "in-network" level from THP's extensive network of participating providers. The SecureChoice PPO plan also provides benefits to SecureChoice PPO members at an "out-of-network" level from any Medicare provider of choice at an additional out-of-pocket expense to the member.

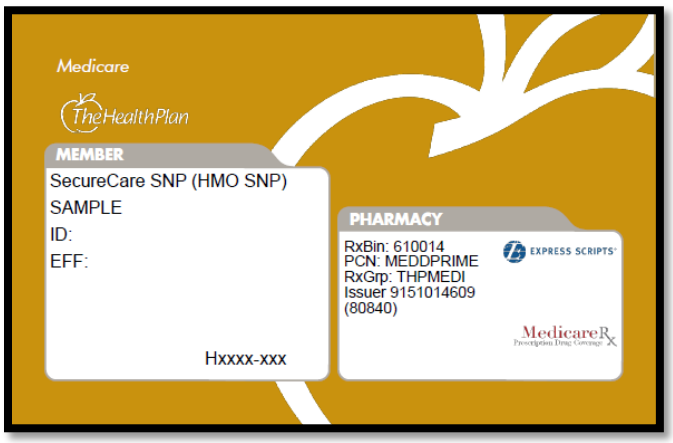
The benefits for SecureChoice PPO members are identical to traditional Medicare benefits. THP also offers enhanced benefits for SecureChoice members. As with the SecureCare HMO plan, it is imperative that you are aware of these rights and responsibilities as a participating provider so that you may assist our members within your practice.

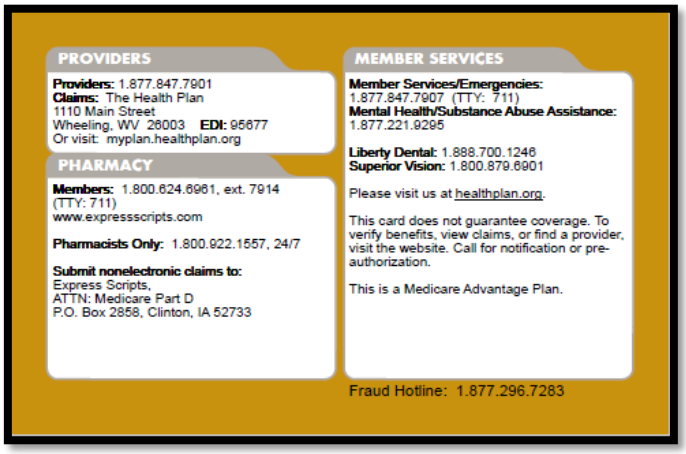
D-SNP Medicare Advantage Special Needs Plan

Effective January 1, 2014, THP began a Medicare Special Needs Plan (SNP) for populations that are dually eligible for both Medicare and Medicaid coverage. These Dual Eligible Special Needs Plan (D-SNP) members are individuals with both Medicare Part A and Part B coverage who also meet the Medicaid eligibility requirements of their state of residence.

Every SNP is required to have a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA). The NCAQ MOC approval process follows standards and scoring guidelines established by Centers for Medicare and Medicaid Services (CMS). THP received approval as a contracted MA-PD (Medicare Advantage Prescription Drug) plan, which also applies to THP's D-SNP program.

THP's developed MOC is a written document describing the fundamental framework and measurable goals of the program. THP's MOC implements a comprehensive approach to managing and coordinating care to enhance access to medically necessary care, improve quality of care and ensure continuity of needed services. The care management team uses a Health Risk Assessment Tool (HRAT) designed to assess information collected from the enrollee about their self-perceived health status and develop an individualized plan of care. As mandated by Medicare, THP provides initial and annual MOC training to personnel and providers (network and out-of-network) about the program to ensure integrated coordination of care for the D-SNP population.





Measurable goals

The list below is a brief description of some of our measurable goals.

