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# Section 1

## **Telephone Directory**

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# Telephone Directory

**US Health and Life Insurance Company - Customer Service** **1-586-693-4410**

(8:30 a.m. - 4:30 p.m., Monday - Friday)

- Confirm member eligibility
- Confirm benefit information
- Verify co-payment and deductible information
- Verify payment of services
- Request new insurance card
- Initiate appeal process for administrative issues
- Initiate claims inquiry process

**United Physicians - Provider Services** **1-800-824-6711\* (Option 2)**

(8:00 a.m. - 4:00 p.m., Monday - Friday)

- Request copy of Provider Manual of Directory
- Communicate changes regarding: physicians address, phone number, tax ID, etc.
- Initiate physician participation and termination
- Confirm provider participation in the United Physicians network

**United Physicians - Medical Management** **1-800-824-6711\* (Option 1)**

(8:30 a.m. - 4:30 p.m., Monday - Friday)

- Obtain an authorization number
- Report clinical criteria
- Medical review requirement
- Address issues regarding medical necessity
- Initiate appeal process for utilization issues

**CareMark Pharmacy** **1-800-824-6349**




\*Telephone tree will identify which number to choose to connect with the appropriate company/department.

# Section 2

## **Provider/Member Related Issues**

Sample Identification Card  
Eligibility/Benefit Verification  
Benefit Plan Summary

# Sample Identification Card

	US Health and Life Insurance Company		
Member Identification Card			
Member Name:			
Member ID #:			
Group #:			

Attention Providers and Members: You must obtain preauthorization for certain services and prior to any non-emergency hospital admission. Failure to do so could result in a 10% benefit penalty. Emergency hospital admissions must be reported within 48 hours or on the first business day following the admission. To verify eligibility and benefits or for claims questions call US Health and Life Insurance Company at (586)693-4410. For preauthorization please contact United Physicians Medical Management Department at (800)824-6711.

Send Preferred claims and  
Out-of-network claims to:  
US Health and Life:  
P.O. Box 1378  
Troy, MI 48099

Send **PPOM** (Secondary)  
claims to:  
PPOM  
P.O. Box 2720  
Farmington Hills, MI 48333

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# Eligibility Benefit Verification

- Contact US Health and Life Insurance Company at 1-586-693-4410 during the hours of 8:30 a.m. to 4:30 p.m., Monday through Friday.
- **Providers** are responsible to confirm eligibility and determine benefit coverage for all services provided.
- US Health and Life Insurance Company representatives are able to supply member number information in the event a member does not have an identification card available.
- US Health and Life Insurance Company can also confirm primary or secondary coverage for those members who have dual medical coverage. See **Section 5: Reimbursement** for more details on Coordination of Benefits.

## Laboratory Services/JVHL

- All Lab services should be performed at any JVHL location, including William Beaumont Hospital Reference Lab. Any services performed or sent to any non-JVHL laboratory will be paid at out-of-network rates. (See pages 8 - 17 for laboratory co-pay information for each plan.)
- Members are encouraged to remind providers that lab work must be sent to a JVHL laboratory.

# Schedule of Medical Coverage - Plan A

In-Network benefits are based on the Network-approved amount. Out-of-Network benefits are based on the reasonable and customary amount. Benefits are determined after any applicable Copay, Deductible and are subject to applicable annual, lifetime and other maximums, general exclusions and other limitations.

	Preferred	Secondary	Out-of-Network
<b>Deductible</b> (Does not apply to Coinsurance maximum)			
individual:	\$0	\$100	\$500
family, aggregate:	\$0	\$300	\$1,500

**Coinsurance\***    individual:                                 \$1,000 maximum\*, In and Out-of-Network combined  
                          family, aggregate:                                 \$3,000 maximum\*, In and Out-of-Network combined

\* (50% coinsurance amounts do not accumulate to the Coinsurance maximum)

**Copay** (Does not apply to Coinsurance maximum)    Applies per Service. Amount as indicated below.

**Lifetime Maximum, All Benefits Combined:**                                 \$2,000,000

		Benefit after Copay	Benefit after Deductible	Benefit after Deductible
<b>Inpatient Hospital Services</b>				
(other than Psychiatric Treatment/Chemical Dependency Care)				
Semi-Private Room and Board, Intensive Care Unit, Ancillary Services				
general conditions:		100%	80%	70%
newborn confinements:		100%	80%	70%
Birthing Center charges		100%	80%	70%
<b>Outpatient Hospital Facility Services</b>				
(other than Psychiatric Treatment/Chemical Dependency Care)				
Emergency Room:				
Medical - life-threatening	\$25 Copay	100%	80%	70%
Medical - non-life-threatening	\$50 Copay	100%	80%	70%
Accident	\$25 Copay	100%	80%	70%
Surgery		100%	80%	70%
Anesthesia		100%	80%	70%
Other Facility Charges		100%	80%	70%
<b>Wellness/Preventive Care Benefits</b>				
Routine physical examinations	\$20 Copay	100%	80%	Not covered
(employee and spouse only; one per calendar year)				
Routine mammography (frequency per Federal guidelines)		100%	80%	70%
Routine well child examinations	\$20 Copay	100%	80%	Not covered
including diagnostic testing (through age 18)				
Routine immunizations (through age 18))		100%	80%	Not covered
<b>Prescription Drugs</b>				
Insulin and prescription drugs to treat diabetes		100%	100%	70%
Optional prescription drug benefits - If selected	See separate optional Prescription Drug Schedule			
<b>Physician Services</b>				
(other than Psychiatric Treatment/Chemical Dependency Care)				
In-Hospital Consultations - general conditions		100%	80%	70%
In Hospital Routine newborn examinations		100%	80%	70%
Office Visits	\$20 Copay	100%	80%	70%

