

Medica Advantage SolutionSM

Terms and Conditions

Medica Advantage SolutionSM is a Medicare Advantage Private Fee For Service Plan offered by Medica Insurance Company (MIC). It has been authorized by the Centers for Medicare and Medicaid Services, and is being offered to Medicare members in Wisconsin. Prior to 1/1/08 this product was offered by Medica Health Plans of Wisconsin but is now offered by MIC.

Medica Advantage SolutionSM plan members are not restricted to a particular provider network, do not need referrals to specialists or other services, and can obtain services from any willing provider in the U.S. who is eligible to be paid under Medicare rules. Prior authorization of services is not required. For pharmacy services, Medica Advantage SolutionSM plan members are not restricted to a particular provider network but may find it more convenient to use one of the 18,000 nationwide plan network affiliates.

Admission Notification:

Medica Advantage SolutionSM asks hospitals and other facilities to voluntarily notify Medica of admissions to acute inpatient facilities, Long Term Acute Care facilities, Skilled Nursing Facilities, and Rehabilitation facilities or units. Hospitals and facilities are encouraged to notify Medica prior to the admission (for surgical admissions) or as soon possible after the admission.

For admissions to acute care hospitals

Acute Care Hospitals, call the following number:

- 1-800-247-0153

For admissions to other facilities

Call the appropriate number below:

- Long Term Acute Hospitals: 1-800-247-0153
- Skilled Nursing Facilities: 1-800-247-0153
- Rehab Facilities: 1-800-247-0153

For admissions to mental health and substance abuse facilities

For admissions to mental health or substance abuse facilities or units, notification of the admission is requested. Additionally a pre-procedure review may be obtained for those procedures where Medicare coverage is dependant upon the medical necessity of the procedure.

Mental health and substance abuse facilities or units, call the following number:
1-800-848-8327

Payment for Physicians, Hospitals and other Providers

MIC payment for covered services is 102 percent of the Medicare allowable amount, less any member cost-sharing amounts that are described below. Also, MIC will comply with Medicare's prompt payment of claims requirements for all clean claims.

