2023 Evidence of Coverage
UCare Connect + Medicare (HMO D-SNP)

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ucare®

Toll free 1-800-203-7225, TTY 1-800-688-2534

Attention. If you need free help interpreting this document, call the above number.

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ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

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請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

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Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ပက်သူဉ်ပက်သးဘဉ်တက့်၊ ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လံာ် တီလံာ်မီတခါအံၤန့ဉ်,ကိးဘဉ်လီတဲစိနီ်ဂံၢ်လၢထးအံၤန့ဉ်တက့်၊

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງ ໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

Civil Rights Notice

Discrimination is against the law. UCare does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by UCare. You can file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:

UCare
Attn: Appeals and Grievances
PO Box 52
Minneapolis, MN 55440-0052
Toll Free: 1-800-203-7225
TTY: 1-800-688-2534
Fax: 612-884-2021
Email: cag@ucare.org

Auxiliary Aids and Services: UCare provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. **Contact** UCare at 612-676-3200 (voice) or 1-800-203-7225 (voice), 612-676-6810 (TTY), or 1-800-688-2534 (TTY).

Language Assistance Services: UCare provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact** UCare at 612-676-3200 (voice) or 1-800-203-7225 (voice), 612-676-6810 (TTY), or 1-800-688-2534 (TTY).

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by UCare. You may also contact any of the following agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion (in some cases)

Contact the OCR directly to file a complaint:

Office for Civil Rights
U.S. Department of Health and Human Services
Midwest Region
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
Customer Response Center: Toll-free: 800-368-1019
TDD Toll-free: 800-537-7697
Email: ocrmail@hhs.gov

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
540 Fairview Avenue North, Suite 201
St. Paul, MN 55104
651-539-1100 (voice)
800-657-3704 (toll-free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

Minnesota Department of Human Services (DHS)

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- race
- color
- national origin
- religion (in some cases)
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. We will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For elders age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.

January 1 – December 31, 2023

Evidence of Coverage:

Your Medicare and Medical Assistance (Medicaid) Health Benefits and Services and Prescription Drug Coverage as a Member of UCare Connect + Medicare (HMO D-SNP)

This document gives you the details about your Medicare and Medical Assistance (Medicaid) health care and prescription drug coverage from January 1 – December 31, 2023. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Customer Service at 612-676-3310 or 1-855-260-9707 (this call is free). TTY users should call 612-676-6810 or 1-800-688-2534 (this call is free). Hours are 8 am – 8 pm, seven days a week.

This plan, UCare Connect + Medicare, is offered by UCare Minnesota. (When this *Evidence of Coverage* says "we," "us," or "our," it means UCare Minnesota. When it says "plan" or "our plan," it means UCare Connect + Medicare.)

You can get this information for free in other formats, such as large print, braille, or audio. Call Customer Service at the number on the back cover of this document.

Benefits and/or copayments/coinsurance may change on January 1, 2024.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

This document explains your benefits and rights. Use this document to understand about:

- Your plan premium and cost sharing;
- Your medical and prescription drug benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

OMB Approval 0938-1051 (Expires: February 29, 2024)

2023 Evidence of Coverage
Table of Contents

2023 Evidence of Coverage
Table of Contents

2023 Evidence of Coverage
Table of Contents

2023 Evidence of Coverage
Table of Contents

CHAPTER 1
Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in UCare Connect + Medicare, which is a specialized Medicare Advantage Plan (Special Needs Plan)

You are covered by both Medicare and Medical Assistance (Medicaid):

- **Medicare** is the Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (kidney failure).
- **Medicaid** is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Medicaid coverage varies depending on the state and the type of Medicaid you have. Some people with Medicaid get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that are not covered by Medicare. In Minnesota, Medicaid is called Medical Assistance. In this document, Medicaid is referred to as Medical Assistance (Medicaid).You have chosen to get your Medicare and Medical Assistance (Medicaid) health care and your prescription drug coverage through our plan, UCare Connect + Medicare.

We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

UCare Connect + Medicare is a specialized Medicare Advantage Plan (a Medicare "Special Needs Plan"), which means its benefits are designed for people with special health care needs. UCare Connect + Medicare is designed for people who have Medicare and who are also entitled to assistance from Medical Assistance (Medicaid).

Because you get assistance from Medical Assistance (Medicaid) with your Medicare Part A and B cost sharing (deductibles, copayments, and coinsurance) you may pay nothing for your Medicare health care services. Medical Assistance (Medicaid) also provides other benefits to you by covering health care services and prescription drugs that are not usually covered under Medicare. You will also receive "Extra Help" from Medicare to pay for the costs of your Medicare prescription drugs. UCare Connect + Medicare will help manage all of these benefits for you, so that you get the health care services and payment assistance that you are entitled to.

UCare Connect + Medicare is run by a non-profit organization. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. The plan also has a contract with the Minnesota Medical Assistance (Medicaid) program to coordinate your Medical Assistance (Medicaid) benefits. We are pleased to be providing your Medicare and Medical Assistance (Medicaid) health care coverage, including your prescription drug coverage.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility

requirement. Please visit the Internal Revenue Service (IRS) website at: www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

Section 1.2 What is the *Evidence of Coverage* document about?

This *Evidence of Coverage* document tells you how to get your Medicare and Medical Assistance (Medicaid) medical care and prescription drugs. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The word "coverage" and "covered services" refers to the medical care and services and the prescription drugs available to you as a member of UCare Connect + Medicare.

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* document.

If you are confused, concerned or just have a question, please contact Customer Service.

Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how UCare Connect + Medicare covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in UCare Connect + Medicare between January 1, 2023 and December 31, 2023.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of UCare Connect + Medicare after December 31, 2023. We can also choose to stop offering the plan in your service area or to offer it in a different service area after December 31, 2023.

Medicare (the Centers for Medicare & Medicaid Services) must approve UCare Connect + Medicare each year. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

Our plan contracts with the Minnesota Department of Human Services for Medical Assistance (Medicaid) services on an annual basis.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B
- -- *and* -- you live in our geographic service area (Section 2.3 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- -- *and* -- you meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who receive certain Medical Assistance (Medicaid) benefits, are under age 65 and have a certified disability through the Social Security Administration or the State Medical Review Team or through the Developmental Disability Waiver. (Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be eligible for both Medicare and Medical Assistance (Medicaid).

Please note: If you lose your eligibility but can reasonably be expected to regain eligibility within three months, then you are still eligible for membership in our plan (Chapter 4, Section 2.1 tells you about coverage and cost sharing during a period of deemed continued eligibility).

Section 2.2 What is Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services, skilled nursing facilities, or home health agencies).
- Medicare Part B is for most other medical services (such as physician's services, home infusion therapy, and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 What is Medicaid?

Medicaid is a joint Federal and state government program that helps with medical and long-term care costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who is eligible, what services are covered, and the cost for services. States also can decide how to run their program as long as they follow the Federal guidelines. In Minnesota, the Medicaid program is called Medical Assistance. Throughout the document, we refer to Medicaid as Medical Assistance (Medicaid).

In addition, there are programs offered through Medical Assistance (Medicaid) that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB)**: Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medical Assistance (Medicaid) benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB)**: Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medical Assistance (Medicaid) benefits (SLMB+).)
- **Qualifying Individual (QI)**: Helps pay Part B premiums

Section 2.4 Here is the plan service area for UCare Connect + Medicare

UCare Connect + Medicare is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in Minnesota: Aitkin, Anoka, Becker, Benton, Blue Earth, Carlton, Carver, Cass, Chippewa, Chisago, Clay, Cook, Cottonwood, Crow Wing, Dakota, Faribault, Fillmore, Freeborn, Hennepin, Houston, Isanti, Itasca, Jackson, Kanabec, Kandiyohi, Kittson, Koochiching, Lac qui Parle, Lake, Lake of the Woods, Le Sueur, Lincoln, Lyon, Mahnomen, Marshall, Martin, Mille Lacs, Morrison, Mower, Murray, Nicollet, Nobles, Norman, Olmsted, Otter Tail, Pennington, Pine, Polk, Ramsey, Red Lake, Redwood, Rice, Rock, Roseau, Scott, Sherburne, St. Louis, Stearns, Swift, Todd, Wadena, Washington, Watonwan, Wilkin, Winona, Wright and Yellow Medicine.

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Customer Service to see if we have a plan in your new area. When you move, you will

have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

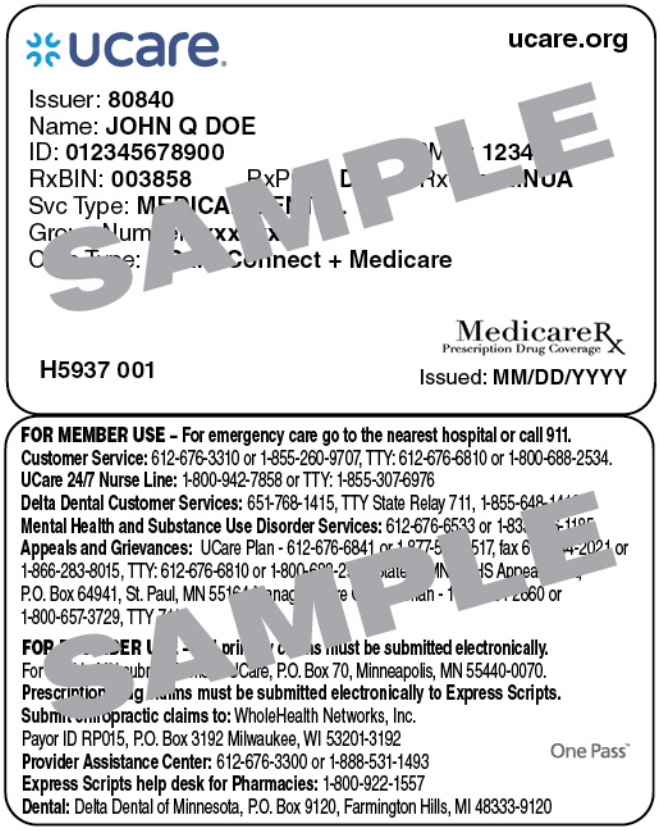
Section 2.5 U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify UCare Connect + Medicare if you are not eligible to remain a member on this basis. UCare Connect + Medicare must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

While you are a member of our plan, you must use your membership card whenever you get services covered by this plan and for prescription drugs you get at network pharmacies. Here's a sample membership card to show you what yours will look like:



You should also show the provider your Minnesota Health Care Programs ID card.

Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your UCare Connect + Medicare membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare approved clinical research studies also called clinical trials.

If your plan membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card.

Section 3.2 *Provider and Pharmacy Directory*

The *Provider and Pharmacy Directory* lists our network providers, pharmacies and durable medical equipment suppliers.

Network providers are the doctors and other health care professionals, including behavioral health providers, medical groups, dentists, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in-network), out-of-area dialysis services, and cases in which UCare Connect + Medicare authorizes use of out-of-network providers.

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the *Pharmacy Directory* to find the network pharmacy you want to use. Refer to Chapter 5, Section 2.5 for information on when you can use pharmacies that are not in the plan's network.

The most recent list of providers, pharmacies and suppliers is available on our website at **ucare.org/searchnetwork**.

If you don't have the *Provider and Pharmacy Directory*, you can request a copy from Customer Service. You can also find this information on our website at **ucare.org/searchnetwork**.

Section 3.3 The plan's *List of Covered Drugs (Formulary)*

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in UCare Connect + Medicare. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the UCare Connect + Medicare Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will provide you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website (**ucare.org/searchdruglist**) or call Customer Service.

SECTION 4 Your monthly costs for UCare Connect + Medicare

Your costs may include the following:

- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.4)
- Income Related Monthly Adjusted Amount (Section 4.5)

Section 4.1 Plan premium

You do not pay a separate monthly plan premium for UCare Connect + Medicare.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare Premiums

Some members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must maintain your eligibility for Medical Assistance (Medicaid) as well as have both Medicare Part A and Medicare Part B. For most UCare Connect + Medicare members, Medical Assistance (Medicaid) pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium.

If Medical Assistance (Medicaid) is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan. This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

Section 4.3 Part D Late Enrollment Penalty

Because you are dual-eligible, the LEP doesn't apply as long as you maintain your dual-eligible status, but if you lose status you may incur LEP. Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. "Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

The Part D late enrollment penalty is added to your monthly premium. When you first enroll in UCare Connect + Medicare, we let you know the amount of the penalty. If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

You **will not** have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
  - **Note:** Any notice must state that you had "creditable" prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.
  - **Note:** The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

Medicare determines the amount of the penalty. Here is how it works:

- First, count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2022 this average premium amount was $38.18. This amount may change for 2023.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times $38.18, which equals $5.3452. This rounds to $5.35. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty**.

There are three important things to note about this monthly Part D late enrollment penalty:

- First, **the penalty may change each year** because the average monthly premium can change each year.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review. Generally, you must request this review **within 60 days** from the date on the first letter you receive stating you have to pay a late enrollment penalty. However, if you were paying a penalty before joining our plan, you may not have another chance to request a review of that late enrollment penalty.

Important: Do not stop paying your Part D late enrollment penalty while you're waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium. If you do not pay the extra amount, you will be disenrolled from the plan and lose prescription drug coverage.**

If you disagree about paying an extra amount, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

Section 4.5 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year, we will tell you in September and the change will take effect on January 1.

However, in some cases, you may be able to stop paying a late enrollment penalty, if owed, or need to start paying a late enrollment penalty. This could happen if you become eligible for the

"Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year:

- If you currently pay the Part D late enrollment penalty and become eligible for "Extra Help" during the year, you would be able to stop paying your penalty.
- If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 5 Keeping your plan membership record up to date

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage, including your Primary Care Provider.

The doctors, hospitals, pharmacists, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered and the cost-sharing amounts for you.** Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study (**Note:** You are not required to tell your plan about the clinical research studies you intend to participate in but we encourage you to do so)

If any of this information changes, please let us know by calling Customer Service.

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

In addition, call your county worker to report these changes:

- Name or address changes

- Admission to a nursing facility
- Addition or loss of a household member
- Lost or stolen Minnesota Health Care Programs ID card
- New job or change in income

SECTION 6 How other insurance works with our plan

Other insurance

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Service. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
  - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
  - If you're over 65 and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.

- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medical Assistance (Medicaid) and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, and/or employer group health plans have paid.

CHAPTER 2
Important phone numbers and resources

SECTION 1 **UCare Connect + Medicare contacts** (how to contact us, including how to reach Customer Service)

How to contact our plan's Customer Service

For assistance with claims, billing, or membership card questions, please call or write to UCare Connect + Medicare Customer Service. We will be happy to help you.

Method	Customer Service - Contact Information
CALL	612-676-3310 1-855-260-9707 (Calls to this number are free.) 8 am – 8 pm, seven days a week Customer Service also has free language interpreter services available for non-English speakers.
TTY	612-676-6810 1-800-688-2534 (Calls to this number are free.) 8 am – 8 pm, seven days a week These numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.
FAX	612-676-6501 1-866-457-7145
WRITE	**Attn: Customer Service** UCare PO Box 52 Minneapolis, MN 55440-0052
WEBSITE	**ucare.org**

How to contact us when you are asking for a coverage decision about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, refer to Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*.

Method	Coverage Decisions for Medical Care – Contact Information
CALL	**Customer Service** 612-676-3310 1-855-260-9707 (Calls to this number are free.) 8 am – 8 pm, seven days a week
TTY	612-676-6810 1-800-688-2534 (Calls to this number are free.) 8 am – 8 pm, seven days a week These numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.
FAX	612-884-2021 1-866-283-8015 **Attn: Appeals and Grievances**
WRITE	**Attn: Standard Review** UCare PO Box 52 Minneapolis, MN 55440-0052
WEBSITE	**ucare.org**

How to contact us when you are making an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, refer to Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*.

Method	Appeals for Medical Care – Contact Information
CALL	**Appeals and Grievances** 612-676-6841 1-877-523-1517 (Calls to this number are free.) 8 am – 4:30 pm, Monday – Friday
TTY	612-676-6810 1-800-688-2534 (Calls to this number are free.) 8 am – 4:30 pm, Monday – Friday These numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.
FAX	612-884-2021 1-866-283-8015 **Attn: Appeals and Grievances**
WRITE	**Attn: Appeals and Grievances** UCare PO Box 52 Minneapolis, MN 55440-0052 Or **email** us at cag@ucare.org
WEBSITE	**ucare.org**

How to contact us when you are making a complaint about your medical care

You can make a complaint about us or one of our network providers or pharmacies including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your medical care, refer to Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*.

Method	Complaints About Medical Care – Contact Information
CALL	**Customer Service** 612-676-3310 1-855-260-9707 (Calls to this number are free.) 8 am – 8 pm, seven days a week
TTY	612-676-6810 1-800-688-2534 (Calls to this number are free.) 8 am – 8 pm, seven days a week These numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.
FAX	612-884-2021 1-866-283-8015 **Attn: Appeals and Grievances**
WRITE	**Attn: Appeals and Grievances** UCare PO Box 52 Minneapolis, MN 55440-0052 Or **email** us at cag@ucare.org
MEDICARE WEBSITE	You can submit a complaint about UCare Connect + Medicare directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

How to contact us when you are asking for a coverage decision about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your Part D prescription drugs. For more information on asking for coverage decisions about your Part D prescription drugs, refer to Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*.

Method	**Coverage Decisions for Part D Prescription Drugs – Contact Information**
CALL	Express Scripts 1-877-558-7521 (Calls to this number are free.) 24 hours a day, seven days a week
TTY	1-800-716-3231 (Calls to this number are free.) 24 hours a day, seven days a week This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	1-877-251-5896
WRITE	**Attn: Medicare Reviews** Express Scripts PO Box 66571 St. Louis, MO 63166-6571
WEBSITE	www.express-scripts.com

How to contact us when you are making an appeal about your Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, refer to Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*.

Method	Appeals for Part D Prescription Drugs – Contact Information
CALL	**Appeals and Grievances** 612-676-6841 1-877-523-1517 (Calls to this number are free.) 8 am – 4:30 pm, Monday – Friday
TTY	612-676-6810 1-800-688-2534 (Calls to this number are free.) 8 am – 4:30 pm, Monday – Friday These numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.
FAX	612-884-2021 1-866-283-8015 **Attn: Appeals and Grievances**
WRITE	**Attn: Appeals and Grievances** UCare PO Box 52 Minneapolis, MN 55440-0052 Or **email** us at cag@ucare.org
WEBSITE	**ucare.org**

How to contact us when you are making a complaint about your Part D prescription drugs

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your Part D prescription drugs, refer to Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*.

Method	**Complaints about Part D Prescription Drugs – Contact Information**
CALL	**Customer Service** 612-676-3310 1-855-260-9707 (Calls to this number are free.) 8 am – 8 pm, seven days a week
TTY	612-676-6810 1-800-688-2534 (Calls to this number are free.) 8 am – 8 pm, seven days a week These numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.
FAX	612-884-2021 1-866-283-8015 **Attn: Appeals and Grievances**
WRITE	**Attn: Appeals and Grievances** UCare PO Box 52 Minneapolis, MN 55440-0052 Or **email** us at cag@ucare.org
MEDICARE WEBSITE	You can submit a complaint about UCare Connect + Medicare directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received

We do not allow UCare Connect + Medicare providers to bill you for services. We pay our providers directly, and we protect you from any charges. The exception is if you pay for Medicare Part D prescription drugs. If you paid for a service that you think we should have covered, contact Customer Service at the phone number printed on the back cover of this document.

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Refer to Chapter 7 *(Asking us to pay our share of a bill you have received for covered medical services or drugs)*.

Please note: If you send us a payment request for a Medicare Part D drug and we deny any part of your request, you can appeal our decision. Refer to Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* for more information.

