Medicare

Group Administrative Manual

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Welcome

It is my pleasure to present to you the 2015 edition of the Univera Healthcare Group Administrative Manual.

This has become a valuable tool in continuing our strong partnership and commitment to meeting your business needs.

The information in this manual is intended to provide you with a quick reference to our most common business processes and answers to frequently-asked questions. Your business is valued and appreciated.

Sincerely,

Roger van Baaren
Vice President, Medicare

Version 4
August 2014

Your guide to Medicare Advantage

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For answers to questions not found in this reference guide, please contact us by using one of the methods listed in the Contact Information section on this page.

Contact Information

Questions about specific plan benefits or premium rates – Please contact your dedicated Account Consultant.

Visit our website: UniveraHealthcare.com

Our mailing address

Medicare Division
P.O. Box 546
Buffalo, New York 14201

Customer Service – Contact Information

Questions specific to an individual member's claims or benefits should be directed to our Medicare Customer Service Department using the phone number on the member's identification card.

Enrollment- Contact Information

Questions regarding the enrollment status or eligibility of a Medicare member can be directed to our Medicare Enrollment Department at 1-877-240-1320.

To comply with federal Health Insurance Portability and Accountability Act (HIPAA) regulations, health plans must obtain a member's permission to share that member's protected health information with any other person. There are limited exceptions to this rule.

The necessary forms can be completed online – or we can fax or mail copies to you.

Please Note: Throughout this document, we use the term "Medicare Advantage Plan" and "Medicare Advantage Prescription Drug Plan" to represent Univera SeniorChoice (HMO-POS) or Univera Medicare PPO. The term "Plan Sponsor" refers to the employer or union that sponsors the group Medicare Advantage Plan. The use of the term "member" refers to any current, potential and/or prior member of the employer or union that sponsors the group Medicare Advantage Plan. These guidelines reflect CMS requirements as of the date of publication and are subject to change with or without advance notice.

General Information

Medicare

Medicare is the federal health insurance program regulated by the Centers for Medicare and Medicaid Services (CMS). Medicare is established for people age 65 and over, certain younger people with disabilities, and people with End-Stage Renal Disease (ESRD). Individuals should be informed of Medicare eligibility requirements, how to apply for Medicare and how Medicare coverage operates in relation to your group health plan. Please consult with your legal counsel regarding your Medicare responsibilities.

Univera Healthcare Plans:

Medicare Advantage (MA) - When a member joins one of our Medicare Advantage Plans, he/she will use the health insurance card that he/she gets from us for his/her health care. In most MA plans, generally there are extra benefits and lower copayments than in the Original Medicare Plan. However, it may be required that the member see doctors that participate in our provider network or go to certain hospitals to get services.

Medicare Advantage Prescription Drug Plan (MA-PD) - A Medicare Advantage Prescription Drug Plan includes Part D drug coverage. When a member joins one of our Medicare Advantage Prescription Drug Plans, the member will use the health insurance card that he/she will get from us for his/her health care and drug coverage. Generally, there are extra benefits and lower copayments with an MA-PD Plan than in the Original Medicare Plan. However, it may be required that the member see doctors that participate in our provider network or go to certain hospitals or pharmacies to get services or covered drugs.

Eligibility

Eligibility requirements for Medicare Advantage and Medicare Advantage Prescription Drug Plans

Members must meet the following eligibility requirements to enroll in a Medicare Advantage or Medicare Advantage Prescription Drug Plan:

- Be entitled to Medicare Part A.
- Be enrolled in Medicare Part B.
- Permanent resident of the plan service area.
- Comply with the CMS guidelines regarding end-stage renal disease.

All enrollments in Medicare Advantage and Medicare Advantage Prescription Drug Plans are processed as single contracts. Any dependents of eligible members must qualify for Medicare individually in order to be eligible to enroll in a Medicare Advantage or Medicare Advantage Prescription Drug Plan. For those members with a spouse or dependent who is not Medicare eligible, the spouse or dependent may enroll in a non Medicare plan if offered, commonly referred to as “commercial” coverage. Commercial enrollments are handled separately and may have different eligibility guidelines.

Plan Service Area

The approved plan service area for Medicare Advantage and Medicare Advantage Prescription Drug Plans is listed below.

Univera SeniorChoice (HMO-POS) and Univera Medicare PPO – Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming counties are covered in New York State.