# Schedule of Medical Coverage - Plan A

		Preferred Benefit after Copay	Secondary Benefit after Deductible	Out-of-Network Benefit after Deductible
<b>Physician Services (continued)</b>				
Maternity (pre & postnatal and delivery per pregnancy)	\$20 Copay	100%	80%	70%
Surgical procedures		100%	80%	70%
Anesthesia services		100%	80%	70%
Allergy testing and therapy (including antigen)	\$20 Copay	100%	80%	70%
Allergy injections		100%	80%	70%
Emergency Room Physician		100%	80%	70%
Non-surgical Podiatry Care including office visit & x-ray (\$750 calendar year maximum)	\$20 Copay	100%	80%	70%
Chiropractic Care including x-rays (\$2,000 calendar year maximum)		Not available	50%	50%
<b>Psychiatric Treatment</b>				
Inpatient Hospital Services	(Maximum 30 days per calendar year In & Out-of-Network combined)			
Semi-private Room & Board, Intensive Care Unit, Ancillary		100%	80%	50%
Physicians Consultations, Treatment, Counseling		100%	80%	50%
Emergency Room: Life-Threatening	\$25 Copay	100%	80%	50%
Non-Life-Threatening	\$50 Copay	100%	80%	50%
Outpatient Services, including testing	(Maximum 30 visits/calendar year In & Out-of-Network combined)			
Copays: Individual, per session, Full \$35/Partial \$20		100%	80%	50%
Group, per session - \$20		100%	80%	50%
Laboratory/Pathology	\$10 Copay	100%	80%	50%
X-Ray/Radiology	\$10 Copay	100%	80%	50%
<b>Chemical Dependency Care</b>				
Inpatient Hospital Services	(Maximum \$15,000 Lifetime and Maximum 15 days per calendar year In and Out-of-Network Combined)			
Emergency Room: Life-Threatening	\$25 Copay	100%	80%	50%
Non-Life-Threatening	\$50 Copay	100%	80%	50%
Intermediate & Outpatient	(Maximum \$3,500 calendar year)			
Copays: Individual - Full Session \$35/Partial Session \$20		100%	80%	50%
Group - Session - \$20		100%	80%	50%
Laboratory/Pathology	\$10 Copay	100%	80%	50%
X-Ray/Radiology	\$10 Copay	100%	80%	50%
<b>Other Services (other than Psychiatry/Chemical Dependency Care)</b>				
Ambulance		100%	80%	70%
Laboratory/Pathology	\$10 Copay	100%	80%	70%
X-Ray/Radiology	\$10 Copay	100%	80%	70%
Medical Supplies		100%	80%	70%
Prosthetic Devices and Durable Medical Equipment	80%	80%	70%	
Physical, Speech and Occupational Therapy		80%	80%	70%
Extended Care Facility (Maximum 31 days per calendar year)		80%	80%	70%
Hospice Care Program (Maximum 6 months per lifetime)		80%	80%	70%
Home Health Care Agency (Maximum: 15 visits per calendar year; 30 visits per lifetime)		80%	80%	70%
Private Duty Nursing (R.N. only)		80%	50%	50%

# Schedule of Medical Coverage - Plan B

In-Network benefits are based on the Network-approved amount. Out-of-Network benefits are based on the reasonable and customary amount. Benefits are determined after any applicable Copay, Deductible and are subject to applicable annual, lifetime and other maximums, general exclusions and other limitations.

	Preferred	Secondary	Out-of-Network
<b>Deductible</b> (Does not apply to Coinsurance maximum)			
individual:	\$250	\$500	\$1,500
family, aggregate:	\$750	\$1,500	\$4,500

**Coinsurance\***    individual:                                 \$1,000 maximum\*, In and Out-of-Network combined  
                          family, aggregate:                                 \$3,000 maximum\*, In and Out-of-Network combined

\* (50% coinsurance amounts do not accumulate to the Coinsurance maximum)

**Copay** (Does not apply to Coinsurance maximum)    Applies per Service. Amount as indicated below.

**Lifetime Maximum, All Benefits Combined:**                                 **\$2,000,000**

		Benefit after Copay & Deductible	Benefit after Deductible	Benefit after Deductible
<b>Inpatient Hospital Services</b> (other than Psychiatric Treatment/Chemical Dependency Care)				
Semi-Private Room and Board, Intensive Care Unit, Ancillary Services				
general conditions:		100%	80%	70%
newborn confinements:		100%	80%	70%
Birthing Center charges		100%	80%	70%
<b>Outpatient Hospital Facility Services</b> (other than Psychiatric Treatment/Chemical Dependency Care)				
Emergency Room:				
Medical - life-threatening	\$25 Copay	100%	80%	70%
Medical - non-life-threatening	\$50 Copay	100%	80%	70%
Accident	\$25 Copay	100%	80%	70%
Surgery		100%	80%	70%
Anesthesia		100%	80%	70%
Other Facility Charges		100%	80%	70%
<b>Wellness/Preventive Care Benefits</b>				
Routine physical examinations	\$20 Copay (employee and spouse only; one per calendar year)	100%	80%	Not covered
Routine mammography (frequency per Federal guidelines)		100%	80%	70%
Routine well child examinations	\$20 Copay including diagnostic testing (through age 18)	100%	80%	Not covered
Routine immunizations (through age 18))		100%	80%	Not covered
<b>Prescription Drugs</b>				
Insulin and prescription drugs to treat diabetes		100%	100%	80%
Optional prescription drug benefits - If selected	See separate optional Prescription Drug Schedule			
<b>Physician Services</b> (other than Psychiatric Treatment/Chemical Dependency Care)				
In-Hospital Consultations - general conditions		100%	80%	70%
In Hospital Routine newborn examinations		100%	80%	70%
Office Visits	\$20 Copay	100%	80%	70%