- Improve access to essential services including medical, behavioral health, and social services by providing a comprehensive network. Every SNP member will be assigned a case manager with licensed social workers readily available.
- Require SNP members to select a primary care provider (PCP) and assign a THP case manager to the member.
- Streamline the process of transition of care across health care settings, providers, and health services coordinated by the physician/provider and the care manager.
- Improve access to preventive care.
- Improve member health outcomes through participating in annual Healthcare Effectiveness Data and Information Set (HEDIS®) data collection, as well as member surveys.

Provider reimbursement and billing

The provider will bill THP for medically appropriate covered services provided to the D-SNP member. THP will reimburse the provider for services rendered, according to the member's benefit plan, less any copays, coinsurance, or deductible amounts. The provider will then be eligible to submit any balance associated with the copays, co-insurance, and deductible directly to the West Virginia or Ohio Medicaid program. THP accepts full and partial D-SNP members. Members who have partial status may have limited coverage from their state plan.

Changes in reimbursement/fee schedules issued by federal and/or state entities will become effective by THP on the date of notification.

Federal law prohibits Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, co-insurance, or copayments from those enrolled in the dual-eligible program. This program exempts individuals from Medicare cost-sharing liability. Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to an eligible member. Providers who bill a qualified dual-eligible member for amounts above the Medicare and Medicaid payments (even when Medicaid pay nothing) are subject to sanctions. See Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997. This section of the act is available on the Social Security Administration's website: ssa.gov "Compilation of the Social Security Laws."

Providers may not discriminate by refusing to serve enrollees because they receive assistance with Medicare cost-sharing from a state Medicaid program.

Provider education

In each calendar year, all Medicare Advantage participating practitioners must complete D-SNP MOC training. THP conducts provider education through several approaches including face-to-face or web-based training, seminars, and ProviderFocus newsletter articles.

THP's D-SNP MOC Annual Training and attestation are on the secure provider portal.

If training is not complete and attested to, THP will issue the provider a documented corrective action plan (CAP).

Each CAP will include a sixty (60) day cure period. During the sixty (60) day cure period, THP will:

1. Stop D-SNP member auto-assignment to network providers with incomplete D-SNP MOC training.

2. Suspend Alternative Payment Model Category 2 care coordination fees for assigned members, as applicable.

If the CAP is cured, THP will re-start member auto-assignment and re-institute care coordination fees, as applicable. If the CAP is not cured, THP will evaluate network providers for removal from the network.

Vision Service Benefit

Members enrolled through THP Medicare Advantage program also have vision benefits. Superior Vision administers routine vision benefits for Medicare Advantage members. Please refer to resources available through Superior Vision for information on benefits and coverage under these vision plans.

Providers must participate with Superior Vision before offering covered vision services to THP members.

Supervisor Vision is available at: superiorvision.com and 877.235.5317 Monday – Friday 8 a.m. to 9 p.m. EST and Saturday 11 a.m. to 4:30 p.m. EST

Members may require ophthalmologic medical services in conjunction with a medical condition. These medical services must be offered through a contracted ophthalmologist or optometrist with THP. A referral from the primary care provider (PCP) may be required for the member to obtain medical services from an ophthalmologist or optometrist.

Billing Medical Eye Exams with a Vision Screening

In most situations, a vision screening (CPT 92015 Determination of Refractive State) is considered non-covered and not separately reimbursed as it is a component part of an eye exam.

Billing Procedures

The visit is billed to THP with the following codes:

92002, 92004, 92012, or 92014	**Eye exam, new or established patient**
92015	**Determination of refractive state**

Coordination of Benefits Medicare Advantage Secondary Payer

Medicare Advantage is not always the primary payer for health insurance claims. THP will comply with the Centers for Medicare and Medicaid Services' (CMS) requirement to provide information pertaining to claims in which Medicare Advantage is secondary. Medicare Advantage is the secondary payer when the beneficiary is entitled to:

- Veteran's Benefits
- Workers' Compensation
- Black Lung Benefits
- Employer Group coverage based on the Medicare secondary payer guidelines.