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Enrollment

Univera Healthcare must receive a signed paper application form from each member who is enrolling in a Medicare Advantage or Medicare Advantage Prescription Drug Plan.

Group Enrollment Applications

- It is important that the correct Employer Group enrollment forms are used. If a member completes an "Individual" enrollment form, he/she will be enrolled in an individual plan.
- Please review all enrollment forms for completeness to ensure proper processing.
- If we determine that the group enrollment form is incomplete, the form cannot be processed and will be sent back to the member.

Alternative Enrollment Method

- In limited cases, Plan Sponsors may be eligible to submit a data file from the employer group for enrollments. Disenrollments, cancellations or terminations of coverage cannot be accepted through this mechanism.
- Any group that wishes to utilize the alternative enrollment method must receive prior approval from both Univera Healthcare and from CMS. Please contact your Account Consultant for further information regarding group requirements and responsibilities.

Effective Date Of Enrollment

Applications completed for enrollment in a Medicare Advantage or Medicare Advantage Prescription Drug Plan must be received by the last day of the month in order to be effective for the first day of the following month. All enrollments are effective as of the first of the month. For example: An application received on August 17th will be effective for September 1st as long as the individual is eligible for Medicare as of that date.

In cases of administrative delay by the Plan Sponsor, we will accept applications for enrollment up to 30 days after the requested effective date. It is important to transmit all applications to us in a timely manner to ensure accurate claims processing for your members. Consistent patterns of late transmission of enrollment applications will not be accepted.

Group enrollments can also be accepted for a future date no further than 2 months in advance of the current calendar month.

All enrollment forms must be signed prior to the requested effective date and must also have the requested effective date listed on the enrollment form. In no event can the requested effective date be prior to the date the member signed the application.

The Enrollment Process

After an enrollment form is entered into the Univera Healthcare membership system, an electronic file is sent to CMS to verify eligibility for each member. Each member will then be mailed an acknowledgement letter with the proposed effective date of coverage.

If the enrollment form is incomplete or eligibility cannot be verified, a letter is mailed to the member requesting the additional information needed to complete the enrollment. The enrollment process will not continue until the additional information is received and Medicare eligibility is verified. If the needed information is not provided by the member within 21 calendar days or the end of the month, whichever is later, the application will be rejected as it is assumed the member is no longer interested in enrolling in the Medicare Advantage or Medicare Advantage Prescription Drug Plan.

The final step in completing the enrollment is confirmation of the enrollment by CMS. At least once a week, CMS will review the files we have submitted and will confirm or deny the enrollment. If the

enrollment is confirmed, the member will be mailed a Confirmation of Enrollment Letter with the final effective date of coverage. If the enrollment is denied, the applicant will receive a Denial Letter; and he or she will be individually responsible for paying the cost of all medical or pharmacy services received while the enrollment application was pending.

Note- Member Contact

With regard to Member eligibility for Medicare Advantage and Medicare Advantage Prescription Drug Plans, we may need to contact the member directly for additional information. It is important that we ensure that the member is making a fully informed decision in regard to his/her enrollment choices. While the Plan Sponsor may be able to provide particular information specific to a member's enrollment request, we may need to contact the member directly to verify information.

Disenrollment

Disenrollment Process – Entire Group

If the Plan Sponsor wishes to terminate the group Medicare Advantage or Medicare Advantage Prescription Drug Plan, a written request must be received by us 45 days prior to the requested effective date.

We must notify members at least 21 days prior to a Plan Sponsor termination that he/she has the option to enroll in a Medicare Advantage or Medicare Advantage Prescription Drug Plan as a direct pay individual. We will provide affected Plan Sponsor members with this notice at least 21 days prior to the plan termination. If we receive written notice of plan termination less than 45 days before the requested termination date, we will extend the termination date of your contract by one month in order to meet the CMS required time frames for this member notification. Retroactive disenrollments will not be processed and are not allowed due to notification requirements for the member per CMS guidance.

Disenrollment Process - Specific Individual

The Plan Sponsor will establish its own criteria for member eligibility in its plan. If it is determined that a member no longer qualifies for the group status, the Plan Sponsor must submit appropriate documentation to request the involuntary disenrollment of the member. This documentation must clearly state the reason why the member is no longer eligible and provide a minimum of 30 day notification prior to disenrollment. If 30 days notification is not provided by the Plan Sponsor, we will extend the disenrollment date of the member by one additional month in order to meet the CMS required time frames for member notification. The Plan Sponsor should maintain records of the notification and the dates in the event of any CMS audit(s).