# Schedule of Medical Coverage - Plan B

		Preferred Benefit after Copay & Deductible	Secondary Benefit after Deductible	Out-of-Network Benefit after Deductible
<b>Physician Services (continued)</b>				
Maternity (pre & postnatal and delivery per pregnancy)	\$20 Copay	100%	80%	70%
Surgical procedures		100%	80%	70%
Anesthesia services		100%	80%	70%
Allergy testing and therapy (including antigen)	\$20 Copay	100%	80%	70%
Allergy injections		100%	80%	70%
Emergency Room Physician		100%	80%	70%
Non-surgical Podiatry Care including office visit & x-ray (\$750 calendar year maximum)	\$20 Copay	100%	80%	70%
Chiropractic Care including x-rays (\$2,000 calendar year maximum)		Not available	50%	50%
<b>Psychiatric Treatment</b>				
Inpatient Hospital Services	(Maximum 30 days per calendar year In & Out-of-Network combined)			
Semi-private Room & Board, Intensive Care Unit, Ancillary		100%	80%	50%
Physicians Consultations, Treatment, Counseling		100%	80%	50%
Emergency Room: Life-Threatening	\$25 Copay	100%	80%	50%
Non-Life-Threatening	\$50 Copay	100%	80%	50%
Outpatient Services, including testing	(Maximum 30 visits/calendar year In & Out-of-Network combined)			
Copays: Individual, per session, Full \$35/Partial \$20		100%	80%	50%
Group, per session - \$20		100%	80%	50%
Laboratory/Pathology	\$10 Copay	100%	80%	50%
X-Ray/Radiology	\$10 Copay	100%	80%	50%
<b>Chemical Dependency Care</b>				
Inpatient Hospital Services	(Maximum \$15,000 Lifetime and Maximum 15 days per calendar year In and Out-of-Network Combined)			
Emergency Room: Life-Threatening	\$25 Copay	100%	80%	50%
Non-Life-Threatening	\$50 Copay	100%	80%	50%
Intermediate & Outpatient	(Maximum \$3,500 calendar year)			
Copays: Individual - Full Session \$35/Partial Session \$20		100%	80%	50%
Group - Session - \$20		100%	80%	50%
Laboratory/Pathology	\$10 Copay	100%	80%	50%
X-Ray/Radiology	\$10 Copay	100%	80%	50%
<b>Other Services (other than Psychiatry/Chemical Dependency Care)</b>				
Ambulance		100%	80%	70%
Laboratory/Pathology	\$10 Copay	100%	80%	70%
X-Ray/Radiology	\$10 Copay	100%	80%	70%
Medical Supplies		100%	80%	70%
Prosthetic Devices and Durable Medical Equipment	80%	80%	70%	
Physical, Speech and Occupational Therapy		80%	80%	70%
Extended Care Facility (Maximum 31 days per calendar year)		80%	80%	70%
Hospice Care Program (Maximum 6 months per lifetime)		80%	80%	70%
Home Health Care Agency (Maximum: 15 visits per calendar year; 30 visits per lifetime)		80%	80%	70%
Private Duty Nursing (R.N. only)				

# Schedule of Medical Coverage - Plan C

In-Network benefits are based on the Network-approved amount. Out-of-Network benefits are based on the reasonable and customary amount. Benefits are determined after any applicable Copay, Deductible and are subject to applicable annual, lifetime and other maximums, general exclusions and other limitations.

	Preferred	Secondary	Out-of-Network
<b>Deductible</b> (Does not apply to Coinsurance maximum)			
individual:	\$250	\$500	\$1,000
family, aggregate:	\$750	\$1,500	\$3,000

**Coinsurance\***    individual:                                \$1,000 maximum\*, In and Out-of-Network combined  
                          family, aggregate:                                \$3,000 maximum\*, In and Out-of-Network combined

\* (50% coinsurance amounts do not accumulate to the Coinsurance maximum)

**Copay** (Does not apply to Coinsurance maximum)    Applies per Service. Amount as indicated below.

**Lifetime Maximum, All Benefits Combined:**                                **\$2,000,000**

	Benefit after Copay & Deductible	Benefit after Deductible	Benefit after Deductible
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## Inpatient Hospital Services

(other than Psychiatric Treatment/Chemical Dependency Care)

Semi-Private Room and Board, Intensive Care Unit, Ancillary Services

general conditions:	90%	70%	60%
newborn confinements:	90%	70%	60%
Birthing Center charges	100%	70%	60%

## Outpatient Hospital Facility Services

(other than Psychiatric Treatment/Chemical Dependency Care)

Emergency Room:

Medical - life-threatening                \$25 Copay	100%	70%	60%
Medical - non-life-threatening        \$50 Copay	100%	70%	60%
Accident                                        \$25 Copay	100%	70%	60%
Surgery	90%	70%	60%
Anesthesia	90%	70%	60%
Other Facility Charges	90%	70%	60%

## Wellness/Preventive Care Benefits

Routine physical examinations                \$20 Copay (employee and spouse only; one per calendar year)	100%	70%	Not covered
Routine mammography (frequency per Federal guidelines)	100%	70%	60%
Routine well child examinations                \$20 Copay including diagnostic testing (through age 18)	100%	70%	Not covered
Routine immunizations (through age 18))	100%	70%	Not covered

## Prescription Drugs

Insulin and prescription drugs to treat diabetes	100%	100%	60%
Optional prescription drug benefits - If selected	See separate optional Prescription Drug Schedule		

## Physician Services

(other than Psychiatric Treatment/Chemical Dependency Care)

In-Hospital Consultations - general conditions	90%	70%	60%
In Hospital Routine newborn examinations	90%	70%	60%
Office Visits                                        \$20 Copay	100%	70%	60%

# Schedule of Medical Coverage - Plan C

		Preferred Benefit after Copay & Deductible	Secondary Benefit after Deductible	Out-of-Network Benefit after Deductible
<b>Physician Services (continued)</b>				
Maternity (pre & postnatal and delivery per pregnancy)	\$20 Copay	100%	70%	60%
Surgical procedures		90%	70%	60%
Anesthesia services		90%	70%	60%
Allergy testing and therapy (including antigen)	\$20 Copay	100%	70%	60%
Allergy injections		100%	70%	60%
Emergency Room Physician		90%	70%	60%
Non-surgical Podiatry Care including office visit & x-ray (\$750 calendar year maximum)	\$20 Copay	100%	70%	60%
Chiropractic Care including x-rays (\$2,000 calendar year maximum)		Not available	50%	50%
<b>Psychiatric Treatment</b>				
Inpatient Hospital Services Semi-private Room & Board, Intensive Care Unit, Ancillary Physicians Consultations, Treatment, Counseling	(Maximum 30 days per calendar year In & Out-of-Network combined)	90%	70%	50%
Emergency Room: Life-Threatening	\$25 Copay	100%	70%	50%
Non-Life-Threatening	\$50 Copay	100%	70%	50%
Outpatient Services, including testing Copays: Individual, per session, Full \$35/Partial \$20 Group, per session - \$20	(Maximum 30 visits/calendar year In & Out-of-Network combined)	100%	70%	50%
Laboratory/Pathology	\$10 Copay	90%	70%	50%
X-Ray/Radiology	\$10 Copay	90%	70%	50%
<b>Chemical Dependency Care</b>				
Inpatient Hospital Services	(Maximum \$15,000 Lifetime and Maximum 15 days per calendar year In and Out-of-Network Combined)			
Emergency Room: Life-Threatening	\$25 Copay	100%	70%	50%
Non-Life-Threatening	\$50 Copay	100%	70%	50%
Intermediate & Outpatient Copays: Individual - Full Session \$35/Partial Session \$20 Group - Session - \$20	(Maximum \$3,500 calendar year)	100%	70%	50%
Laboratory/Pathology	\$10 Copay	90%	70%	50%
X-Ray/Radiology	\$10 Copay	90%	70%	50%
<b>Other Services (other than Psychiatry/Chemical Dependency Care)</b>				
Ambulance		90%	70%	60%
Laboratory/Pathology	\$10 Copay	90%	70%	60%
X-Ray/Radiology	\$10 Copay	90%	70%	60%
Medical Supplies		90%	70%	60%
Prosthetic Devices and Durable Medical Equipment	80%	70%	60%	
Physical, Speech and Occupational Therapy		80%	70%	60%
Extended Care Facility (Maximum 31 days per calendar year)		80%	70%	60%
Hospice Care Program (Maximum 6 months per lifetime)		90%	70%	60%
Home Health Care Agency (Maximum: 15 visits per calendar year; 30 visits per lifetime)		80%	70%	60%
Private Duty Nursing (R.N. only)				