Method	Payment Requests - Contact Information
CALL	**Customer Service** 612-676-3310 1-855-260-9707 (Calls to this number are free.) 8 am – 8 pm, seven days a week
TTY	612-676-6810 1-800-688-2534 (Calls to this number are free.) 8 am – 8 pm, seven days a week These numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.
FAX	**For medical claims only:** 612-884-2021 1-866-283-8015 **For prescription drug claims only (Express Scripts):** 1-608-741-5483

Method	Payment Requests - Contact Information
WRITE	**For medical claims**, submit to UCare's Direct Member Reimbursement Department (DMR): **Attn: DMR Department** UCare PO Box 52 Minneapolis, MN 55440-0052 **For prescription drug claims**, submit to Express Scripts: **Attn: Medicare Part D** Express Scripts PO Box 14718 Lexington, KY 40512-4718
WEBSITE	**ucare.org**

How to contact us to report fraud and abuse

To Report Fraud and Abuse contact UCare's Compliance/Fraud Hotline by phone toll free at 1-877-826-6847 (available 24 hours per day, 7 days per week); TTY users can call UCare's TTY lines at 612-676-6810 or 1-800-688-2534 (available 8 am – 8 pm, 7 days per week); or by email at compliance@ucare.org. You may remain anonymous. Or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. To report fraud or abuse directly to the State, contact the Surveillance and Integrity Review Section (SIRS) at the Minnesota Department of Human Services (DHS) by phone at 651-431-2650 or 1-800-657-3750 (this call is free); by fax at 651-431-7569; or by email at DHS.SIRS@state.mn.us.

SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Advantage organizations including us.

Method	Medicare - Contact Information
CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free. 24 hours a day, 7 days a week
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

Method	Medicare - Contact Information
WEBSITE	www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about UCare Connect + Medicare: • **Tell Medicare about your complaint:** You can submit a complaint about UCare Connect + Medicare directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Minnesota, the SHIP is called Senior LinkAge Line®.

Senior LinkAge Line® is an independent (not connected with any insurance company or health plan) state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Senior LinkAge Line® counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. Senior LinkAge Line® counselors can also help you with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit www.medicare.gov
- Click on "**Talk to Someone**" in the middle of the homepage
- You now have the following options:
  - Option #1: You can have a **live chat with a 1-800-MEDICARE representative**
  - Option #2: You can select your **STATE** from the dropdown menu and click GO. This will take you to a page with phone numbers and resources specific to your state.

Method	Senior LinkAge Line® (Minnesota SHIP) - Contact Information
CALL	1-800-333-2433 (Calls to this number are free.)
TTY	Call the Minnesota Relay Service at 711 or use your preferred relay service. (Calls to this number are free.)
WRITE	Minnesota Board on Aging PO Box 64976 St. Paul, MN 55164-0976
WEBSITE	www.seniorlinkageline.com

Disability Hub MN™ is a free statewide resource network that helps you solve problems, navigate the system and plan for your future. This team knows the ins and outs of community resources and government programs, and has years of experience helping people fit them together.

Method	Disability Hub MN - Contact Information
CALL	1-866-333-2466 Calls to this number are free. Monday through Friday from 8:30 am – 5:00 pm
TTY	Call the Minnesota Relay Service at 711 or use your preferred relay service. Calls to this number are free.
WRITE	PO Box 64967 St. Paul, MN 55164-0976
WEBSITE	disabilityhubmn.org

The Veterans LinkAge Line™ provides information and referrals to veterans and their families. The Minnesota Department of Veterans Affairs (MDVA) provides the LinkVet call center. During business hours, trained MDVA staff will provide information on veterans' benefits, healthcare, education, and reintegration.

Method	Veterans LinkAge Line™ – Contact Information
CALL	1-888-LinkVet (546-5838) Hours of Operation Mon-Fri: 7 a.m. to 8 p.m., CST Sat: 9 a.m. to 2:30 p.m., CST Sun: 11 a.m. to 4:30 p.m., CST Closed Holidays.
TTY	TTY at (800) 627-3529 Calls to this number are free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Minnesota, the Quality Improvement Organization is called Livanta.

Livanta has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. Livanta is an independent organization. It is not connected with our plan.

You should contact Livanta in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Method	**Livanta (Minnesota's Quality Improvement Organization) – Contact Information**
CALL	1-888-524-9900 (Calls to this number are free.) 9 am – 5 pm, Monday – Friday 11 am – 3 pm on weekends
TTY	1-888-985-8775 (Calls to this number are free.) This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	1-855-236-2423
WRITE	Livanta BFCC-QIO 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105
WEBSITE	www.livantaqio.com

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Method	Social Security - Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday.
WEBSITE	www.ssa.gov

SECTION 6 Medicaid

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. In Minnesota, the Medicaid program is called Medical Assistance. To find out more about Medical Assistance and its programs, contact the Minnesota Department of Human Services.

Our plan is a part of the program called Special Needs BasicCare (SNBC). The Minnesota Department of Human Services designed this program to provide coordinated care for people with disabilities. It coordinates benefits for certain people who have Medical Assistance

(Medicaid) with Medicare. It combines your doctors, hospitals, some home care, behavioral health, dental, nursing home care and other care into one coordinated system. In this program, if you are eligible, you receive personal care assistance and home care nursing services through Medical Assistance (Medicaid) fee-for-service – not through our Plan. If you are not currently receiving, but are in need of Home and Community Based Services, contact your county.

In addition, there are programs offered through Medical Assistance (Medicaid) that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medical Assistance (Medicaid) benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medical Assistance (Medicaid) benefits (SLMB+).)

If you have questions about the assistance you get from Medical Assistance (Medicaid), contact Minnesota Department of Human Services.

Method	Minnesota Department of Human Services (Minnesota's Medical Assistance (Medicaid) program) - Contact Information
CALL	651-431-2670 (Twin Cities Metro area) 1-800-657-3739 (outside the Twin Cities Metro area) Calls to this number are free. 8 am – 5 pm, Monday – Friday
TTY	1-800-627-3529 (You need special telephone equiment to call this number.) Or Call the Minnesota Relay Service at 711 or use your preferred relay service (You do **not** need special telephone equipment to call this number.) Calls to these numbers are free.
WRITE	Minnesota Department of Human Services 4444 Lafayette Road North St. Paul, MN 55155
WEBSITE	mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs

The Ombudsperson for Public Managed Health Care Programs helps people enrolled in Medicaid with service or billing problems. They can help you file a grievance or appeal with our plan.

Method	Ombudsperson for Public Managed Health Care Programs – Contact Information
CALL	1-651-431-2660 (Twin Cities Metro area) or 1-800-657-3729 (Outside Twin Cities Metro area) Calls to this number are free. Monday through Friday, between 8:00 am and 4:30 pm.
TTY	1-800-627-3529 (You need special telephone equipment to call this number.) Call the Minnesota Relay Service at 711 or use your preferred relay service. (You do not need special telephone equipment to call this number.) Calls to these numbers are free.
FAX	651-431-7472
WRITE	Minnesota Department of Human Services Ombudsperson for State Managed Health Care Programs PO Box 64249 St. Paul, MN 55164-0249 dhsombudsman.smhcp@state.mn.us
WEBSITE	mn.gov/dhs/managedcareombudsman

The Minnesota Office of Ombudsperson for Long-Term Care helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

Method	Minnesota Office of Ombudsperson for Long-Term Care – Contact Information
CALL	1-651-431-2555 (Twin Cities Metro area) or 1-800-657-3591 (outside Twin Cities Metro area) Calls to this number are free. Monday through Friday, between 8:00 am and 4:30 pm.
TTY	1-800-627-3529 (You need special telephone equipment to call this number.) Or Call the Minnesota Relay Service at 711 or use your preferred relay service. (You do not need special equipment to call this number.) Calls to these numbers are free.
WRITE	Minnesota Office of Ombudsperson for Long-Term Care PO Box 64971 St. Paul, MN 55164-0971
WEBSITE	www.mnaging.net/Advocate/OLTC.aspx

The Office of Ombudsman for Mental Health and Developmental Disabilities helps people get information concerning services for persons with mental or developmental disabilities, substance use disorder or emotional disturbance.

Method	The Office of Ombudsman for Mental Health and Developmental Disabilities – Contact Information
CALL	1-651-757-1800 (Twin Cities Metro area) or 1-800-657-3506 (outside Twin Cities Metro area) Calls to this number are free. Monday through Friday, between 8:00 am and 4:30 pm.
TTY	Call the Minnesota Relay Service at 711 or use your preferred relay service. Calls to this number are free.
WRITE	The Office of Ombudsman for Mental Health and Developmental Disabilities 121 7th Place East Suite 420 Metro Square Building St. Paul, MN 55101-2117 ombudsman.mhdd@state.mn.us
WEBSITE	https://mn.gov/omhdd/

SECTION 7 Information about programs to help people pay for their prescription drugs

The Medicare.gov website (https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

Medicare's "Extra Help" Program

Because you are eligible for Medical Assistance (Medicaid), you qualify for and are getting "Extra Help" from Medicare to pay for your prescription drug plan costs. You do not need to do anything further to get this "Extra Help."

If you have questions about "Extra Help," call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048 (applications), 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 8 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medical Assistance (Medicaid) Office (applications) (Refer to Section 6 of this chapter for contact information).

If you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has a process for you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- First, contact Customer Service (phone numbers are printed on the back cover of this booklet). We will help you identify what documentation must be sent to us. Upon receipt of your documentation, we will review it and determine if it meets Medicare requirements. If the documentation meets Medicare requirements, we will correct your cost-sharing amount. If the documentation does not support a change in your cost-sharing amount, we will notify you.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make the payment directly to the state. Please contact Customer Service if you have questions.

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?
What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost-sharing assistance through the HIV/AIDS Programs.

This program may help you if you:

- Are not eligible for medication coverage through programs like Medicaid or MinnesotaCare
- Have medication coverage through Medicare Part D and need help to pay medication copays and deductibles

Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. If you change plans please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call:

Method	Minnesota's AIDS Drug Assistance Program (ADAP) - Contact Information
CALL	**Twin Cities Metro area:** 651-431-2398 **Statewide:** 1-800-657-3761 (Calls to this number are free.)
TTY	1-800-627-3529 (This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.) Or 711 or use your preferred relay service (You do not need special telephone equipment to call this number.) Calls to this number are free.
FAX	651-431-7414
WRITE	HIV/AIDS Programs, Department of Human Services PO Box 64972 St. Paul, MN 55164-0972
WEBSITE	https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/programs-services/medications.jsp

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Method	Railroad Retirement Board - Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press "0," you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press "1", you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	rrb.gov/

SECTION 9 Do you have "group insurance" or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Customer Service if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Service are printed on the back cover of this document.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

If you have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact **that group's benefits administrator**. The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

CHAPTER 3

Using the plan's coverage for your medical and other covered services

SECTION 1 Things to know about getting your medical care and other services as a member of our plan

This chapter explains what you need to know about using the plan to get your medical care and other services covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, equipment, prescription drugs, and other medical care that are covered by the plan.

For the details on what medical care and other services are covered by our plan, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered*).