Disenrollment Process - Individual Initiated

If a member requests to voluntarily disenroll from the employer-sponsored plan, he/she may submit his/her own written request to us to do so. CMS requires that these requests be processed regardless of the member's enrollment in an employer-sponsored plan. These types of requests are processed for the first of the following month after the written disenrollment request is received. In addition to this form of disenrollment, if a member enrolls in another Medicare Advantage or Medicare Prescription Drug Plan he/she will be automatically disenrolled from his/her current plan. In order to re-enroll, a new enrollment application will need to be submitted.

Disenrollment Process- Medicare Supplement Plans

Disenrollment requests are processed for the first of the following month after the written disenrollment request is received or for a specific date as long as the effective date is written on the request and there has been no claims utilization.

A group may disenroll a member from a Medicare Supplement plan for loss of eligibility or non-payment of premiums.

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Disenrollment Process – Medicare Initiated

In certain cases, a member may be involuntarily disenrolled from an MA or MA-PD plan due to loss of eligibility for continued enrollment. We are notified of these eligibility changes electronically each week by CMS. The list below provides examples of when a member may be involuntarily disenrolled:

- Loss of entitlement to Medicare Part A
- Termination of enrollment in Medicare Part B
- Permanent move outside of the plan service area *
- Enrollment in another Medicare Advantage and/or Medicare Prescription Drug Plan
- Death

When we complete an involuntary disenrollment for one of the above reasons, we will send written notification directly to the member or his/her estate.

* Note - Permanent Move Outside Of The Plan Service Area

Members are given a 6 month period for which they may reside outside of our plan service area. If the member resides outside of the plan service area for more than 6 consecutive months, they will no longer be eligible to be enrolled in one of our Medicare Advantage or Medicare Advantage Prescription Drug Plans, as this is considered a permanent change of residence. When information becomes available about a residency change, from either the member or CMS, our Medicare Enrollment Department will initiate contact with the member to ensure compliance with service area requirements. The member will be asked to confirm their place of permanent residence and the date of the change. Based on the information provided, this will determine the member's eligibility to remain enrolled in one of our MA or MA-PD plans.

Low Income Subsidy (LIS)

Medicare also provides extra help (a subsidy) with Part D prescription drug costs and premiums for eligible individuals whose income and resources are limited. This help takes the form of subsidies paid by the federal government to the Medicare Prescription Drug Plan in which the eligible individual enrolls. The subsidy provides assistance with the premium, deductible and copayments/coinsurance of the program.

Further information on the low income subsidy can be found on the Social Security Administration website at **SSA.gov.**

Low Income Subsidy Eligibility

Individuals become LIS eligible either by being deemed eligible by CMS or through application to the Social Security Administration (SSA).

- Individuals are deemed when they receive Medicaid benefits either as a full dual eligible or a partial dual eligible or if they are a Supplemental Security Income (SSI) recipient. Individuals are often deemed retroactively and are always deemed through the end of the calendar year.
- Individuals that apply for LIS through SSA may gain, lose or have a change to their LIS status at any point during a calendar year.

Low Income Subsidy Enrollment Process

We are notified of LIS status changes on a regular basis by CMS and by individual members. If it is determined that a member is eligible for this subsidy, the member's enrollment will be updated accordingly once our Medicare Enrollment Department receives notification.

Low Income Premium Subsidy Pass Through Requirement

Plan Sponsors are required to comply with the same requirements related to the low income premium subsidy amount that applies to Medicare Prescription Drug Plan sponsors offering Part D plans to individual beneficiaries. Any low income premium subsidy amount paid on behalf of a member who is LIS eligible must first be used to reduce any portion of the premiums paid by the member for the Medicare Advantage Prescription Drug Plan. Any remainder may then be used to reduce any portion of the Plan Sponsor's Medicare Advantage Prescription Drug premium contribution.

For Plan Sponsors with a community rated or prospective experience rated Medicare Advantage Prescription Drug Plan, we will reduce the monthly premium charged to the Plan Sponsor for the LIS beneficiary. It is the responsibility of the Plan Sponsor to reduce the LIS eligible member's contribution to premiums or refund the appropriate amounts directly to him/her within 45 days from the date we receive the subsidy payment from CMS.