# Schedule of Medical Coverage - Plan D

In-Network benefits are based on the Network-approved amount. Out-of-Network benefits are based on the reasonable and customary amount. Benefits are determined after any applicable Copay, Deductible and are subject to applicable annual, lifetime and other maximums, general exclusions and other limitations.

	Preferred	Secondary	Out-of-Network
<b>Deductible</b> (Does not apply to Coinsurance maximum)			
individual:	\$500	\$1,000	\$2,000
family, aggregate:	\$1,500	\$3,000	\$6,000

**Coinsurance\***    individual:                    \$1,000 maximum\*, In and Out-of-Network combined  
                          family, aggregate:                    \$3,000 maximum\*, In and Out-of-Network combined

\* (50% coinsurance amounts do not accumulate to the Coinsurance maximum)

**Copay** (Does not apply to Coinsurance maximum)    Applies per Service. Amount as indicated below.

**Lifetime Maximum, All Benefits Combined:**                    **\$2,000,000**

	Benefit after Copay & Deductible	Benefit after Deductible	Benefit after Deductible
<b>Inpatient Hospital Services</b> (other than Psychiatric Treatment/Chemical Dependency Care) Semi-Private Room and Board, Intensive Care Unit, Ancillary Services			
general conditions:	90%	70%	60%
newborn confinements:	90%	70%	60%
Birthing Center charges	100%	70%	60%

**Outpatient Hospital Facility Services**  
(other than Psychiatric Treatment/Chemical Dependency Care)  
Emergency Room:

Medical - life-threatening            \$25 Copay	100%	70%	60%
Medical - non-life-threatening    \$50 Copay	100%	70%	60%
Accident                                \$25 Copay	100%	70%	60%
Surgery	90%	70%	60%
Anesthesia	90%	70%	60%
Other Facility Charges	90%	70%	60%

**Wellness/Preventive Care Benefits**

Routine physical examinations            \$20 Copay (employee and spouse only; one per calendar year)	100%	70%	Not covered
Routine mammography (frequency per Federal guidelines)	100%	70%	60%
Routine well child examinations            \$20 Copay including diagnostic testing (through age 18)	100%	70%	Not covered
Routine immunizations (through age 18))	100%	70%	Not covered

**Prescription Drugs**

Insulin and prescription drugs to treat diabetes	100%	100%	60%
Optional prescription drug benefits - If selected	See separate optional Prescription Drug Schedule		

**Physician Services**

(other than Psychiatric Treatment/Chemical Dependency Care)			
In-Hospital Consultations - general conditions	90%	70%	60%
In Hospital Routine newborn examinations	90%	70%	60%
Office Visits                                \$20 Copay	100%	70%	60%

# Schedule of Medical Coverage - Plan D

		Preferred Benefit after Copay & Deductible	Secondary Benefit after Deductible	Out-of-Network Benefit after Deductible
<b>Physician Services (continued)</b>				
Maternity (pre & postnatal and delivery per pregnancy)	\$20 Copay	100%	70%	60%
Surgical procedures		90%	70%	60%
Anesthesia services		90%	70%	60%
Allergy testing and therapy (including antigen)	\$20 Copay	100%	70%	60%
Allergy injections		100%	70%	60%
Emergency Room Physician		90%	70%	60%
Non-surgical Podiatry Care including office visit & x-ray (\$750 calendar year maximum)	\$20 Copay	100%	70%	60%
Chiropractic Care including x-rays (\$2,000 calendar year maximum)		Not available	50%	50%
<b>Psychiatric Treatment</b>				
Inpatient Hospital Services Semi-private Room & Board, Intensive Care Unit, Ancillary Physicians Consultations, Treatment, Counseling	(Maximum 30 days per calendar year In & Out-of-Network combined)	90%	70%	50%
Emergency Room: Life-Threatening	\$25 Copay	100%	70%	50%
Non-Life-Threatening	\$50 Copay	100%	70%	50%
Outpatient Services, including testing Copays: Individual, per session, Full \$35/Partial \$20 Group, per session - \$20	(Maximum 30 visits/calendar year In & Out-of-Network combined)	100%	70%	50%
Laboratory/Pathology	\$10 Copay	90%	70%	50%
X-Ray/Radiology	\$10 Copay	90%	70%	50%
<b>Chemical Dependency Care</b>				
Inpatient Hospital Services	(Maximum \$15,000 Lifetime and Maximum 15 days per calendar year In and Out-of-Network Combined)			
Emergency Room: Life-Threatening	\$25 Copay	100%	70%	50%
Non-Life-Threatening	\$50 Copay	100%	70%	50%
Intermediate & Outpatient Copays: Individual - Full Session \$35/Partial Session \$20 Group - Session - \$20	(Maximum \$3,500 calendar year)	100%	70%	50%
Laboratory/Pathology	\$10 Copay	90%	70%	50%
X-Ray/Radiology	\$10 Copay	90%	70%	50%
<b>Other Services (other than Psychiatry/Chemical Dependency Care)</b>				
Ambulance		90%	70%	60%
Laboratory/Pathology	\$10 Copay	90%	70%	60%
X-Ray/Radiology	\$10 Copay	90%	70%	60%
Medical Supplies		90%	70%	60%
Prosthetic Devices and Durable Medical Equipment	80%	70%	60%	
Physical, Speech and Occupational Therapy		80%	70%	60%
Extended Care Facility (Maximum 31 days per calendar year)		80%	70%	60%
Hospice Care Program (Maximum 6 months per lifetime)		90%	70%	60%
Home Health Care Agency (Maximum: 15 visits per calendar year; 30 visits per lifetime)		80%	70%	60%
Private Duty Nursing (R.N. only)				

# Schedule of Medical Coverage - Plan E

In-Network benefits are based on the Network-approved amount. Out-of-Network benefits are based on the reasonable and customary amount. Benefits are determined after any applicable Copay, Deductible and are subject to applicable annual, lifetime and other maximums, general exclusions and other limitations.