THP Insurance Company Medicare Supplemental Plans

Original Medicare beneficiaries who have Original Medicare as their primary insurance can select a THP Medicare Supplement Plan and pay a monthly premium to THP to cover their Medicare deductibles and coinsurance. These plans do not require a member to choose a primary care provider (PCP) or obtain a referral for specialty physician services.

Medicare Non-Covered Service Guidelines

THP Medicare Advantage plans, SecureCare (HMO), SecureChoice (PPO), or SecureCare SNP (HMO SNP), fall under Medicare Advantage (Part C) rules. These rules require THP to provide appropriate notice of non-coverage/coverage to the members and educate providers on 1) coverage and exclusions of medical services; 2) limits of plan coverage; and 3) how to correctly advise members prior to providing services of such limitations or service exclusion under Medicare. To ensure that providers understand your role and responsibility regarding covered and non-covered medical services, we are providing this training information as a guide.

Providing Notice of Non-Coverage

The first method THP utilizes to educate members of non-covered services is provided upon enrollment, through the Evidence of Coverage (EOC) booklet Chapter 4, Section 3: "What services are not covered by the plan?"

The second method is provided through the "Notice of Denial (or partial denial) of Medical Coverage" issued through prior authorization, coverage determination, or organization determination) process.

For every service billed to THP, the member receives an Explanation of Benefits (EOB) that provides an explanation of the charges and what, if any, the member is financially responsible for paying to the provider.

Unsure if Covered

For a service or item that is typically not covered but could be covered under specific conditions (i.e., dental care that is necessary to treat an illness or injury), the EOC, in and of itself, is not adequate notice of non-coverage for purposes of determining member financial liability. In such instances, the appropriate process is for the member, or the provider acting on behalf of the member, to request a pre-service determination.

Never Covered

If a service is never covered by the plan (statutorily excluded from coverage per Medicare rules) and the plan's Evidence of Coverage (EOC) provided to the member is clear that the service or item is never covered, THP is not required to hold the member harmless from the full cost of the service or item.

Appeal Rights

For any payment or coverage request for service that THP receives and denies, a standardized denial notice, as stated above, is provided with appeal rights. The member, or you as their treating provider, has the right to appeal any denial of a service or item. THP will not take punitive action against providers who request an expedited resolution or support a member's appeal.

Member Liability

When the provider, or the plan acting on behalf of the provider, can show that a member was notified (via a clear exclusion in the EOC or the standardized denial notice) prior to receipt of the item or service that:

a) The item or service is not covered by the plan; or

b) That coverage is available only if the member is referred for the service by a contracted provider and nonetheless, the member receives that item or service in the absence of a referral, the regulation at §422.105(a) does not require that plans hold the member harmless from the full cost of the service or item charged by the provider.

Medicare Advantage Billing Rules are Different

This section explains how and when to bill a member for non-covered services.

As a contracted provider with THP, you must always submit a claim for payment of services to THP prior to billing our members, even if you have received a pre-service determination denial.

Billing for Non-covered Services

GY - No pre-service determination was made

Use this modifier to tell us that you informed/explained to the member that in his/her Health Plan EOC there was a "clear" exclusion, and the service was not covered.

GA - Pre-service notice of non-coverage was provided by the plan

Use this modifier to tell us that:

- A pre-service determination was requested and the "Notice of Denial (or partial denial) of Medical Coverage" was issued; or
- The member either refused your offer of obtaining a pre-service determination or wanted to proceed with the service.

***Note**: When using this modifier please also provide the pre-service determination number on the claim*

- When providers bill with these modifiers, the claims are processed with the appropriate codes for member financial liability, and you may bill the member. If you bill for non-covered services without using the GA or GY modifier, THP will deny your claim as

provider responsibility. If you bill us for covered services with the GY or GA modifier, THP will deny your claim for incorrect use of modifier. Part of your responsibility as a contracted provider is to inform your patients when a service is not covered (or statutorily excluded) by THP. For THP Medicare department to know if you have given proper notice of non-coverage to our members, you must follow the billing rules and use the modifiers as stated above.