For Plan Sponsors with a claims-based billing arrangement or self-funded arrangement, we will issue a refund check directly to the Plan Sponsor for the premium subsidy amounts received on behalf of the LIS eligible member. It is the responsibility of the Plan Sponsor to reduce the LIS eligible member's contribution to premiums or refund the appropriate amounts directly to the LIS eligible member within 45 days from the date we receive the subsidy payment from CMS.

Creditable Coverage

Plan Sponsors who offer prescription drug coverage are required to notify Medicare eligible policyholders whether their prescription drug coverage is creditable coverage. Creditable coverage is coverage that is expected to pay on average as much as the standard Medicare prescription drug coverage. Please visit CMS.gov/CreditableCoverage for more information.

Medicare Late Enrollment Penalty

Individuals eligible for Medicare who do not join a Medicare Prescription Drug Plan (Part D) when they are first eligible, and who do not have prescription drug coverage that is at least as good as standard Medicare prescription drug coverage (creditable drug coverage) may pay a late enrollment penalty if they later join a Medicare Prescription Drug Plan. Individuals must pay the late enrollment penalty if they join a Medicare Prescription Drug Plan after having a period of 63 days or longer without Medicare prescription drug coverage or other creditable prescription drug coverage after they are first eligible to join. This period will start after either May 15, 2006 or three months after they are first eligible to join a Medicare Prescription Drug Plan. Individuals are eligible to join a Medicare Prescription Drug Plan once they are entitled to Medicare Part A and/or enrolled in Medicare Part B.

Individuals will have to pay a penalty for every month he/she was eligible to join a Medicare Prescription Drug Plan and was not enrolled in one. They will have to pay this penalty in addition to his/her monthly premium for as long as they are enrolled in a Medicare Prescription Drug Plan.

The late enrollment penalty amount is at least 1% of the Part D national average premium for each full uncovered month that an individual was eligible to join a Medicare Prescription Drug Plan and did not.

Upon application for enrollment in a Medicare Advantage Prescription Drug Plan, the Medicare Enrollment Department will consult CMS eligibility systems and our internal eligibility systems for the following information.

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- The date the member was first eligible to enroll in a Medicare Prescription Drug Plan.
- The start and end dates of any period in which the member was previously enrolled in a Medicare Prescription Drug Plan.
- The start and end dates of any period in which the member was enrolled in a creditable drug plan for which a former employer or union was receiving the Retiree Drug Subsidy from CMS.
- The start and end dates of any period in which the member was enrolled in a creditable drug plan offered by the same Plan Sponsor through Univera Healthcare.

If we determine that the member had a period of 63 days or longer without Medicare prescription drug coverage or other creditable prescription drug coverage, we will calculate the number of full months that the member did not have coverage.

The late enrollment penalty will appear on the Plan Sponsor's monthly bill for any member that is subject to the late enrollment penalty. The Plan Sponsor has the discretion to pay the penalty amount on behalf of their members or to bill the member for the penalty amount. Regardless of which option is chosen, the Plan Sponsor is responsible for remitting the entire amount due to Univera Healthcare each month.

Billing And Payment Information

Billing

- It is important that you reconcile your billing statement each month to ensure that all members being billed are still active and enrolled in the correct MA or MA-PD plan. This will ensure that our records are up-to-date, allow timely claim payments and prevent denials of activity requests due to CMS retroactivity guidelines.

Payments

- Submit the payment with the payment remittance stub to the address shown on the reverse side of the remittance stub.
- Do not send any activity with your premium payment to our bank lock box. Activity such as new adds, cancellations or changes will not be processed with your payment.

Benefit Changes

Mandated Benefit Changes

- During the year, Congress may mandate Medicare to provide coverage for specific items. These changes generally are effective the first of the year; however, effective dates may vary. CMS requires that each member receive notification of these benefit enhancements, as well as any other plan benefit changes.
- The plan will notify members directly of any mandated Medicare benefit changes.

Voluntary Group Benefit Changes

- Voluntary benefit changes may be requested on renewal and must be received by us no less than 30 calendar days prior to the requested effective date.
- In addition, group Medicare Advantage and Medicare Advantage Prescription Drug members must be provided with written notice of any change in benefits, contributions or service areas at least 30 days prior to the effective date of the change. Plan Sponsors that voluntarily make changes to its plan offering are responsible for mailing this notice to their members. Records of the notification and the dates should be retained in the event of any CMS audit(s).