	Preferred	Secondary	Out-of-Network
<b>Deductible</b> (Does not apply to Coinsurance maximum)			
individual:	\$0	\$100	\$500
family, aggregate:	\$0	\$300	\$1,500

**Coinsurance\***    individual:                                \$1,000 maximum\*, In and Out-of-Network combined  
                          family, aggregate:                                \$3,000 maximum\*, In and Out-of-Network combined

\* (50% coinsurance amounts do not accumulate to the Coinsurance maximum)

**Copay** (Does not apply to Coinsurance maximum)    Applies per Service. Amount as indicated below.

**Lifetime Maximum, All Benefits Combined:**                                \$2,000,000

		Benefit after Copay	Benefit after Deductible	Benefit after Deductible
<b>Inpatient Hospital Services</b>				
(other than Psychiatric Treatment/Chemical Dependency Care)				
Semi-Private Room and Board, Intensive Care Unit, Ancillary Services				
general conditions:		100%	80%	70%
newborn confinements:		100%	80%	70%
Birthing Center charges		100%	80%	70%
<b>Outpatient Hospital Facility Services</b>				
(other than Psychiatric Treatment/Chemical Dependency Care)				
Emergency Room:				
Medical - life-threatening	\$25 Copay	100%	80%	70%
Medical - non-life-threatening	\$50 Copay	100%	80%	70%
Accident	\$25 Copay	100%	80%	70%
Surgery		100%	80%	70%
Anesthesia		100%	80%	70%
Other Facility Charges		100%	80%	70%
<b>Wellness/Preventive Care Benefits</b>				
Routine physical examinations	\$15 Copay	100%	80%	Not covered
(employee and spouse only; one per calendar year)				
Routine mammography (frequency per Federal guidelines)		100%	80%	70%
Routine well child examinations	\$15 Copay	100%	80%	Not covered
including diagnostic testing (through age 18)				
Routine immunizations (through age 18))		100%	80%	Not covered
<b>Prescription Drugs</b>				
Insulin and prescription drugs to treat diabetes		100%	100%	70%
Optional prescription drug benefits - If selected	See separate optional Prescription Drug Schedule			
<b>Physician Services</b>				
(other than Psychiatric Treatment/Chemical Dependency Care)				
In-Hospital Consultations - general conditions		100%	80%	70%
In Hospital Routine newborn examinations		100%	80%	70%
Office Visits	\$15 Copay	100%	80%	70%

# Schedule of Medical Coverage - Plan E

		Preferred Benefit after Copay	Secondary Benefit after Deductible	Out-of-Network Benefit after Deductible
<b>Physician Services (continued)</b>				
Maternity (pre & postnatal and delivery per pregnancy)	\$15 Copay	100%	80%	70%
Surgical procedures		100%	80%	70%
Anesthesia services		100%	80%	70%
Allergy testing and therapy (including antigen)	\$15 Copay	100%	80%	70%
Allergy injections		100%	80%	70%
Emergency Room Physician		100%	80%	70%
Non-surgical Podiatry Care including office visit & x-ray (\$750 calendar year maximum)	\$15 Copay	100%	80%	70%
Chiropractic Care including x-rays (\$2,000 calendar year maximum)		Not available	50%	50%
<b>Psychiatric Treatment</b>				
Inpatient Hospital Services	(Maximum 30 days per calendar year In & Out-of-Network combined)			
Semi-private Room & Board, Intensive Care Unit, Ancillary		100%	80%	50%
Physicians Consultations, Treatment, Counseling		100%	80%	50%
Emergency Room: Life-Threatening	\$25 Copay	100%	80%	50%
Non-Life-Threatening	\$50 Copay	100%	80%	50%
Outpatient Services, including testing	(Maximum 30 visits/calendar year In & Out-of-Network combined)			
Copays: Individual, per session, Full \$35/Partial \$20		100%	80%	50%
Group, per session - \$20		100%	80%	50%
Laboratory/Pathology		100%	80%	50%
X-Ray/Radiology		100%	80%	50%
<b>Chemical Dependency Care</b>				
Inpatient Hospital Services	(Maximum \$15,000 Lifetime and Maximum 15 days per calendar year In and Out-of-Network Combined)			
Emergency Room: Life-Threatening	\$25 Copay	100%	80%	50%
Non-Life-Threatening	\$50 Copay	100%	80%	50%
Intermediate & Outpatient	(Maximum \$3,500 calendar year)			
Copays: Individual - Full Session \$35/Partial Session \$20		100%	80%	50%
Group - Session - \$20		100%	80%	50%
Laboratory/Pathology		100%	80%	50%
X-Ray/Radiology		100%	80%	50%
<b>Other Services (other than Psychiatry/Chemical Dependency Care)</b>				
Ambulance		100%	80%	70%
Laboratory/Pathology		100%	80%	70%
X-Ray/Radiology		100%	80%	70%
Medical Supplies		100%	80%	70%
Prosthetic Devices and Durable Medical Equipment		80%	80%	70%
Physical, Speech and Occupational Therapy		80%	80%	70%
Extended Care Facility (Maximum 31 days per calendar year)		80%	80%	70%
Hospice Care Program (Maximum 6 months per lifetime)		80%	80%	70%
Home Health Care Agency (Maximum: 15 visits per calendar year; 30 visits per lifetime)		80%	80%	70%
Private Duty Nursing (R.N. only)		80%	50%	50%



# Section 3

## **Medical Management Program**

Services Requiring Medical Review  
Authorization process: Admission  
Authorization process: Outpatient Services  
Authorization process: Services requiring  
Benefit Predetermination

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# Key Points about Obtaining Authorizations

**1. Remember:** When authorizing services, a call must first be made to US Health and Life Insurance Company to verify benefits and eligibility. Your call may then be placed to United Physicians/BIDS for authorization at 1-800-824-6711 or you may fax your request to 248-593-0200. Authorizations only indicate services are approved based on medical criteria, and **does not guarantee payment**.