- Following the billing rules and appropriate use of the modifiers ensures that you understand when to provide proper notice of non-coverage of medical services to our Medicare Advantage plan members in advance and limits the confusion of coverage and financial responsibility between the members and THP.

Improper Use of Advance Notices of Non-Coverage (ABN)

On May 5, 2014, CMS released a memo titled "Improper Use of Advance Notices of Non-coverage", directing all Medicare Advantage organizations (MAO) and their contracted providers to cease with using ABN notices and ABN-like notices as they are not compliant with the Medicare Advantage organization determination requirements. Per CMS, an ABN does not apply in or under the Medicare Advantage context because a MAO member has the right under these statutes and regulations to a pre-service determination prior to receiving services.

For information on this topic, see the Claims Processing Manual Chapter 1 and MLN Booklet available on CMS' website cms.gov:

Medicare Advance Written Notices of Noncoverage ICN 006266

CMS Quality Measures/Standards

CMS implements quality initiatives to assure quality health care for Medicare beneficiaries through accountability and public disclosure.

CMS uses quality measures in its various quality initiatives that include quality improvement, pay for reporting, and public reporting. Please review the information found under **Chapter 10 - Quality** for additional information.

Quality measures are tools that help measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include effective, safe, efficient, patient-centered, equitable, and timely care.

Medicare Wellness Visits

Medicare has distinct opportunities for practitioners to evaluate and treat beneficiaries, each of which has very specific purposes and claim submission requirements. THP encourages practitioners to complete the visits according to Medicare requirements to develop a personalized prevention plan, competed health risk assessments and fully assess social determinants of health and report this information via claims data.

Appointment of Representative Statement for a Medicare Member

To appoint a representative, a Medicare member or their representative should complete the form entitled: Appointment of Representative -CMS-1696 - PDF.

If you do not use form CMS-1696, your appointment must:

- Be in writing and signed and dated by you and your representative.
- Provide a statement appointing the representative to act on your behalf.
- Authorize the release of your personal health information to your representative.
- Include a written explanation of the purpose and scope of the representation.
- List your name and your representative's names, phone numbers, and addresses.
- Include your Medicare Number (Health Insurance Claim Number or Medicare Beneficiary Identifier) or National Provider Identifier (NPI)
- Indicate your representative's professional status, if any, or relationship to you; and
- Be filed with the entity processing your appeal.

Unless revoked, an appointment is considered valid for one year from the date the form is signed. Once the form is filed, it is valid for the duration of the appeal. Therefore, a signed form can be used for more than one appeal if the appeal is filed within one year of the date on the form.

In addition, there are certain individuals who can bring an appeal on the member's behalf, pursuant to State or other applicable laws**.** Such an individual, known as an "authorized representative," may be a court-appointed guardian, an individual who has durable power of attorney, a health care proxy, or a person designated under a state's health care consent statute.

Appointment of Representative Forms are available in English, Spanish & Large Print. Visit https://www.cms.gov/medicare/cms-forms/cms-forms/cms-forms-items/cms012207 to access the form in these versions.

Notice of Medicare Non-Coverage (NOMNC)

When to Deliver the NOMNC

A Medicare provider, or THP, must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries (or the beneficiary's appointed or authorized representative) for Enrollees receiving covered skilled nursing, home health (including psychiatric home health), comprehensive outpatient rehabilitation facility, and hospice services.

The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily.

Provider Delivery of the NOMNC

Providers must deliver the NOMNC to all beneficiaries eligible for the expedited determination process per section §260 of Chapter 30 of the Medicare Claim Processing Manual (https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c30.pdf) or Section 100.2 in the Part C & D Enrollee Grievances, Organization/Coverage Determination, and Appeals Guidance Section of the Medicare Managed Care Manual (https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf.)