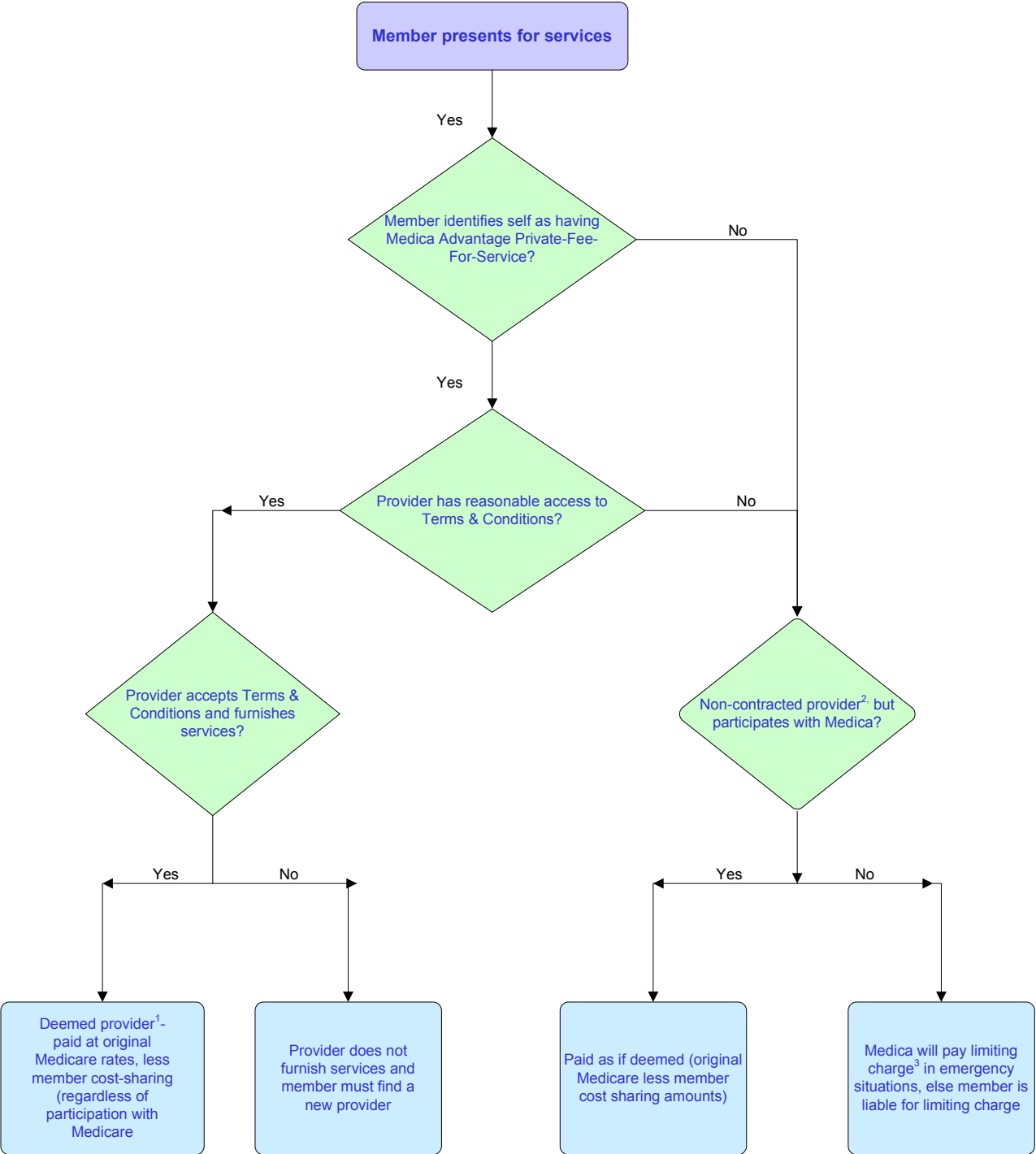
Provider Deeming

MIC will not contract with physicians and providers for Medica Advantage Solution SM; rather, you may choose to become deemed. Physicians and providers are considered deemed when:

- (1) You know before you provide services that a Medicare member is enrolled in Medica Advantage Solution SM. Medica Advantage Solution SM will provide members with an identification or enrollment card that they must show you each time they need care.
- (2) You have a reasonable opportunity to obtain Medica Advantage Solution Terms and Conditions for participation in the Plan. These Terms and Conditions are found below. (The Terms and Conditions are also available through our Provider Services toll-free number, 1-800-458-5512, or our Web site @ www.medica.com) and;
- (3) You subsequently provide services to that member.

The flow chart on page 3 explains the deeming process.

Private-Fee-For-Service Deeming Process



1). Deemed providers do not have a signed contract, but agree to Terms & Conditions; therefore, they are “deemed” to be contracted.
 2). Non-contracted providers are not deemed when unable to make an informed decision regarding PFFS Terms & Conditions
 3). Limiting charge is the highest amount a provider not participating with Medicare can charge the member. The limit set by CMS is 15% over the Medicare approved amount for a provider not participating with Medicare.
 4). Both deemed and non-participating providers are prohibited from collecting from enrollees more than the cost sharing amounts set by the plan for covered services.

Once these steps are completed, you are deemed to be contracted for the services provided and are therefore subject to these Terms and Conditions.

If you choose not to accept the Terms and Conditions you will only be paid if you treat Medica Advantage SolutionSM members for urgent or emergency care, and you may only collect any applicable co-payments or coinsurance from the member. You may not balance bill the member for emergency or urgent care.

The Medica Advantage SolutionSM plan reimburses deemed providers at 102 percent of the current Medicare allowable amount minus any member co-payments or coinsurance for all services covered by Medicare. Please refer to the benefit chart below for additional information.

Providers may collect only applicable co-payment or coinsurance amounts from Medica Advantage SolutionSM and may not otherwise charge or bill the members. Balance billing is prohibited by deemed providers who provide services to Medica Advantage SolutionSM members. Co-payments or coinsurance should be collected from the member at the time of service. If a provider (either deemed or not deemed) mistakenly collects more from a member than the designated co-payment or coinsurance amount, the provider must refund the difference to the member.

In addition, you:

- Must be licensed or certified by the state and be acting within the scope of that license or certification, and not be sanctioned or have opted out of Medicare.
- Must comply with all Medicare and other federal health care program laws, regulations and program instructions that apply to the services furnished to members. These regulations can be found by directly accessing the cms.hhs.gov website or through a link on www.medica.com.
- Have a Medicare billing number or be eligible for a Medicare number.
- Be certified to treat Medicare beneficiaries if you are an institutional provider.
- Follow the standards for confidentiality and patient privacy rights outlined in HIPAA regulations.
- Inform Medica Advantage SolutionSM if you believe a facility claim qualifies for an outlier payment. Medica Advantage SolutionSM follows Medicare's methodology in reimbursing outlier payments according to the appropriate prospective payment methodology. Notification to the plan can be made either on the claim, on an attachment, or by phoning Medica Provider Services if the claim has already been paid.
- Agree to comply with all Medica Advantage SolutionSM appeal and grievance procedures, including hospitals (acute, long term care acute, rehabilitation, mental health and substance abuse), skilled nursing facilities, home health agencies or certified outpatient rehabilitation facilities providing appropriate written notices to members in advance of services ending. Copies of these procedures are available at <http://www.cms.hhs.gov/manuals/downloads/mc86c13.pdf>