Section 1.1 What are "network providers" and "covered services"?

- "**Providers**" are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- "**Network providers**" are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you use a network provider, you pay nothing for covered services.
- "**Covered services**" include all the medical care, health care services, supplies, equipment, and prescription drugs that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

Section 1.2 Basic rules for getting your medical care and other services covered by the plan

As a Medicare and Medical Assistance (Medicaid) health plan, UCare Connect + Medicare must cover all services covered by Original Medicare and may offer other services in addition to those covered under Original Medicare as described in the Chapter 4 *Benefits Chart*.

UCare Connect + Medicare will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive is considered medically necessary.** "Medically necessary" means that the services, supplies, equipment, or drugs are needed for the prevention,

diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, refer to Section 2.1 in this chapter).

- **You must receive your care from a network provider** (for more information about this, refer to Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. This means that you will have to pay the provider in full for the services furnished. *Here are three exceptions:*

  - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to find out what emergency or urgently needed services means, refer to Section 3 in this chapter.

  - If you need medical care that Medicare or Medical Assistance (Medicaid) requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. You must get Prior Authorization before getting this care from out-of-network providers. In this situation, we will cover these services as if you got the care from a network provider. For information about getting approval to use an out-of-network doctor, refer to Section 2.4 in this chapter.

  - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan's network the cost sharing for the dialysis may be higher.

SECTION 2 Use providers in the plan's network to get your medical care and other services

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your care

What is a "PCP" and what does the PCP do for you?

A PCP is a provider who knows you and your medical history. Your PCP is trained to give you basic medical care. When you become a member of the plan, you must choose a Primary Care Clinic. A Primary Care Clinic is a clinic within UCare Connect + Medicare's network. You can see any PCP at this clinic. The types of providers that can act as a PCP are family medicine doctors, general practitioners, internists, geriatricians, doctors in obstetrics/gynecology, nurse midwives, physician assistants and nurse practitioners, or a specialist who is your primary physician. You can get your routine or basic care from your PCP who will also coordinate the rest of the covered services you get as a plan member. This includes but is not limited to:

- Diagnostic tests
- X-rays
- Laboratory tests
- Therapies
- Hospital admissions
- Follow-up care
- Care from doctors who are specialists (you do not need a referral to see an in-network specialist)

"Coordinating" your services includes checking or consulting with other network providers about your care and how it is going. Some services will need prior authorization (see Chapter 4 for details). Because your provider will coordinate your medical care, you should have all of your past medical records sent to your provider's office. Chapter 8 tells you how we protect the privacy of your medical records and personal health information.

How do you choose your PCP?

When you are a member or become a member of UCare Connect + Medicare you chose or were assigned to a Primary Care Clinic. You can change your Primary Care Clinic at any time.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP. If we are notified that your clinic is leaving the network, we will notify you in writing.

You may change your provider or clinic at any time. To change your provider or clinic, call Customer Service (phone numbers are printed on the back cover of this booklet).

Section 2.2 What kinds of medical care and other services can you get without a referral from your PCP?

You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider
- Flu shots, COVID-19 vaccinations, Hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider
- Emergency services from network providers or from out-of-network providers
- Urgently needed services are covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call Customer Service before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.)

Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer
- Cardiologists care for patients with heart conditions
- Orthopedists care for patients with certain bone, joint, or muscle conditions

Our plan is a direct access plan. This means you don't need to get a referral or plan approval to see network providers, including specialists. For some types of services, you may need to get approval from UCare before getting the service. This is called getting Prior Authorization.

To get Prior Authorization, your provider should submit a Prior Authorization request to UCare. A form for doing this is available on our website (**ucare.org/formembers**). Medical records showing a medical necessity for the service you are asking us to cover should be

submitted along with the form. UCare's utilization management staff will carefully review your Prior Authorization request and decide whether it is medically necessary.

If necessary, UCare's clinical staff may review your request and discuss your care with board-certified specialists in the field related to your request before making a decision. Refer to Chapter 4, Section 2.1, to find out which medical care or services require Prior Authorization.

If we are unable to find you a qualified plan network provider, we must give you a standing service authorization for you to go to a qualified specialist for any of these conditions:

- A chronic (on-going) condition;
- A life-threatening mental or physical illness;
- A pregnancy that is beyond the first three months (first trimester);
- A degenerative disease or disability;
- Any other condition or disease that is serious or complex enough to require treatment by a specialist.

If you do not get a prior authorization from us when needed, the bill may not be paid. For more information, call Customer Service at the phone number printed on the back page of this document.

UCare has a mental health and substance use disorder triage line to assist members with any questions about how to get care from a mental health specialist, substance use disorder specialist or other network providers. Our triage line is available by phone 8 am – 5 pm, Monday – Friday at 612-676-6533 or 1-833-276-1185 toll free to support the mental health or substance use disorder needs of our members.

What if a specialist or another network provider leaves our plan?

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If our network does not have a qualified specialist for a plan-covered service, we must cover that service at in-network cost sharing. In some cases, we must give you a standing Prior Authorization before you get care.

- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 9.

Section 2.4 How to get care from out-of-network providers

In some cases, if we are unable to find you a qualified provider in UCare's network, we must give you a standing Prior Authorization for you to get care from a specialist. For more information, please call Customer Service at the number on the back of your member ID card.

If Prior Authorization is required, and you do not get it from us before getting care from providers not in our network, the bill may not be paid. Usually, your provider will contact us to get Prior Authorization. You can get additional information on how to access out-of-network care by calling Customer Service (phone numbers are on the back cover of this booklet), or visit **ucare.org/important-coverage-information**.

SECTION 3 How to get services when you have an emergency or urgent need for care or during a disaster

Section 3.1 Getting care if you have a medical emergency

What is a "medical emergency" and what should you do if you have one?

A "**medical emergency**" is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent your loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they are not part of our network.

What is covered if you have a medical emergency?

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over, you are entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan.

If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, we will cover additional care *only* if you get the additional care in one of these two ways:

- You use a network provider to get the additional care.
- – *or* – The additional care you get is considered "urgently needed services" and you follow the rules for getting this urgent care (for more information about this, refer to Section 3.2 below).

Section 3.2 Getting care when you have an urgent need for services

What are "urgently needed services"?

An urgently needed service is a non-emergency situation requiring immediate medical care but, given your circumstances, it is not possible or not reasonable to obtain these services from a network provider. The plan must cover urgently needed services provided out of network. Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

You can find a list of providers online at **ucare.org/searchnetwork** or by calling Customer Service at the number on the back of your member ID card. To find out how to access urgently needed care, you can call your provider, or the UCare 24/7 nurse line at 1-800-942-7858 (this call is free), 24 hours a day, seven days a week. TTY users call 1-855-307-6976 (this call is free).

Our plan does not cover emergency services, urgently needed services, nor any other services for care received outside of the United States and its territories.

Section 3.3 Getting care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from your plan.

Please visit the following website: **ucare.org/important-coverage-information** for information on how to obtain needed care during a disaster.

If you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please refer to Chapter 5, Section 2.5 for more information.

SECTION 4 What if you are billed directly for the full cost of your services?

Section 4.1 You can ask us to pay our share of the cost of Medicare Part D drugs only for covered services

We do not allow UCare Connect + Medicare providers to bill you for services. We pay our providers directly, and we protect you from any charges. The exception is if you pay for Medicare Part D prescription drugs. If you paid for a service that you think we should have covered, contact Customer Service at the phone number printed on the back cover of this document.

If you have paid more than your share of Medicare Part D drugs, or if you have received a bill for covered medical services, go to Chapter 7 *(Asking us to pay our share of a bill you have received for covered medical services or drugs)* for information about what to do.

Section 4.2 What should you do if services are not covered by our plan?

UCare Connect + Medicare covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan or services obtained out-of-netowrk and were not authorized, you are responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. These costs will not count toward your out-of-pocket maximum. In certain cases, additional coverage may be

available for covered services that have a benefit limit. Your provider can request a Prior Authorization. Without a Prior Authorization, you may be responsible for the cost of any services you get beyond the benefit limit.

SECTION 5 How are your medical services covered when you are in a "clinical research study"?

Section 5.1 What is a "clinical research study"?

A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

Once Medicare approves the study, and you express interest, someone who works on the study will contact you to explain more about the study and find out if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in any Medicare-approved clinical research study, you do *not* need to tell us or get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study*.

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you receive as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare has paid its share of the cost for these services, our plan will pay the rest. Like for all covered services, you will pay nothing for the covered services you get in the clinical research study.

When you are part of a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication "Medicare and Clinical Research Studies." (The publication is available at: www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf.) You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 6 Rules for getting care in a "religious non-medical health care institution"

Section 6.1 What is a religious non-medical health care institution?

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 Receiving Care from a Religious Non-Medical Health Care Institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is "non-excepted."

- "Non-excepted" medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.
- "Excepted" medical treatment is medical care or treatment that you get that is *not* voluntary or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
  - – *and* – You must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

This coverage is not limited as long as it is medically necessary.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of UCare Connect + Medicare, however, you usually will not acquire ownership of rented DME items while a member of our plan, even if you made up to 12 consecutive payments for the DME item under Original Medicare before

you joined our plan. Under certain limited circumstances we will transfer ownership of the DME item to you. Call Customer Service for more information.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. The payments made while enrolled in your plan do not count.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count. You will have to make 13 payments to our plan before owning the item.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage UCare Connect + Medicare will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave UCare Connect + Medicare or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

What happens if you leave your plan and return to Original Medicare?

Original Medicare requires an oxygen supplier to provide you services for five years. During the first 36 months you rent the equipment. The remaining 24 months the supplier provides the equipment and maintenance (you are still responsible for the copayment for oxygen). After five years, you may choose to stay with the same company or use another company. At this point, the five-year cycle begins again, even if you remain with the same company, requiring you to pay copayments for the first 36 months. If you join or leave our plan, the five-year cycle starts over.

CHAPTER 4

Medical Benefits Chart (what is covered)

SECTION 1 Understanding covered services

This chapter provides a Medical Benefits Chart that lists your covered services as a member of UCare Connect + Medicare. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 You pay nothing for your covered medical services

Because you get assistance from Medical Assistance (Medicaid), you pay nothing for your covered services as long as you follow the plan's rules for getting your care. (Refer to Chapter 3 for more information about the plan's rules for getting your care.)