A NOMNC must be delivered even if the beneficiary agrees with the termination of services. Medicare providers are responsible for the delivery of the NOMNC. Providers may formally delegate the delivery of the notices to a designated agent such as a courier service; however, all requirements of valid notice delivery apply to designated agents.

The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision may be disputed. Use of assistive devices may be used to obtain a signature.

Instructions and CMS Forms are available on the CMS website CMS.gov https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms

Medicare Outpatient Observation Notice (MOON)

On August 6, 2015, Congress passed the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, which requires all hospitals and critical access hospitals (CAHs) to provide written and oral notification to all Medicare beneficiaries receiving observation services as outpatients for more than twenty-four (24) hours. The written notice must include the reason the individual is receiving observation services and must explain the implications of receiving outpatient observation services, in particular the implications for cost-sharing requirements and subsequent coverage eligibility for services furnished by a skilled nursing facility.

The Medicare Outpatient Observation Notice (MOON) was developed by the Centers for Medicare & Medicaid Services (CMS) to serve as the standardized written notice. Effective March 8, 2017, the MOON must be presented to Medicare beneficiaries, including those with Medicare Advantage plans, to inform them that the observation services they are receiving are outpatient services and that they are not an inpatient of the hospital or CAH. Hospitals and CAHs must deliver the notice no later than thirty-six (36) hours after observation services are initiated, or sooner if the individual is transferred, discharged, or admitted.

The hospital or CAH must obtain the signature of the patient or a person acting on behalf of the patient ("representative") to acknowledge receipt of the notification. If the individual or representative refuses to sign it, the written notification is signed by the hospital staff member who presented it.

The CMS approved standardized MOON form (CMS-10611) and accompanying instructions are available on the CMS website CMS.gov https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms

THP will monitor hospitals and critical care hospitals annually for compliance to valid delivery of the MOON.

Medicare Appeals Overview

When an enrollee requests coverage for a particular service, the decision on whether to provide such coverage is considered an "Organization Determination." Enrollees have the right within 60 days of a denial to request either a standard pre-service (30-day), a post service claim (60-day) or an expedited (72 hours) reconsideration whenever a Medicare Advantage organization has denied an enrollee's request for services, Part B drugs will have a standard turn-around time of 7 days effective January 1, 2020.

Where the Medicare Advantage organization affirms its advice "Organization Determination" in whole or in part, the Medicare Advantage organization must automatically forward the case file to CMS's independent review entity so that it may make a final reconsidered determination. CMS contracts with MAXIMUS Federal Service, Inc.

The parties to an organization determination for purposes of an appeal include:

- The enrollee (including their representative)
- An assignee of the enrollee (i.e., a physician or other provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service
- The legal representative of a deceased enrollee's estate; or
- Any other provider or entity (other than the Medicare health plan) determined to have an appealable interest in the proceeding.

Who may request reconsideration (Parts C&D Enrollee Grievances, Organization/Coverage Determination, and Appeals Guidance – 50.1) An enrollee, an enrollee's representative or a non-contract practitioner or provider to the Medicare health plan may request that the determination be reconsidered; however, contract providers do not have appeal rights. An enrollee, an enrollee's representative, or physician (regardless of whether the practitioner is affiliated with the Medicare health plan) are the only parties who may request that a Medicare health plan expedite a reconsideration.

For standard pre-service reconsiderations, a practitioner who is providing treatment to an enrollee may, upon providing notice to the enrollee, request a standard reconsideration on the enrollee's behalf without submitting a representative form.

If the reconsideration request comes from the enrollee's primary care provider in THP's contract network, no enrollee notice verification is required.

If the request comes from either an in-network (contract) physician or a non-contract physician, and the patient's record indicates he or she visited this physician at least once before, a Medicare health plan may assume the physician has informed the enrollee about the request and no further verification is needed.