- Medica Advantage PFFS Providers are delegated the responsibility of issuing the Notice of Medicare Non-Coverage (NOMNC) and Detailed Explanation of Non-coverage (DENC) and it is the delegated responsibility for hospitals to provide the Detailed Notice of Discharge (DN) . Providers that seek deemed status with Medica Advantage PFFS will be obligated to comply with all notice and case submission requirements. Additional information and copies of these notices are available at <http://www.cms.hhs.gov/mmcag>
- Agree not to balance bill members and collect from members only the 2008 cost-sharing amounts listed in the following benefits chart:

Medica Advantage SolutionSM Benefit Plans

Medica Advantage SolutionSM offers a variety of benefit plans. The specific benefit plan is noted on the member’s identification card. The card provides important information about member payment responsibility for covered services. It also identifies whether or not the member has a prescription drug benefit through the Medica Advantage SolutionSM plan. The following charts include information about covered services and member payment levels for each product.

Benefits Chart – a list of covered services- Medica Advantage Solution Standard Wisconsin

Benefits chart – Medica Advantage Solution Standard	What the member pays for covered services
Inpatient Services	\$550 co-payment for each Medicare-covered hospital stay.
Inpatient mental health care	\$550 co-payment for each Medicare-covered hospital stay.
Skilled nursing facility care	\$0 per day for days 1-3 (\$90 co-payment for days 4-100) Waive 3 day inpatient requirement
Long Term Acute Care	\$0 per day for days 1-3 (\$90 co-payment for days 4-100)
Home health care	No co-payment for Medicare-covered visits.
Hospice care	Covered by Medicare in a Medicare-certified hospice. (Submit claims to Medicare)
Physician, specialist, chiropractic and podiatry services	\$15 co-payment for visits to a primary care physician for Medicare-covered services.

Benefits chart – Medica Advantage Solution Standard	What the member pays for covered services
Specialist, Chiropractic and Podiatry Services	\$30 co-payment for visits to a specialist for Medicare-covered services.
Outpatient mental health care	\$30 co-payment for individual/group visits.
Outpatient substance abuse services	\$30 co-payment for individual/group visits.
Ambulatory Surgical Center	20% coinsurance for each Medicare-covered visit.
Outpatient facility services	20% coinsurance for each Medicare-covered visit.
Ambulance services	20% coinsurance for each Medicare-covered visit.
Emergency care	\$50 co-payment per visit.
Urgently needed care	\$15-\$30 co-payment for each Medicare-covered visit.
Outpatient rehabilitation services (physical therapy, occupational therapy, cardiac rehabilitation, and speech and language therapy)	\$30 co-payment for each Medicare-covered visit.
Durable medical equipment, supplies, prosthetics and orthotics <ul style="list-style-type: none"> • Durable medical equipment includes items such as wheelchairs, crutches, hospital beds, IV infusion pump, oxygen equipment, nebulizer and walkers • Supplies include blood glucose meters, blood glucose test strips and lancets • Prosthetics and orthotics include colostomy bags, pacemakers, braces, prosthetic shoes, artificial limbs and breast prostheses 	20% (25% for Medica Advantage Solution with Rx plan) coinsurance for each Medicare-covered item
Preventive care and screening tests <ul style="list-style-type: none"> ▪ Bone mass measurement ▪ Cardiovascular screening exams ▪ Colorectal screening ▪ Diabetes services ▪ Glaucoma testing ▪ Immunizations ▪ Mammography screening ▪ Pap smears, pelvic exams and clinical breast exams ▪ Prostate cancer screening exams ▪ Physical exams 	No co-payment for Medicare-covered services.