**2. Save time:** Have the following information available before calling or faxing United Physicians/BIDS for authorization:

**Demographics:**

Patient Name

Member ID#

Date of Birth

Referring Physician Name

Diagnosis

Services to be performed

**Clinical Criteria:**

Reason for request

Pertinent clinical criteria

Copy of applicable medical records

**3. Avoid rejected claims:** If dates of service change (after service has been authorized) remember to notify United Physicians/BIDS at 800-824-6711.

**4. Penalties for NO authorization:** Failure to obtain prior authorizations will result in a 10% benefit penalty to a maximum penalty of \$2000 per occurrence for both physicians and facility. This includes **all** networks.

**5. Be responsible:** Do your part. Coordinating healthcare and obtaining authorizations are **not the responsibility of the member**. Only providers should be calling United Physicians/BIDS at 800-824-6711 to authorize treatment. Only services listed require authorization (see pages 20 - 24).

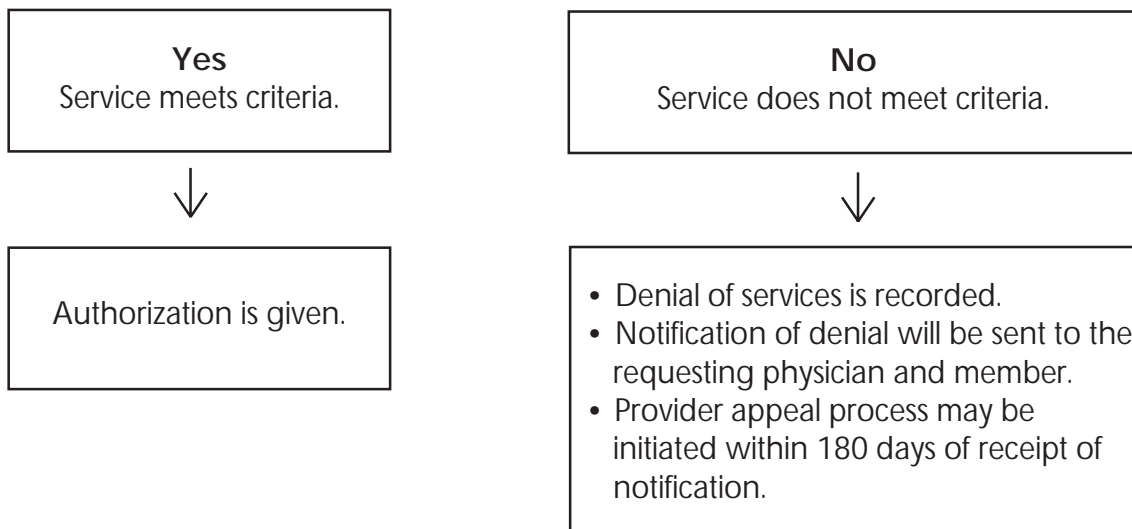
# Medical Review for Specialty Care

## To United Physicians:

- Participating physicians may refer patients to any preferred or secondary network specialty care physician.
- No referral forms are necessary.
- **Remember, it is the responsibility of the referring physician to obtain authorization within the provider network.**

## To physicians not affiliated with United Physicians:

- Call 800-824-6711 to obtain authorization to any services that requires **prior authorization** (see page 20) being performed by physicians or ancillary providers non-participating in the preferred network.
- All requests for out of network services will be reviewed for medical necessity. Please have the appropriate clinical information available to discuss.



For more information regarding the provider appeal process, see **Section 4: Quality Management**.

**All authorizations are approved pending verification of eligibility and benefits.**

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# Services Requiring Authorization

- All inpatient admissions (**in and out-of-network**)
- Outpatient surgeries (**out-of-network only**)
- Skilled nursing facilities
- Home Health Care Services
- Care and treatment of TMJ
- Ancillary Services
  - Ambulance Services - facility to facility only, non-emergent transport
  - Durable Medical Equipment/Prosthetics and Orthotics - >\$500 per rental per item or > \$1000 per purchase per item
  - Physical, Occupation and Speech therapy
- Mental Health/Chemical Dependency Services
  - No review required
  - Patient may self-refer
- Benefit Predetermination
  - Service which may be ruled cosmetic, must be review at least **10 days** in advance and require authorization.

# Services Requiring Authorization

## Admissions

The following table summarizes the authorization protocol for services which result in an inpatient stay.

Service	Admitting physician must contact United Physicians/BIDS to obtain authorization	Hospital staff must contact United Physicians/BIDS to obtain authorization	Clinical criteria is required
Elective admission	Yes, at least 5 business days prior to admission		Yes
Direct/Urgent Admission (Member sent from home or physician office)		Yes, must be reported within 2 business days	Yes
Admission from ER department		Yes, must be reported within 2 business days	Yes
Admission from Observation room		Yes, must be reported within 2 business days	Yes
Admission following Outpatient surgery		Yes, must be reported within 2 business days	Yes
All elective admissions to secondary or out-of-network facilities	Yes, at least 5 business days prior to admission		Yes

**All referral/authorizations are approved pending verification of eligibility and benefits.**

# Services Requiring Authorization

## Outpatient Services

The following table summarizes the authorization protocol for the identifies outpatient procedures listed below:

<b>Service</b>	<b>Ordering physician must contact United Physicians/BIDS to obtain authorization</b>	<b>Hospital staff must contact United Physicians/BIDS to obtain authorization</b>	<b>Clinical Criteria is required</b>
Non-emergent transport	Yes, at least 2 business days prior to service (when applicable).	Yes, when service is upon discharge	Yes
Durable Medical Equipment	Yes, at least 2 business days prior to service (when applicable.)	When applicable	Yes
Physical, Occupational and Speech therapy	Yes, at least 2 business days prior to service (when applicable).	When applicable	Yes
Elective outpatient surgery (out-of-network)	Yes, at least 2 business days prior to procedure		Yes
Urgent outpatient surgery (direct from home or physician's office)	Yes, must call prior to procedure when performed during normal business hours.	Yes, must be reported within 2 business days when not performed during normal business hours.	Yes

**All referral/authorizations are approved pending verification of eligibility and benefits.**

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# Services Requiring Authorization

## Benefit Predetermination

The following table summarizes the identified benefits which require predetermination.