If this appears to be the first contact between the practitioner requesting the reconsideration and the enrollee, a Medicare health plan is to undertake reasonable efforts to confirm the practitioner has given the enrollee appropriate notice. For example:

- If the practitioner makes the request by phone, during the call a health plan may confirm the practitioner gave the enrollee notice that he or she is acting on the enrollee's behalf.
- The physician makes the request by a fax, letter, or email, and copies the enrollee on the correspondence, and/or the writing includes a statement affirming that the enrollee knows that the physician is acting on the enrollee's behalf with the enrollee's knowledge and approval.
- The Medicare health plan may call the enrollee and ask if he or she knows that this physician making the request is acting on his or her behalf with his or her knowledge and approval. Notice of Medicare Hospital Discharge Appeals Notices

An Important Message from Medicare about Your Rights (Form CMS-R-193)

Hospitals are required to deliver the Important Message from Medicare (IM), CMS-R-193, to all Medicare beneficiaries (Original Medicare beneficiaries and Medicare Advantage plan enrollees) who are hospital inpatients. The IM informs hospitalized inpatient beneficiaries of their hospital discharge appeal rights. A detailed notice of discharge (DND) is given only if a beneficiary requests an appeal. The DND explains the specific reasons for the discharge.

Forms and instructions can be found on the CMS website CMS.gov.

Detailed Notice of Discharge (Form CMS 10066)

A member who wishes to appeal the determination made by the facility or THP that inpatient care is no longer medically necessary must request an immediate review by the peer review organization (PRO) of the determination. The member must request the immediate PRO review by noon of the first working day after receipt of the notice. The member will not be financially responsible for the hospital care until the PRO makes its decision. If the admission was not authorized by THP or the admission did not constitute emergency or urgently needed care and the PRO upholds THP's determination, the member is financially responsible for the hospital costs.

A member who fails to request an immediate PRO review may request expedited reconsideration by THP through the appeal process.

Forms and instructions can be found on the CMS website CMS.gov.

Low Income Medicare Beneficiaries

The qualified Medicare beneficiary (QMB) program is a Medicaid benefit that pays Medicare premiums and cost sharing for certain low-income Medicare beneficiaries. Federal law prohibits Medicare providers from collecting Medicare Part A and Part B coinsurance, copayments, and deductibles from those enrolled in the QMB program, including those enrolled in Medicare Advantage and other Part C Plans.

The patient should make the provider aware of their QMB status by showing both their Medicare and Medicaid or QMB card each time they receive care. A patient should not get a bill for medical care that Medicare covers. Patients cannot be charged for Medicare deductibles, coinsurance, and copayments.

Medicare Provider Rights and Responsibilities

Overview of Physician Responsibilities

Primary Care Physicians (PCPs):

- Act as a health care manager for members to arrange and coordinate their medical care, including but not limited to, routine care, and follow-up care after the receipt of emergency services.

Specialists:

- Provide continuity and coordination of care by sending a written report to PCPs regarding any treatment or consultation provided to members, regardless of whether the service was a result of a PCP referral or the member making his/her own arrangements.

All Contracted Physicians and Practitioners Must

- Arrange for the provision of medical services to THP's members by a participating practitioner after hours, on weekends, vacations, and holidays. Services from non-participating covering practitioners may not be covered, unless otherwise approved by THP.
- Have 24-hour on-call capability, either directly or through an answering service, not an answering machine.
- Help members obtain their benefit coverage by getting written prior authorization for services that require it and prior to referring for out-of-plan services, as appropriate.
- Facilitate candid discussion with members regarding appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage. Such discussion should include complete and current information concerning a diagnosis, treatment, and prognosis, in terms that the member (or designee) can be expected to understand.
- Provide to members the information necessary to give informed consent prior to the start of any procedure or treatment.
- Maintain appropriate medical records regarding members and their treatment, recognizing that said records are confidential and ensuring that they are maintained in accordance with legal and ethical requirements concerning confidentiality and security.
- Cooperate with THP, or its designee, in the resolution of members' complaints, expedited appeals, appeals and/or grievances.
- Comply with other administrative requirements as specified in the applicable contract or stipulated in this Provider Manual or its updates.
- Promote the efficient delivery of medical services to maximize health care resources and the member's premium dollar and improve quality of care provided.
- Refrain from providing treatment to the physician's own family members.
- Provide medical information in a culturally competent manner to all members, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities.