Benefits chart – Medica Advantage Solution Standard	What the member pays for covered services
Hearing Tests	\$30 co-payment for Medicare-covered test.
Drugs Covered Under Part B	25% coinsurance for Medicare-covered Part B drugs.
Prescription Drugs	<p>Offered with Medica Advantage Solution Standard with Rx:</p> <ul style="list-style-type: none"> ▪ Level 1: \$0 to \$2,510 in total drug costs. Co-payments- \$10/\$30/\$60/25% ▪ Level 2 (Medicare coverage gap): up to \$4,050 in True Out-of-Pocket Costs (TrOOP) ▪ Level 3: After \$4,050 in TrOOP, co-payments are \$2.25 for generic (including brand drugs treated as generic) and \$5.60 for all other drugs or 5% coinsurance.

Please note: Medica also offers Group Advantage Solution. Please contact Medica Provider Services at 1-800-458-5512 for additional information.

Claims Submission

Physicians, hospitals and other health professionals, submit claims to:

Medica
PO Box 30990
Salt Lake City, UT 84130

You may also submit claims electronically. For questions, contact Medica's Provider Service Center at 1-800-458-5512.

Additional guidelines

In addition, please follow the guidelines below regarding your claims:

- Inform Medica Advantage SolutionSM if you believe a facility claim qualifies for an outlier payment. Medica Advantage SolutionSM follows Medicare's methodology in reimbursing outlier payments according to the appropriate prospective payment methodology. Notification to the plan can be made either on the claim, on an attachment, or by phoning Medica Provider Services at 1-800-458-5512 if the claim has already been paid.
- Medica Advantage SolutionSM requires that claims be filed on, or before, December 31 of the calendar year following the year in which the services were furnished. Services furnished in the last quarter of the year are considered furnished in the following year; i.e., the time limit is the second year after the year in which such service were furnished.
- Agree that if you do not agree to accept the Terms and Conditions stated herein, you may not provide services to a Medica Advantage SolutionSM member, except for emergency and urgent care services.
- Agree that in no event, including, but not limited to nonpayment by Medica Advantage SolutionSM, Medica Advantage SolutionSM insolvency or breach of this Agreement, shall you or your assignees and/or subcontractors bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members of Medica Advantage SolutionSM or persons other than Medica Advantage SolutionSM acting on their behalf, for covered services provided to members by you. This provision shall not prohibit collection of payments for any non-covered services or member cost-share amounts set for the above. You further agree that: (i) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between you and a member or persons acting on their behalf and (ii) this provision shall apply to all of your employees, agents, trustees, assignees and subcontractors, and you shall obtain from such persons specific agreement to this provision.

Federal health care providers are not eligible for payment for services to Medica Advantage SolutionSM members, except for emergency services.

If a provider disagrees with our payment rate and has information that Original Medicare would pay more for a service, such documentation may be submitted for review and appropriate adjustment to payment. You may contact our Provider Service Center at 1-800-458-5512 if you have any questions regarding our payment rate or if you wish to request an adjustment. Additional details about claim adjustments are available in the Provider Administrative Manual, Chapter 11, Section D <http://provider.medica.com/router/default.pdf?doc=/C6/ProviderManualAdmin/Document%20Library/chap11.pdf>

The Adjustment Request Form is available at http://provider.medica.com/router/default.pdf?doc=/C13/ClaimsToolsForms/Document%20Library/forms_AdjustmentRequestForm.pdf

Providers not participating with Medicare

Furnishing services to Medica Advantage SolutionSM members as a deemed provider requires that the non participating provider knows the patient is in the Medica Advantage SolutionSM program and has reasonable access to the plan's terms and conditions, which includes payment information.

Emergency situations:

For providers who do not participate with Medicare, the limiting charge may be applied in emergency situations, when the patient is not able to inform the provider they were Medica Advantage SolutionSM members and/or the provider could not access the terms and conditions. In these instances, Medica will pay the limiting charge minus any applicable member cost-sharing amount.

Providers may apply the limiting charge only one time per patient. Once the patient is known as a Medica Advantage SolutionSM member, the provider will access the Terms and Conditions and decide whether or not to provide services. If the provider accepts the Terms and Conditions and provides services, the limiting charge cannot be applied.

Non-emergency situations

If in a non-emergency situation a provider who does not participate with Medicare is not informed by the patient about membership in Medica Advantage SolutionSM and the provider did not access the terms and conditions, the limiting charge may be applied only once. The provider may balance bill the patient up to the Medicare limiting charge.

If you have any questions or concerns about your payment, Medica Advantage SolutionSM Terms and Conditions, or, if you would like more information on Medica Advantage SolutionSM please contact Medica Provider Services **at 1-800-458-5512**, or on our Web site at www.medica.com. Staff is available to assist you Monday through Friday 8:00 am to 5:00 pm. Central Standard Time.