Section 1.2 What is the most you will pay for covered medical services?

If you are eligible for Medicare cost sharing assistance under Medical Assistance (Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Because you are enrolled in a Medicare Advantage Plan, there is a limit on the amount you have to pay out-of-pocket each year for medical services that are covered by our plan (refer to the *Medical Benefits Chart* in Section 2, below). This limit is called the maximum out-of-pocket (MOOP) amount for medical services. For calendar year 2023, this amount is $0.

Note: Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum. You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

The amounts you pay for covered services count toward this maximum out-of-pocket amount. The amounts you pay for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. If you reach the maximum out-of-pocket amount of $0, you will not have to pay any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medical Assistance (Medicaid) or another third party).

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered

Section 2.1 Your medical benefits as a member of the plan

The Medical Benefits Chart on the following pages lists the services UCare Connect + Medicare covers. Part D prescription drug coverage is in Chapter 5. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare and Medical Assistance (Medicaid) covered services must be provided according to the coverage guidelines established by Medicare and Medical Assistance (Medicaid).
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) must be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered unless it is emergent or urgent care services from an out-of-network provider. This means that you will have to pay the provider in full for the services furnished.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart by an asterisk (*). In addition, the following services not listed in the Benefits Chart require prior authorization: inpatient rehabilitation services, spine surgery, bone growth stimulators, spinal cord stimulators and molecular/genetic testing (for example – screening for cancer).

Other important things to know about our coverage:

- You are covered by both Medicare and Medical Assistance (Medicaid). Medicare covers health care and prescription drugs. Medical Assistance (Medicaid) covers your cost sharing for Medicare services. Medicaid also covers services Medicare does not cover, like dental and behavioral health services.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2023* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you.
- If Medicare adds coverage for any new services during 2023, either Medicare or our plan will cover those services.
- If you are within our plan's 3-month period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, we will continue to cover Medicaid benefits that are included under the Medicaid State Plan, as well as the Medicare premiums or cost sharing for which the state would otherwise be liable. Medicare cost-sharing amounts for Medicare basic and supplemental benefits do not change during this period.

You do not pay anything for the services listed in the Medical Benefits Chart, as long as you meet the coverage requirements described above.

If you are eligible for Medicare cost-sharing assistance under Medical Assistance (Medicaid), you do not pay anything for the services listed in the Medical Benefits Chart, as long as you meet the coverage requirements described above.

Restricted Recipient Program

- The Restricted Recipient Program is for members who have misused health services. This includes getting health services that members did not need using them in a way that costs more than they should, or using then in a way that may be dangerous to a member's health. UCare will notify members if they are placed in the Restricted Recipient Program.
- If you are in the Restricted Recipient Program, you must get health services from one designated primary care provider, one clinic, one hospital used by the primary care provider, and one pharmacy. UCare may designate other health care providers. You may also be assigned to a home health agency. You may not be allowed to use the personal care assistance choice or flexible use options or consumer directed services.
- You will be restricted to these designated health care providers for at least 24 months of eligibility for Minnesota Health Care Programs (MHCP). All referrals to specialists must be from your primary care provider, and received by the UCare Restricted Recipient Program. Restricted recipients may not pay out-of-pocket to go to see a non-designated provider who is the same provider type as one of their designated providers.
- Placement in the program will stay with you if you change health plans. Placement in the program will also stay with you if you change to MHCP fee-for-service. You will not lose eligibility for MHCP because of placement in the program.
- At the end of the 24 months, your use of health care services will be reviewed. If you still misused health services, you will be placed in the program for an additional 36 months of eligibility.

- You have the right to appeal placement in the Restricted Recipient Program. You must file an appeal within 60 days from the date on the notice from us. You must appeal within 30 days to prevent the restriction from being implemented during your appeal. A member may request a State Appeal (Medicaid Fair Hearing with the State) after receiving our decision that we have decided to enforce the restriction. Refer to Chapter 9 for more information about your right to appeal.
- The Restricted Recipient Program does not apply to Medicare-covered services. If you use opioid medications that you get from several doctors or pharmacies, we may talk to your doctors to make sure your use is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. Refer to Chapter 9 for more information.

Important Benefit Information for Enrollees with Chronic Conditions

- If you are diagnosed with the following chronic condition(s) identified below and meet certain medical criteria, you may be eligible for special supplemental benefits for the chronically ill.
  - Hypertension
  - Diabetes
  - Lipid disorder
  - Anxiety
  - Substance Use Disorder
- Your UCare care coordinator or UCare care navigator will confirm your substance use disorder diagnosis and obtain an authorization for you.
- Please go to the “Special Supplemental Benefits for the Chronically Ill” row in the below Medical Benefits Chart for further detail.
- Please contact us to find out exactly which benefits you may be eligible for.

 You will find this apple next to the preventive services in the benefits chart.

* You will see this asterisk next to services that may require a prior authorization.

Medical Benefits Chart

Services that are covered for you	**What you must pay** when you get these services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist. Additional benefits may be covered by us through Medical Assistance (Medicaid).	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture Acupuncture services are covered when provided by a licensed acupuncturist or by another Minnesota licensed practitioner with acupuncture training and credentialing. Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. In addition, the plan will pay for up to 20 units of acupuncture services per calendar year without	$0

Services that are covered for you	**What you must pay** when you get these services
Acupuncture (continued) authorization for pain and other specific conditions. Acupuncture services are covered when provided by a licensed acupuncturist or by another Minnesota licensed practitioner with acupuncture training and credentialing. – Acupuncture services are covered for the following: – Acute and chronic pain – Depression – Anxiety – Schizophrenia – Post-traumatic stress syndrome – Insomnia – Smoking cessation – Restless legs syndrome – Menstrual disorders – Xerostomia (dry mouth) associated with the following: • Sjogren's syndrome • Radiation therapy – Nausea and vomiting associated with the following: • Postoperative procedures • Pregnancy • Cancer care	
Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	$0

Services that are covered for you	**What you must pay** when you get these services
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results. Additional benefits may be covered by us through Medical Assistance (Medicaid).	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for members age 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation	$0

Services that are covered for you	**What you must pay** when you get these services
Cardiac rehabilitation services (continued) programs that are typically more rigorous or more intense than cardiac rehabilitation programs. Additional benefits may be covered by us through Medical Assistance (Medicaid).	
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy. Additional benefits may be covered by us through Medical Assistance (Medicaid).	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months). Additional benefits may be covered by us through Medical Assistance (Medicaid).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
Care coordination A care coordinator is a nurse or social worker who is available to help you with your health care and social services needs. Your care coordinator will work with you in partnership to create a care plan to help keep you healthy and safe in your home. For example call your care coordinator when changes happen with your health, you are hospitalized unexpectedly, if you can't get to the doctor,	There is no coinsurance, copayment, or deductible for the care coordination.

Services that are covered for you	**What you must pay** when you get these services
Care coordination (continued) need a dentist, or have a health care concern. They are here to help you. If you accept care coordination, it is your responsibility to work with your care coordinator. You also have the right to refuse care coordination. If you do not want care coordination from a care coordinator, let us know. Your care coordination team will contact you to offer a health risk assessment to determine care coordination needs.	
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months Additional benefits may be covered by us through Medical Assistance (Medicaid).	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Child and Teen Checkups (C&TC) for members under 21 C&TC preventive health visits include: • Growth measurements • Health education • Health history including nutrition • Developmental Screening • Social-emotional or Mental Health Screening • Head-to-toe Physical Exam • Immunizations • Lab tests • Vision checks • Hearing checks	There is no coinsurance, copayment, or deductible for the child and teen checkups benefit.

Services that are covered for you	**What you must pay** when you get these services
Child and Teen Checkups (C&TC) for members under 21 (continued) • Oral health, including fluoride varnish application C&TC is a health care program of well-child visits for members under age 21. C&TC visits help keep members of this population healthy and can provide more support, if needed. Each visit may include one-on-one time with the healthcare provider. This gives time for questions and discussion about health needs and goals and helps young adults learn to manage their own health.	
Chiropractic services* Covered services include: • We cover only manual manipulation (adjustment) of the spine to correct subluxation – up to 24 visits per calendar year, limited to six per month. Visits exceeding 24 per calendar year or six per month require a service authorization.* • One evaluation or exam per year – covered by us through Medical Assistance (Medicaid) • Acupuncture for pain management and other specific conditions within the scope of practice by chiropractors with acupuncture training or credentialing – covered by us through Medical Assistance (Medicaid) • X-rays when needed to support a diagnosis of subluxation of the spine – covered by us through Medical Assistance (Medicaid) Not Covered Services • Other adjustments, vitamins, medical supplies, therapies and equipment from a chiropractor.	$0

Services that are covered for you	**What you must pay** when you get these services
Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy Additional benefits may be covered by us through Medical Assistance (Medicaid).	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.
Dental Services for adults except pregnant people In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover the following services through Medical Assistance (Medicaid): Diagnostic services including: • Comprehensive exam (once every five years) (cannot be performed on same date as a periodic or limited evaluation) • Periodic exam (once per calendar year) (cannot be performed on same date as a periodic or limited evaluation) • Limited (problem focused) exams (once per day) (cannot be performed on same date as a periodic or	$0

Services that are covered for you	**What you must pay** when you get these services
Dental Services for adults except pregnant people (continued) comprehensive oral evaluation or dental cleaning service) • Teledentistry for diagnostic services • Imaging services, limited to: – Bitewing (once per calendar year) – Single x-rays for diagnosis of problems (four per date of service) – Panoramic (once every five years and as medically necessary; once every two years in limited situations; or with a scheduled outpatient facility or freestanding Ambulatory Surgery Center (ASC) procedure.) – Full mouth x-rays (once every five years and only when provided in an outpatient hospital or freestanding Ambulatory Surgical Center (ASC) as part of the outpatient dental surgery) Preventive services including: • Dental cleaning(s) (limited to two per calendar year up to four times per year if medically necessary) • Fluoride varnish (once per calendar year) (cannot be performed on same date as emergency treatment of dental pain service) • Cavity treatment (once per tooth per six months) (cannot be performed on same date as fluoride varnish service or emergency treatment of dental pain service) Restorative services including: • Fillings (limited to once per 90 days per tooth) • Sedative fillings for relief of pain (cannot be performed on same date as emergency treatment of dental pain service) • Endodontics (Root canals) (on anterior teeth and premolars only and once per tooth per lifetime; retreatment is not covered)	