### Procedure

Excision skin tags, multiple fibrocutaneous tags, any area (performed in an outpatient facility setting only)  
 Cervicoplasty  
 Destruction of cutaneous vascular proliferative lesions  
 Unlisted procedure, skin mucous membrane and subcutaneous tissue  
 Mastectomy for gynecomastia through circumareolar or other incision  
 Breast repair and reconstruction  
 Breast repair and reconstruction  
 Arthrotomy, temporomandibular joint  
 Condylectomy, temporomandibular joint  
 Meniscectomy, partial or complete, temporomandibular joint  
 Repair, revision or reconstruction of skull, facial bones and temporomandibular joint  
 Malar augmentation; prosthetic material  
 Reduction of masseter muscle and bone  
 Treatment of temporomandibular dislocation; open or closed  
 Excision tumor, soft tissue of neck or thorax; subcutaneous  
 Deep, subfacial, intramuscular  
 Excision, abdominal wall tumor, subfacial  
 Arthroscopy, temporomandibular joint  
 Excision or surgical planning of skin of nose for rhinophyma  
 Repair of nose or septum  
 Reconstruction, functional, internal nose  
 Sclerotherapy  
 Ligation of saphenous vein/varicose veins  
 Penile venous occlusive procedure  
 Excision of lip  
 Vestibuloplasty; anterior and posterior, unilateral or bilateral; entire arch, complex  
 Excision, lesion of dentoalveolar structure; with or without repair  
 Palatopharyngoplasty  
 Gastric bypass; Gastroplasty; Gastroenterostomy for morbid obesity  
 Repair, removal or replacement and insertion of penile prosthesis  
 Canthotomy  
 Repair of brow ptosis, blepharoptosis, lid retraction  
 Repair entropion by blepharoplasty  
 Canthoplasty  
 Otoplasty, protruding ear, with or without size reduction  
 Temporomandibular joint arthrography; supervision and interpretation only

# Services requiring authorization

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## Benefit Predetermination

The following table summarizes the authorization protocol for services requiring benefit predetermination:

Steps	When	What's needed
Ordering physician requests authorization from United Physicians/ BIDS	At least 10 business days prior to services being rendered	<ol style="list-style-type: none"> <li>1. Patient demographics</li> <li>2. Reason for request</li> <li>3. Supporting clinical criteria</li> </ol>
United Physicians/ BIDS determines if service is medically necessary	Within 2 business days of receiving all necessary data	<p>Notification to requesting provider of determination. If:</p> <p><b>No:</b> Written notification sent to requesting provider. Provider appeal process may be initiated within 30 days upon receipt of notification.</p> <p><b>Yes:</b> Authorization is given.</p>

**All referral/authorizations are approved pending verification of eligibility and benefits.**





# Section 4

## **Quality Management Program**

Concurrent Review  
Discharge Planning  
Retrospective Review  
Provider Appeal Process

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# Quality Management Services

## **Concurrent Review**

Concurrent review establishes ongoing dialogue between United Physicians/BIDS staff and UR staff for the facility where a patient is confined. The primary purpose is to maximize coordination of care opportunities to allow for high quality health care at the most appropriate treatment level. Established treatment protocols for the respective facility will be complied with when applicable. When necessary, the attending physician may be contacted directly to participate in the process. For complex LOS cases, the United Physicians/BIDS medical director will be available for support and assistance.

## **Discharge Planning**

Discharge planning is initiated at the time of admission. The goal is to identify and coordinate a patient's need for continuing treatment after discharge. This includes such services as: Home Care, DME, etc. Efforts will be coordinated with discharge planning staff from the respective hospital.

## **Retrospective Review**

All in-network services billed to US Health and Life Insurance Company without an authorization number will be reviewed retrospectively. United Physicians/BIDS will confirm the authorization was obtained for the services and then will conduct a detailed review of the case. The purpose of the review is to determine appropriateness of the service, setting, and why an authorization was not obtained. The medical director will review the case for sign-off on denials.

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# Quality Management Services

## Appeal Process for Adverse Determination

A physician or member may appeal an adverse pre-certified determination by submitting a written request of such, with supporting medical documentation, addressed to:

Medical Director  
Beaumont Integrated Delivery System  
30800 Telegraph Road, Suite 3700  
Bingham Farms, MI 48025  
**Attn: UPHIP**

If the physician feels that the time frame would jeopardize the member's outcome, an expedited appeal process may be requested. Such requests should be made via telephone to the Medical Director of Beaumont Integrated Delivery System (800-824-6711) with supporting documentation submitted via facsimile or overnight mail.

**This process does not apply to eligibility or benefit determination issues.**



# Section 5

## **Billing and Reimbursement**

How to File a Claim for Professional Services  
Provider Reimbursement Issues  
Provider Payment Inquiry Process  
Coordination of Benefits

# How to File a Claim for Professional Services

The criteria for submitting professional claim forms is summarized in the table below:

Who	When	Where	How
All participating providers are required to submit claim forms for professional services.	Claim form must be received by US Health and Life within 6 months from the date of service. Claims submitted for secondary payment must be received 6 months from the date the primary payor processed the claim.	Submit <b>Preferred</b> and <b>Out-of-Network</b> claims to: US Health and Life P.O. Box 1378 Troy, MI 48099  Submit <b>Secondary Network</b> claims to: PPOM P.O. Box 2720 Farmington Hills, MI 48333	HCFA1500 or UB92 claim forms are accepted.

**To avoid rejected claims, please be sure to include the following data elements:**

- Member ID#
- Patient's name
- Patient's date of birth and sex
- Indication of Auto - Employment - Emergency related condition (when applicable)
- Name of referring physician - Mandatory for all claims. If the patient self-referred, type "self"
- Diagnosis code
- Date of service
- Procedure code (CPT-4 or HCPC when applicable)
- Billed charges
- Ft of units
- Total charges
- Provider Tax ID#
- Provider's billing address and phone number

**Claims received with any of the above referenced data elements missing will be returned to the provider for completion.**

- Claims are processed and paid by US Health and Life Insurance Company for the preferred network as well as out-of-network.
- Claims are processed and paid by PPOM for the secondary network.
- Claims submitted with all required data elements (clean claims) can be expected to be processed within 10 business days from the receipt of the claim.
- An explanation of payment (EOB) will accompany payment.
- Secondary claims must be submitted within a year from date of service.