Individual Notification Of Changes

Annual Notice of Change (ANOC)/Evidence of Coverage (EOC)

- Each September, CMS requires Medicare Advantage and Medicare Advantage Prescription Drug organizations to provide written notification to each MA or MA-PD member detailing all benefit changes or enhancements, as well as any service area changes that affect all members. This mailing is sent to individual and group members and includes the following documents:
  - Annual Notice of Change (ANOC)
  - Evidence of Coverage (EOC)
  - Formulary (For Medicare Advantage Prescription Drug Plans only)
- The annual mailing that will be sent to group members is based on the active benefit package as of August 1.

Medicare Secondary Payer (MSP) Rules and Regulations

Medicare has rules regarding when it is the primary or secondary payer of benefits. You, as the group administrator are responsible to know your group's size and how these MSP rules and regulations apply to your group.

Working aged rules:

- If company has 19 employees or fewer during the specified time frame – Medicare is primary
- If company has 20 or more employees during the specified time frame and subscriber is actively working, Medicare is secondary and Univera Healthcare is primary

Disability rules (for members who are Medicare-eligible and are under age 65):

- If company has fewer than 100 employees during the specified time frame – Medicare is primary
- If company has 100 or more employees during the specified time frame and subscriber is actively working, Medicare is secondary and Univera Healthcare is primary
- If subscriber is not in active employee status, regardless of company size, Medicare is primary to subscriber's plan for Medicare eligible members

End-stage renal disease (ESRD):

- For members who have permanent kidney failure, Medicare bases its Primary/Secondary status on a diagnosis consistent with ESRD
- A member is given a 30-month coordination period where Univera Healthcare is primary
- At the end of the coordination period, Medicare becomes primary
- If a member receives a successful kidney transplant, Medicare eligibility may end
- We require a letter from the Medicare office advising us when Medicare ends
- We correspond directly with a member who is eligible for Medicare due to ESRD
- We require dialysis and transplant information to determine Medicare primacy

This is a simplified explanation, and there are many exceptions to the above rules and regulations. Please visit Medicare.gov for additional Medicare information.

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Miscellaneous

Reinstatements

If a member unintentionally disenrolls from the employer group Medicare Advantage or Medicare Advantage Prescription Drug Plan due to enrollment in another similar plan they may be reinstated under certain circumstances. In order for the member to be reinstated with no break in coverage he/she must make this request within 30 days of notification of disenrollment. If this request is received within 30 days of notification of disenrollment, the member will be reinstated into our plan and notification will be sent to CMS of his/her reinstatement. However, if the member fails to provide notification of his/her request to stay with our plan within the 30 day time frame or if he/she has used another plan's services he/she will be required to re-enroll as of the first of the month after a new application is received.

Deliberate and intentional disenrollments made by the member are only eligible for reinstatement if the member directly contacts the other plan to cancel his/her enrollment prior to the effective date of a deliberate disenrollment. This request is the responsibility of the member and cannot be performed by the employer representative.

Enrollment Cancellation

Cancellations may be necessary in cases of mistaken enrollment made by a member. A member may cancel his/her enrollment only by contacting us prior to the effective date of the enrollment. Cancellations properly made to the Plan Sponsor prior to the effective date of the enrollment request being cancelled are also acceptable. Plan Sponsors must submit appropriate documentation showing that the member contacted the Plan Sponsor prior to the effective date of coverage in order to cancel the enrollment.

Requests to cancel an enrollment that are made after the effective date of coverage will be considered for disenrollment effective the first of the following month.

Address Changes

When an address for a member has changed, it is the responsibility of the member to notify us by contacting Customer Service at the phone number listed on their Identification Card. If it is determined that the member resides outside of our plan service area as a result of the move, then the member will no longer be eligible to stay in one of our MA or MA-PD plans and must be disenrolled.

Individuals' Demographic Changes

Includes name changes, date of birth changes and Social Security number changes

For updates to personal information due to typographical errors by us, notifications can be made to Customer Service for correction. However, other updates to personal information must be initiated by the member through the Social Security Administration. We will be notified of these changes electronically by CMS each month. Once the change is processed, the member's information will be updated and a new Univera Healthcare ID card will be issued if necessary.

NOTES

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