Services that are covered for you	**What you must pay** when you get these services
Dental Services for adults except pregnant people (continued) • Oral surgery* (limited to extractions, removal of impacted teeth or tooth roots, biopsies and incision and drainage of abscess) Periodontics including: • Gross removal of plaque and tartar (full mouth debridement) (once every five years) (cannot be performed on same date as dental cleaning service, comprehensive exam, oral evaluation or periodontal evaluations service) • Scaling and root planing (cannot be performed on same date as dental cleaning or full mouth debridement) (once every two years for each quadrant) – Follow-up procedures (periodontal maintenance) (four (4) per calendar year) Prosthodontics including: • Removable appliances (dentures and partials) (one appliance every six years per dental arch) • Adjustments, modifications, relines, repairs and rebases of removable appliances (dentures and partials) (repairs to missing or broken teeth are limited to five teeth per 180 days) • Replacement of appliances that are lost, stolen, or damaged beyond repair under certain circumstances • Replacement of partial appliances if the existing partial cannot be altered to meet dental needs • Tissue conditioning liners (once per appliance) • Precision attachments and repairs Additional general services including: • Emergency treatment for pain (once per day) • General anesthesia, deep sedation (when provided in an outpatient hospital or freestanding Ambulatory Surgery Center (ASC) as part of an outpatient dental surgery) • Extended care facility/house call in certain institutional settings including: boarding care homes, Institutions for	

Services that are covered for you	**What you must pay** when you get these services
Dental Services for adults except pregnant people (continued) Mental Diseases (IMDs), Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DDs), hospices, Minnesota Extended Treatment Options (METO), nursing facilities, skilled nursing facilities, and swing beds (a nursing facility bed in a hospital) (cannot be performed on same date as oral hygiene instruction service) • Behavioral management when necessary to ensure that a covered dental service is correctly and safely performed • Oral or IV sedation only if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center If you choose to get dental benefits from a Federally Qualified Health Center (FQHC) or a state-operated dental clinic, you will have the same benefits that you are entitled to under Medical Assistance (Medicaid). Additional dental benefits offered by UCare Connect + Medicare are only available if you go to a dental provider in UCare Connect + Medicare's provider network. We also offer a supplemental dental benefit per year for certain additional services beyond what is listed above or not covered by Medical Assistance (Medicaid). Additional coverage limits may apply. These services include: • One additional preventive dental exam per calendar year • One comprehensive oral evaluation per calendar year • One panoramic x-ray per calendar year (beyond five year frequency) • One full mouth x-ray series per five years in a dental clinic • One additional topical application of fluoride varnish per calendar year, for patients at high risk of cavities • Two porcelain or porcelain fused to high noble metal crowns per calendar year	

Services that are covered for you	**What you must pay** when you get these services
Dental Services for adults except pregnant people (continued) • One dental crown repair per calendar year • One root canal per tooth per lifetime • One root canal re-treatment per tooth per lifetime • Up to four periodontal maintenance visits per calendar year • One scaling and root planing per two years • One gross removal of plaque and calculus (full mouth debridement) per calendar year • Nitrous oxide for preventive or comprehensive services, twice per year • Electric toothbrush (one every three years) • Electric toothbrush replacement heads (one package of two per year)	
Dental Services for members under age 21 and pregnant people In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover the following services through Medical Assistance (Medicaid): Diagnostic services including: • Comprehensive exam (once per five years) (cannot be performed on same date as a periodic or limited evaluation) • Periodic exam (cannot be performed on same date as a limited or comprehensive evaluation) • Limited (problem focused) exams (cannot be performed on same date as a periodic or comprehensive oral evaluation or dental cleaning) • Oral evaluation (cannot be performed on same date as full mouth debridement) • Detailed periodontal evaluation (cannot be performed on same date as full mouth debridement) • Teledentistry for diagnostic services	$0

Services that are covered for you	**What you must pay** when you get these services
Dental Services for members under age 21 and pregnant people (continued) • Imaging services, limited to: – Bitewing (once per calendar year) – Single x-rays for diagnosis of problems (four per date of service) – Panoramic (once in a five-year period except when medically necessary; once every two years in limited situations; or with a scheduled outpatient hospital or freestanding Ambulatory Surgery Center (ASC) procedure) – Full mouth x-rays (once in a five-year period) Preventive services including: • Dental cleaning(s) (limited to twice per calendar year; up to four per year as medically necessary) • Fluoride varnish (once every six months) (cannot be performed on same date as emergency treatment of dental pain service) • Sealants for children under age 21 (one every five years per permanent molar) • Cavity treatment (once per tooth per six months) (cannot be performed on same date as emergency treatment of dental pain service or fluoride varnish application) • Oral hygiene instruction service* Restorative services including: • Fillings (limited to once per 90 days per tooth) • Sedative fillings for relief of pain (cannot be performed on same date as emergency treatment of dental pain service) • Individual crowns (must be made of prefabricated stainless steel or resin) (with Prior Authorization) • Endodontics (Root canals) (anterior and premolar are limited to once per tooth per lifetime) Periodontics including:	

Services that are covered for you	**What you must pay** when you get these services
Dental Services for members under age 21 and pregnant people (continued) • Gross removal of plaque and tartar (full mouth debridement) (once per five years) cannot be performed on same date as dental cleaning service, comprehensive exam, oral evaluation or periodontal evaluation service) • Scaling and root planing (with Prior Authorization) (once every two years for each quadrant) – Follow-up procedures (periodontal maintenance) (four (4) per calendar year). Prosthodontics including: • Removable appliances (dentures, partials overdentures) (one appliance every six years per dental arch) • Adjustments, modifications, relines, repairs, and rebases of removable appliances (denture and partials) (repairs to missing or broken teeth are limited to five teeth per 180 days) • Replacement of appliances that are lost, stolen, or damaged beyond repair under certain circumstances • Replacement of partial appliances if the existing partial cannot be altered to meet dental needs • Tissue conditioning liners • Precision attachments and repairs Oral surgery including extractions* (with Prior Authorization) Orthodontics* (only when medically necessary for very limited conditions for members age 20 and younger) (with Prior Authorization) Additional general services: • Emergency treatment of dental pain • General anesthesia, deep sedation • Nitrous oxide • Extended care facility/house call in certain institutional settings including: boarding care homes, Institutions for Mental Diseases (IMDs), Intermediate Care Facilities	

Services that are covered for you	**What you must pay** when you get these services
Dental Services for members under age 21 and pregnant people (continued) for Persons with Developmental Disabilities (ICF/DDs) Hospices, Minnesota Extended Treatment Options (METO) nursing facilities, school or Head Start program, skilled nursing facilities, and swing beds (a nursing facility bed in a hospital) (cannot be performed on same date as oral hygiene instruction service) • Medications (only when medically necessary for very limited conditions) • Behavioral management when necessary to ensure that a covered dental service is correctly and safely performed • Oral bite adjustments (complete adjustments with Prior Authorization) (limited to once per day) If you begin orthodontia services, we will not require completion of the treatment plan in order to pay the provider for services received. If you are new to our health plan and have already started a dental service treatment plan (ex. Orthodontia care), please contact us for coordination of care. If you choose to get dental benefits from a Federally Qualified Health Center (FQHC) or a state-operated dental clinic, you will have the same benefits that you are entitled to under Medical Assistance (Medicaid). Additional dental benefits offered by UCare Connect + Medicare are only available if you go to a dental provider in UCare Connect + Medicare's provider network. We also offer a supplemental dental benefit per year for certain additional services beyond what is listed above or not covered by Medical Assistance (Medicaid). Additional coverage limits may apply. These services include: • One additional preventive dental exam per calendar year • One comprehensive oral evaluation per calendar year • One panoramic x-ray per calendar year • One full mouth x-ray series per five years	

Services that are covered for you	**What you must pay** when you get these services
Dental Services for members under age 21 and pregnant people (continued) • One additional topical application of fluoride varnish (beyond five year frequency), for patients at high risk of cavities • Two porcelain or porcelain fused to high noble metal crown per calendar year • One dental crown repair per calendar year • One root canal per tooth per lifetime • One root canal re-treatment per tooth per lifetime • Up to four periodontal maintenance visits per calendar year • One scaling and root planing per two years (in a dental clinic) • One gross removal of plaque and calculus (full mouth debridement) per year • Nitrous oxide for preventive or comprehensive services, twice per year • Electric toothbrush (one every three years) • Electric toothbrush replacement heads (one package of two per year)	
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals. Additional benefits may be covered by us through Medical Assistance (Medicaid).	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.

Services that are covered for you	**What you must pay** when you get these services
Diabetes screening (continued) of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months. Additional benefits may be covered by us through Medical Assistance (Medicaid).	
Diabetes self-management training, diabetic services, and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. We limit the brands and makers of diabetic supplies we will pay for. To get the list that tells you the brands and makers of diabetic supplies that we will pay for, contact Customer Service at the phone number on the back of this booklet. The most recent list of brands, makers, and suppliers is also available on our website at **ucare.org/dsnp-druglist**.	$0 Coverage for diabetes monitoring supplies is limited to specific manufacturer brands.

Services that are covered for you	**What you must pay** when you get these services
Durable medical equipment (DME) and related supplies*	
(For a definition of "durable medical equipment," refer to Chapter 12 as well as Chapter 3, Section 7 of this document.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen and oxygen equipment, nebulizers, and walkers. Additional items covered by us through Medical Assistance (Medicaid) include: • Repairs of medical equipment • Batteries for medical equipment • Medical supplies you need to take care of your illness, injury or disability • Incontinence products • Nutritional/enteral products when specific conditions are met • Family planning supplies – open access service – refer to Family Planning Services section. • Augmentative communication devices, including electronic tablets • Allergen-reducing products (for eligible members under the age of 21 who are diagnised as having poorly controlled asthma) For Diabetic Supplies refer to the "Diabetes self-management training, diabetic services and supplies" section in this benefit chart. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at **ucare.org/searchnetwork**.	$0 Your cost sharing for Medicare oxygen equipment coverage is $0 in-network every month. Your cost-sharing will not change after being enrolled for 36 months. However, after 36 months you will be responsible for the full cost. After five years from the first date of service, we will resume paying our share of the cost if applicable. If prior to enrolling in UCare Connect + Medicare, you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in UCare Connect + Medicare is $0.