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# Provider Payment Inquiry Process

Payment inquiries are welcome for claims that have been submitted for dates of service that are greater than 30 days old.

The process is as follows:

When	How	What's Needed	When a response can be expected
30 days after the date of service	By phone	Please limit call to 4 claims	Immediately

## Coordination of Benefits

In situations where a member has health care coverage by more than one health plan, a primary and secondary payor is established. US Health and Life Insurance Company will coordinate benefits provided under this program with benefits from any other group insurance carrier. The intent is that the total reimbursement from ALL carriers will not exceed 100% of allowable expenses.

### **Claim submission for secondary coverage:**

Submit a claim form with an attached copy of the explanation of payment from the primary payor.

### **Payment:**

In cases where United Physicians Health Insurance Program (UPHIP) is the secondary payor, UPHIP will only reimburse covered services up to the contracted amount for covered services.



# Section 6

## **Participating Provider Obligations**

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# Participating Provider Obligations

Participating providers in the United Physicians (UP) Preferred Provider Network agree to the following:

- 1.1 Covered Services are provided to Covered Persons in accordance with the Program.
- 1.2 Preferred Network Providers make and accept referrals of Covered Persons in accordance with the requirements of the Program. In the event of non-compliance, UP will institute appropriate corrective action to cure such failure.
- 1.3 Preferred Network Providers participate in utilization management and quality assurance initiatives, credentialing, and grievance and appeals procedures administered by UP subject to restrictions imposed by HIPAA or other privacy and confidentiality rules and regulations, and that they promptly comply with reasonable requests from US HEALTH or UP for medical records and other documentation when not prohibited by legal or ethical restrictions on the disclosure of patient information or where authorized by the patient.
- 1.4 Each Provider submit in writing information necessary for publication in a provider directory including: Provider's name, specialty, address(s) and telephone number(s) and all other information useful or necessary for the proper identification, description and location of the health care services offered by that Provider.
- 1.5 Each Provider maintain medical, financial and administrative records in accordance with State and Federal laws and regulations for at least seven years from the date the service was rendered, and that upon proper request and patient authorization, such Providers provide medical and demographic information to US HEALTH, UP, the Third Party Administrator or any government or regulatory agency as may be necessary for compliance with applicable laws, regulations, and contracts. The obligation to maintain and retain records and provide information hereunder shall survive termination of participation in the Network. Unless required as a part of the claims submission and verification process, Providers may charge a reasonable fee for the cost of copying medical and financial records.
- 1.6 Adherence to policies, procedures or provider manuals to the extent that UP has approved such policies, procedures and provider manuals and Network Providers have received and had a reasonable opportunity to review them.
- 1.7 Continuation of services pursuant to this Agreement following suspension, termination or withdrawal of a Participating Provider for any Covered Persons under active treatment until UP makes reasonable and medically appropriate arrangements for the transfer of such Covered Person's care to another provider or until treatment is completed.
- 1.8 Participation in compliance programs developed by UP, US HEALTH or any hospital or medical group with which the Provider is affiliated.
- 1.9 Reasonable and timely accessibility of Covered Persons to professional service, 24 hours a day, seven (7) days a week if urgent or emergency care is not otherwise reasonably available.
- 1.10 Each Provider maintain policies of general and professional liability insurance in minimum amounts required under UP's credentialing policy. Documentary evidence of such insurance policy or policies

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# Participating Provider Obligations

must be available to US HEALTH upon request, and Network Providers must provide notification to UP of any material change in coverage within five (5) days of receiving notice of such change in coverage.

- 1.11 Preferred Network Providers shall, as a condition of continued participation in the network, be subject to the credentialing, utilization management and other medical management activities of UP.
- 1.12 Network Providers are and remain licensed and fully qualified to practice medicine (or other professional discipline) in the State of Michigan in full compliance with all applicable State, Medicare, Medicaid and other Federal laws and regulations relating to the delivery of Covered Services to Covered Persons; have and retain full admitting privileges at an accredited, Participating Hospital within the area served by US HEALTH (unless waived by UP); and give immediate notification to UP of any action to suspend, revoke or restrict such Physician's license to practice medicine, Drug Enforcement Agency certificate, medical staff privileges at any hospital, or any action with respect to limiting participation in the Medicare or Medicaid programs.
- 1.13 Each Preferred Network Provider shall: accept payment for Covered Services provided to Covered Persons based on the fee schedule negotiated by UP and applicable to the Preferred Provider Network as described on Attachment 1; submit claims on a timely basis; collect applicable copayments and deductibles permitted under the Program; cooperate in claims payment administration including, but not limited to, coordination of benefits, subrogation, checking for eligibility and coverage, prior certification of designated procedures, and record keeping procedures; and, if US HEALTH overpays a provider or pays for services that are not a benefit under the Group Policy, or if US HEALTH pays a Provider on the basis of an assignment of benefits which is successfully contested, Provider shall return such amounts to US HEALTH or agree to allow US HEALTH to offset such amount(s) against other payments owed to such Provider.
- 1.14 Preferred Network Providers shall not balance bill, charge or collect a deposit or other sum or seek compensation, remuneration or reimbursement from or maintain any action or have recourse against, or make any surcharge upon any Covered Person or any person acting on any Covered Person's behalf. If UP receives notice of any surcharge upon or balance billing of any Covered Person or of any other such action by a Preferred Network Provider, it shall be entitled to take appropriate action including termination of participation for cause. Notwithstanding the foregoing, Preferred Network Providers may collect from Covered Persons, appropriate co-payments or deductibles, payments received from primary carriers where there is double coverage subject to applicable coordination of benefits policies, and payments for non-Covered Services upon proper notice to Covered Persons and written agreement by the Covered Person to be financially responsible for such non-Covered Services. The obligations contained in this section shall survive termination of this Agreement.

Although US HEALTH will not pay for non-covered, medically unnecessary or inappropriate services, if a Covered Person requests such services after being informed that the services are not or may not be Covered Services, or are or may not be medically necessary, and such Covered Person agrees in writing to pay for such service, then the Preferred Network Provider may bill the Covered Person for such services, and the Covered Person shall be obligated to pay for such services. Network Providers shall obtain written confirmation from the Covered Person of such request prior to providing such services.