NCQA Requirements:

- Comply with THP medical records policy, quality assurance programs, medical management programs, and HEDIS® data collection.

CMS Marketing Guidelines:

- Comply with CMS Marketing Guidelines (available online at https://www.cms.gov/Medicare/HealthPlans/ManagedCareMarketing/FinalPartCMarketingGuideli nes) for provider-based activities. The guidelines govern how providers can and cannot inform or educate patients about enrollment and plan information.

SecureCare/SecureChoice Member Rights and Responsibilities

An excerpt from THP's Medicare Member Handbook

Our plan must honor your rights as a member of the plan.

We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)

To receive information from us in a way that works for you, please call Customer Services at 1.877.847.7907.

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. We can also give you information in Braille, large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services at 1.877.847.7907 or contact our Director of Medicare.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with THP Appeals Coordinator at 1.877.847.7907 (TTY: 711). You may also file a complaint with Medicare by calling 1.800.MEDICARE (1.800.633.4227) or directly with the Office for Civil rights. Contact information is included in the Evidence of Coverage, or you may contact Member Services for additional information.

We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' Office for Civil Rights at 1.800.368.1019
(TTY: 1.800.537.7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Member Services at 1.877.847.7907. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

We must ensure that you get timely access to your covered services and drugs

As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services. Call Member Services to learn which doctors are accepting new patients at 1.877.847.7907. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

As a plan member, you have the right to get appointments and covered services from the plan's network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 10 of this booklet tells what you can do. (If we have denied coverage for your medical care or drugs and you do not agree with our decision, Chapter 9, Section 4 tells what you can do.)

We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells you about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people do not see or change your records.
- In most situations, if we give your health information to anyone who is not providing your care or paying for your care, we are required to obtain written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.

- For example, we are required to release health information to government agencies that are checking on quality of care.
- Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee 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 work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Member Services at 1.877.847.7907.

We must give you information about the plan, its network of providers, and your covered services

As a member of SecureCare (HMO) or SecureChoice (PPO), you have the right to get several kinds of information from us. (As explained above, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Member Services at 1.877.847.7907:

- Information about our plan. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- Information about our network providers including our network pharmacies.
    - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
    - For a list of the providers in the plan's network, see the Plan Provider Directory.
    - For a list of the pharmacies in the plan's network, see the Plan Pharmacy Directory.
    - For more detailed information about our providers or pharmacies, you can call Member Services at 1.877.847.7907 or visit our website at healthplan.org.
- Information about your coverage and the rules you must follow when using your coverage.
    - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
    - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's List of Covered Drugs (Formulary). These chapters, together with the List of Covered Drugs (Formulary), tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
    - If you have questions about the rules or restrictions, please call Member Services at 1.877.847.7907.
- Information about why something is not covered and what you can do about it.

- If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
- If you are not happy or if you disagree with a decision, we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells you about how to make a complaint about quality of care, waiting times, and other concerns.)
- If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