Services that are covered for you	**What you must pay** when you get these services
Early Intensive Developmental Behavioral Intervention (EIDBI) Services for members under 21*	
The purpose of the EIDBI benefit is to provide medically necessary, early and intensive intervention for people with Autism Spectrum Disorder (ASD) and related conditions. The benefit is also intended to: • Educate, train and support parents and families • Promote people's independence and participation in family, school and community life • Improve long-term outcomes and the quality of life for people and their families EIDBI services are provided by enrolled EIDBI providers who have expertise in the approved modalities which include: • Applied Behavior Analysis (ABA) • Developmental, Individual Difference, Relationship-Based (DIR)/Floortime model • Early Start Denver Model (ESDM) • PLAY Project • Relationship Development Intervention (RDI) • Early Social Interaction (ESI) **Covered services include:** • Comprehensive Multi-Disciplinary Evaluation (CMDE) which is needed every three years to access EIDBI services • Individual Treatment Plan (ITP) Development (Initial) – Individual Treatment Plan (ITP) Development and Progress Monitoring • Direct Intervention: Individual and/or Group • Intervention Observation and Direction • Family/Caregiver Training and Counseling: Individual or Group • Coordinated Care Conference (one per year without authorization) • Travel time	$0

Services that are covered for you	**What you must pay** when you get these services
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are pregnant, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. This coverage is only available within the United States and its territories.	$0 If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan.
E-visits We cover E-visits as a convenient way to receive online diagnosis and treatment for minor conditions at no charge. These services are available 24/7, without an appointment, through Virtuwell® at virtuwell.com and other UCare network care systems that offer E-visits. Please see Chapter 12 for a definition of E-visit.	$0
Family planning services Federal and State law allow you to choose any doctor, clinic, hospital, pharmacy, or family planning agency to get open access services. You can get open access services from any provider, even if they are not in the Plan network. • Family planning exam and medical treatment – **open access service** • Family planning lab and diagnostic tests – **open access service**	$0

Services that are covered for you	**What you must pay** when you get these services
Family planning services (continued) • Family planning methods (for example, birth control pills, patch, ring, Intrauterine Device (IUD), injections, implants) – **open access service** • Family planning supplies with prescription (for example, condom, sponge, foam, film, diaphragm, cap) – **open access service** • Counseling and diagnosis of infertility, including related services – **open access service** • Treatment for medical conditions of infertility – **Not an open access service.** You must go to a provider in our plan's network. **Note**: This service does not include artificial ways to become pregnant. • Counseling and testing for sexually transmitted disease (STDs), AIDS and other HIV-related conditions – **open access service** – Treatment for sexually transmitted diseases (STDs) - **open access service**. – Voluntary sterilization (You must be age 21 or older and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery) - **open access service** – Genetic counseling - **open access service** – Genetic testing – **Not an open access service**. You must go to a provider in the plan network. • Treatment for AIDS and other HIV-related conditions – **Not an open access service.** You must go to a provider in the plan network Note: Our plan does not cover artificial ways to become pregnant (artificial insemination, including in vitro fertilization and related services; fertility drugs and related services), and reversal of voluntary sterilization, and sterilization of someone under conservatorship or guardianship.	

Services that are covered for you	**What you must pay** when you get these services
Health and wellness education programs UCare offers for eligible members programs to improve your health and wellbeing. Go to **ucare.org/healthwellness**, call Customer Service or talk to your care coordinator for more details. • Adult Dental Care kit and Adult Dental Refill kit options for healthy teeth and gums. • Breast pumps and resources to help with breastfeeding for new mothers. • Car seat and car seat safety education at no cost from UCare through our Seats, Education, And Travel Safety (SEATS) Program. • Childbirth, breastfeeding, and pregnancy-related education classes. • Connect to Wellness stress reduction kit: Plan covers 1 stress reduction kit per year. – Kit options include: fitness, sleep aid, dental stress reduction, and Amazon echo • Mask and Sanitizer Kit to help keep the germs away. Call UCare Customer Service at the number on the back of your ID card to order. One kit per year. • Connect to Wellness Kit with fitness and wellness tools to improve wellbeing. Call UCare Customer Service at the number on the back of your ID card to order. • WW (formerly WeightWatchers) – Access to 13 consecutive weeks of WW Workshops – 14 consecutive weeks of access to WW digital tools – No meeting registration fee required – Call UCare Customer Service or contact your care coordinator to order your WW meeting vouchers • Medication Toolkit to help make taking your medication easier. Contact your care coordinator or case manager to order.	$0

Services that are covered for you	**What you must pay** when you get these services
Health and wellness education programs (continued) • Management of Maternity Services (MOMS) program to support expectant mothers stay healthy during and after pregnancy. • Get free help to quit smoking, chewing tobacco or vaping through counseling with the Tobacco and Nicotine Quit Line. – Call the tobacco quit line at 1-855-260-9713 (this call is free) to get started today. TTY users should call 711. – Go to myquitforlife.com/ucare or download the Rally Coach Quit For Life mobile app.	
One Pass™ One Pass™ is a complete fitness solution for your body and mind, available to you at no additional cost. You'll have access to more than 23,000 participating fitness locations nationwide, plus: • More than 32,000 on-demand and live-streaming fitness classes • Workout builders to create your own workouts and walk you through each exercise • Home Fitness Kits available to members who are physically unable to visit or who reside at least 15 miles outside a participating fitness location • Personalized, online brain training program to help improve memory, attention and focus • Over 30,000 social activities, community classes, and events available for online or in-person participation Go to **ucare.org/onepass** or call 1-877-504-6830 or for TTY access use 711, 8 am – 9 pm, Monday – Friday.	$0
UCare 24/7 nurse line A telephone service provided for members that is available for access to medical and health information 24 hours a day, 7 days a week, including weekends and holidays. Call	There is no cost for this service.

Services that are covered for you	**What you must pay** when you get these services
Health and wellness education programs (continued) 1-800-942-7858 (this call is free). TTY: 1-855-307-6976 (this call is free).	
Health services • Advanced Practice Nurse services: Services provided by a nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist • Enhanced asthma care services (for eligible members under the age of 21 who are diagnosed as having poorly controlled asthma, when specific criteria are met) – Home visits to determine if there are asthma-triggers – Must be provided by a registered environmental health specialist, healthy home specialist, and lead risk assessor. You must contact one of these health care professional to help you or you can contact member services. • Behavioral Health Home: coordination of behavioral and physical health services • Certified Community Behavioral Health Clinics; services designed to integrate mental health and substance use disorder (SUD) services, and coordinate with primary care and social/community services for children with emotional disturbance (including Severe Emotional Disturbance SED) and services for adults with Serious Mental Illness (SMI) (including Serious Persistent Mental Illness (SPMI)). • Clinical trial coverage – Routine care that is provided as part of the protocol treatment of a clinical trial; is usual, customary, and appropriate to your condition; and would typically be provided outside of a clinical trial. – This includes services and items needed for the treatment of effects and complications of the protocol treatment. – For more information, please refer to Chapter 3	$0

Services that are covered for you	**What you must pay** when you get these services

Health services (continued)
 	
• Community health worker care coordination and patient education services
• Community Medical Emergency Technician (CMET) services
  – Post-hospital/post-nursing home discharge visits ordered by your primary care provider
  – Safety evaluation visits ordered by your primary care provider
• Community Paramedic: certain services provided by a community paramedic for some members. The services must be a part of a care plan ordered by your primary care provider and must meet other requirements. The services may include:
  – Health assessments
  – Chronic disease monitoring and education
  – Help with medications
  – Immunizations and vaccinations
  – Collecting lab specimens
  – Follow-up care after being treated at a hospital
  – Other minor medical procedures
• Gender Confirmation Surgery
• Health Care Home services; care coordination for members with complex or chronic health care needs.
• Hospital In-reach Community-based Service Coordination: coordination of services targeted at reducing hospital emergency department (ED) use under certain circumstances. This service addresses health, social, economic, and other needs of members to help reduce the usage of ED and other health care services.
• Medical nutrition therapy
• Services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic under a governmental unit
• Tuberculosis care management and direct observation of drug intake	

Services that are covered for you	**What you must pay** when you get these services
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. The following are covered by us through Medical Assistance (Medicaid): • Hearing aids and batteries • Repair and replacement of hearing aids due to normal wear and tear, with limits	$0
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For people who are pregnant, we cover: • Up to three screening exams during a pregnancy Additional benefits may be covered by us through Medical Assistance (Medicaid).	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home and Community Based Services Information Your SNBC care coordinator will give you information about community services. A county worker will help you find services to stay in your home or community, and help you find services to move out of a nursing home or other facility. This information can be given to you by mail, phone, or in person. If you choose to have a visit, you have the right to have friends or family present. You can designate a representative to help you make decisions. You can decide what your needs are and where you want to live. You can ask for services to best meet your needs. You can make the final decisions about your plan for services and help. You can	$0

Services that are covered for you	**What you must pay** when you get these services
Home and Community Based Services Information (continued) choose who you want to provide the services and supports from those providers available from our Plan's network. After the visit, your SNBC care coordinator will send you a copy of the service or care plan you helped put together. If you are currently on the Community Access for Disability Inclusion (CADI), Community Alternative Care (CAC), Brain Injury (BI), or the Developmental Disability (DD) waiver, your county case-manager will coordinate home health agency services with your SNBC care coordinator. If you need transition planning and coordination services to help you move to the community, you may be eligible to get Relocation Service Coordination.	
Home health agency care* Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. For Medical Assistance (Medicaid) you receive these services wherever normal life activities take you. For Medicare, you must be homebound, which means leaving home is a major effort. For both Medicare and Medical Assistance (Medicaid), covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services • Physical therapy, occupational therapy, and speech therapy • Respiratory therapy – covered by us through Medical Assistance (Medicaid) • Medical and social services • Medical equipment and supplies	$0

Services that are covered for you	**What you must pay** when you get these services
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	$0
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services related to	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not UCare Connect + Medicare.