- Utilization Review. THP has a Utilization Management Program in place that monitors the use of, or evaluates the clinical necessity, appropriateness, efficacy or efficiency of, health care services, procedures or care settings. Areas of utilization management include:
  - Prior authorization of health care services, for example elective admissions, home health services, durable medical equipment or imaging studies. Prior authorizations may be for non-urgent services, urgent services or post services. The decisions for prior authorizations are made within strict time frames to minimize any disruption in the provision of health care. Non-authorization decisions are communicated to members and providers within strict time frames with sufficient information to understand the reason for the non-authorization and to decide whether to appeal the non-authorization. Only medical directors who are physicians may not authorize services for medical necessity.
  - Hospital inpatient review– Clinical information is received from hospitals that enable registered nurses at THP to assist with post-hospital care needs and arranging services to ensure care across the continuum.
  - Care/case management is a personalized process to assess treatment options and opportunities to coordinate care, design care plans to improve quality and efficacy of care, manage cost and benefits patient care to ensure optimal outcomes for members

with catastrophic illness or those needing episodic management of health care needs. Registered nurses perform the functions of utilization management.

- New Technology
    - THP tries to keep pace with change and ensure members have access to safe and effective care. THP continually reviews new trends in medical technology, procedures, pharmacological treatments and drugs. Scientific evidence, medical effectiveness and determinations from regulatory bodies are all components of the review of new technology. THP reviews this information to form the basis for coverage decisions in the future.

We must support your right to make decisions about your care.

You have the right to know your treatment options and participate in decisions about your health care.

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices in a way that you can understand.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- To know about all of your choices. This means that you have the right to be told 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. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- To know about the risks. 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. You always have the choice to refuse any experimental treatments.

- The right to say "no." You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- To receive an explanation if you are denied coverage for care. You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself.

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, if you want to, you can:

- Fill out a written form to give someone the legal authority to make medical decisions for you if you ever become unable to make decisions for yourself.
- 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 use an "advance directive" to give your instructions, here is what to do:

- Get the form. 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. You can also contact Member Services to ask for the forms at 1.877.847.7907.
- Fill it out and sign it. 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.
- Give copies to appropriate people. 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. Be sure to keep a copy at home.

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.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with Probate Court in the county in which you reside.

You have the right to make complaints and to ask us to reconsider decisions we have made.

If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – we are required to treat you fairly.

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services at 1.877.847.7907.

What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights.

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' Office for Civil Rights at 1.800.368.1019 or TTY 1.800.537.7697 or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having:

- You can call Member Services at 1.877.847.7907.
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or you can call Medicare at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

How to get more information about your rights

There are several places where you can get more information about your rights:

- You can call Member Services (phone numbers are printed on the back cover of this booklet).
- You can call the SHIP. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact Medicare.
    - Visit the Medicare website, medicare.gov, to read or download "Your Medicare Rights & Protections"
    - Call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week (TTY:1.877.486.2048)

You have some responsibilities as a member of the plan.

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services at 1.877.847.7907. We're here to help.

- Get familiar with your covered services and the rules you must follow to get these covered services. Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
    - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
    - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- If you have any other health insurance coverage or prescription drug coverage in addition to our

plan, you are required to tell us. Please call Member Services to let us know at 1.877.847.7907.

  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "coordination of benefits" because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 10.)

- Tell your doctor and other health care providers that you are enrolled in our plan. Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information, they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- Be considerate. We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- Pay what you owe. As a plan member, you are responsible for these payments:
  - You must pay your plan premiums to continue being a member of our plan.
  - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.
  - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your

medical services. Chapter 6 tells what you must pay for your Part D prescription drugs.
    - If you get any medical services or drugs that are not covered by our plan or by other insurance, you may have, you must pay the full cost.
        - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.
    - If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
    - If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.
- Tell us if you move. If you are going to move, it's important to tell us right away. Call Customer Services at 1.877.847.7907.
    - If you move outside of our plan service area, you cannot remain a member of our plan. (Chapter 1 tells you about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
    - If you move within our service area, we still need to know so we can keep your membership record up to date and know how to contact you.
    - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- Call Customer Services for help if you have questions or concerns. We also welcome any suggestions you may have for improving our plan.
    - Call Customer Services at 1.877.847.7907.
- Contacting Utilization Review Staff
    - During business hours 8:00 AM – 5:00 PM Monday through Friday, you may call us toll free at 1.800.624.6961, ext. 7644.