Services that are covered for you	**What you must pay** when you get these services
Hospice care (continued) your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. <u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis</u>: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider is our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization). • If you obtain the covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare) <u>For services that are covered by UCare Connect + Medicare but are not covered by Medicare Part A or B</u>: UCare Connect + Medicare will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. <u>For drugs that may be covered by the plan's Part D benefit</u>: If these drugs are unrelated to your terminal hospice condition you pay cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5, Section 9.4 (*What if you're in Medicare-certified hospice*) **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Members age 21 and under can still receive treatment for their terminal condition in addition to hospice services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	

Services that are covered for you	**What you must pay** when you get these services
Housing Stabilization Services*	
The plan will pay for the following services for members eligible for Housing Stabilization Services: • Housing consultation services to develop a person-centered plan for people without Medical Assistance (Medicaid) case management services • Housing transition services to help you plan for, find, and move into housing • Housing sustaining services to help you maintain housing • Transportation to receive Housing Stabilization Services (within a 60 mile radius) You must have a Housing Stabilization Services eligibility assessment done and be found eligible for these services. If you need Housing Stabilization Services, you can ask for an assessment or be supported by your provider or case manager. If you have a targeted case manager, waiver case manager or care coordinator, that case manager can support you in accessing services, or you can contact a Housing Stabilization Services provider directly to help you. Department of Human Services (DHS) staff will use the results of the assessment to determine whether you meet the needs-based criteria to receive this service. DHS will send you a letter of approval or denial for Housing Stabilization Services.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered housing stabilization services.
Immunizations	
Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B and COVID-19 vaccines.

Services that are covered for you	**What you must pay** when you get these services
Immunizations (continued) • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit. You can find out more about vaccines by referring to Section 9.1.	
Inpatient hospital care* Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. For heart transplants this also includes a Ventricular Assist Device inserted as a bridge or as a destination therapy treatment. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a	$0

Services that are covered for you	**What you must pay** when you get these services
Inpatient hospital care* (continued) candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If UCare Connect + Medicare provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Inpatient services in a psychiatric hospital • Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day lifetime limit does not apply to inpatient mental	$0

Services that are covered for you	**What you must pay** when you get these services
Inpatient services in a psychiatric hospital (continued) health services provided in a psychiatric unit of a general hospital.	
Interpreter services • Spoken language interpreter services • Sign language interpreter services	$0
Medical Assistance (Medicaid) covered prescription drugs • Our Plan will cover some Medical Assistance (Medicaid) covered drugs that are not covered by Medicare Parts B and D. These include some over-the-counter products, some prescription cough and cold medicines and some vitamins. • The drug must be on our covered drug list (formulary). We will cover a non-formulary drug if your doctor shows us that: 1) the drug that is normally covered has caused a harmful reaction to you; 2) there is a reason to believe the drug that is normally covered would cause a harmful reaction; or 3) the drug prescribed by your doctor is more effective for you than the drug that is normally covered. The drug must be in a class of drugs that is covered. If pharmacy staff tells you the drug is not covered and asks you to pay, ask them to call your doctor. We cannot pay you back if you pay for it. There may be another drug that will work that is covered by our Plan. If the pharmacy won't call your doctor, you can. You can also call our Plan Customer Service at the phone number printed on the back cover of this document.	$0

Services that are covered for you	**What you must pay** when you get these services
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year. Additional benefits may be covered by us through Medical Assistance (Medicaid).	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B prescription drugs* These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services	$0 Part B drugs may be subject to Step Therapy.

Services that are covered for you	**What you must pay** when you get these services
Medicare Part B prescription drugs* (continued) • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens (Allergy shots) • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: **ucare.org/searchdruglist**. We also cover some vaccines under our Part B and Part D prescription drug benefit. Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.	
Nursing home services* Our Plan is responsible for paying a total of 100 days of nursing home services. This includes health care and room and board. If you continue to live in the nursing home beyond the 100 days, the Minnesota Department of Human Services (DHS) will pay directly for your nursing home room and board. Our Plan will continue to be responsible for your health care.	$0

Services that are covered for you	**What you must pay** when you get these services
Nursing home services* (continued) If you are enrolled into SNBC while living in the nursing home, DHS, not our Plan, will continue to pay for your nursing home room and board. Medical Assistance (Medicaid) will cover both Skilled and Non-skilled (custodial care) if you do not have Medicare. Refer to Skilled nursing facility (SNF) care for additional nursing home coverage covered by us through Medicare.	
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more. Additional benefits may be covered by us through Medical Assistance (Medicaid).	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Obstetrics and Gynecology (OB/GYN) services **Covered Services:** • Prenatal, delivery, and postpartum care • Childbirth classes • HIV counseling and testing for pregnant people – **open access service** • Treatment for HIV-positive pregnant people • Testing and treatment of sexually transmitted diseases (STDs) – **open access service** • Pregnancy-related services received in connection with an abortion (does not include abortion-related services) • Doula services by a certified doula supervised by either a physician, nurse practitioner, or certified nurse midwife	$0

Services that are covered for you	**What you must pay** when you get these services
Obstetrics and Gynecology (OB/GYN) services (continued) and registered with the Minnesota Department of Health (MDH) • Services provided by a licensed health professional at licensed birth centers, including services of certified nurse midwives and licensed traditional midwives **Not Covered Services:** • Abortion: This service is not covered under the Plan. It may be covered by the state. Call the Minnesota Health Care Programs Member Helpdesk at 651-431-2670 or 1-800-657-3739 (toll free) or 711 (TTY) or use your preferred relay service. Also refer to Section 9. • Planned home births You have "direct access" to OB-GYN providers for the following services: annual preventive health exam, including follow-up exams that your qualified health care provider says are necessary; maternity care; evaluation and treatment for gynecologic conditions or emergencies. To get the direct access services, you must go to a provider in the Plan network. For services labeled as open access, you can go to any qualified health care provider clinic, hospital, pharmacy, or family planning agency.	
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy	$0

Services that are covered for you	**What you must pay** when you get these services
Opioid treatment program services (continued) • Toxicology testing • Intake activities • Periodic assessments	
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Allergy immunotherapy and allergy testing • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Diagnostic radiology services (for example: MRI, CT and PET scans) • Other outpatient diagnostic tests	$0
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient. Even if	$0

Services that are covered for you	**What you must pay** when you get these services
Outpatient hospital observation (continued) you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself* **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff.	$0

Services that are covered for you	**What you must pay** when you get these services
Outpatient hospital services (continued) You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Outpatient mental health care* Covered services include: • Certified Community Behavioral Health Clinic (CCBHC) • Clinical Care Consultation • Crisis response services including: – Screening – Assessment – Intervention – Stabilization including residential stabilization – Community intervention • Diagnostic assessments including screening for the presence of co-occurring mental illness and substance use disorders • Dialectical Behavioral Therapy (DBT) Intensive Outpatient Program (IOP) for adult members age 18 or older • Forensic Assertive Community Treatment (FACT) (for members age 18 or older) • Mental health provider travel time • Mental health targeted case management (MH-TCM) • Outpatient mental health services including: – Explanation of findings – Family psychoeducation services (for members under age 21) – Mental health medication management	$0

Services that are covered for you	**What you must pay** when you get these services
Outpatient mental health care* (continued) – Neuropsychological services – Psychotherapy (patient and/or family, family, crisis, and group) • Psychological testing • Physician Mental Health Services including: – Health and behavior assessment/intervention – Inpatient visits – Psychiatric consultations to primary care providers – Physician consultation, evaluation, and management • Rehabilitative Mental Health Services including: – Assertive Community Treatment (ACT) – Adult Day Treatment – Adult Rehabilitative Mental Health Services (ARMHS) – Certified Family Peer Specialist (for members under age 21) – Certified Peer Specialist (CPS) support services in limited situations – Children's Therapeutic Services and Supports (CTSS) including Children's Day Treatment (for members under age 21) – Family psychoeducation services (for members under age 21) – Intensive Residential Treatment Services (IRTS) – Intensive Rehabilitation Mental Health Services (IRMHS) (for members age 18 through 20) – Intensive Treatment Foster Care Services (for members under age 21) – Youth Assertive Community Treatment (Youth ACT): intensive non-residential rehabilitative mental health services (for members ages 18 through 25) • Psychiatric Residential Treatment Facility (PRTF) for members ages 21 and under • Telemedicine	

Services that are covered for you	**What you must pay** when you get these services
Outpatient mental health care* (continued) **Not Covered Services:** • Conversion therapy	
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Respiratory therapy is covered by us through Medical Assistance (Medicaid). Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	$0
Outpatient substance use disorder (SUD) services Services covered by us through Medical Assistance (Medicaid) include: • Screening/Assessment/Diagnosis • Outpatient treatment • Inpatient hospital • Residential non-hospital treatment • Outpatient methadone treatment • Detoxification (only when inpatient hospitalization is medically necessary because of conditions resulting from injury or accident or medical complications during detoxification) • SUD Treatment Coordination • Peer Recovery Support • Withdrawal Management A qualified assessor who is a part of the Plan network will decide what type of substance use disorder care you need. You may get a second assessment if you do not agree with the first one. To get a second assessment you must send us a request.	$0

Services that are covered for you	**What you must pay** when you get these services
Outpatient substance use disorder (SUD) services (continued) We must get your request within five working days of when you get the results of your first assessment or before you begin treatment (whichever is first). We will cover a second assessment by a different qualified assessor. We will do this within five working days of when we get your request. If you agree with the second assessment, you may access services according to substance use disorder standards and the second assessment. You have the right to appeal. Refer to Chapter 9.	
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers* **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient. Even if you stay in the hospital overnight, you might still be considered an "outpatient."	$0
Partial hospitalization services "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	$0
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory	$0

Services that are covered for you	**What you must pay** when you get these services
Physician/Practitioner services, including doctor's office visits (continued) surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP OR specialist, if your doctor orders it to find out if you need medical treatment • Certain telehealth services, including those for: – Medicare-approved services, including urgently needed services, primary care provider and specialist visits, individual and group mental health sessions, podiatry services, diagnostic procedures and tests, dialysis services, kidney disease education services and eye exams. – You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: – You have an in-person visit within 6 months prior to your first telehealth visit – You have an in-person visit every 12 months while receiving these telehealth services – Exceptions can be made to the above for certain circumstances	

Services that are covered for you	**What you must pay** when you get these services
Physician/Practitioner services, including doctor's office visits (continued) • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: – You're not a new patient **and** – The check-in isn't related to an office visit in the past 7 days **and** – The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: – You're not a new patient **and** – The evaluation isn't related to an office visit in the past 7 days **and** – The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) For other dental services covered by us through Medical Assistance (Medicaid), refer to the Dental Services section. • Preventive and physical exams – covered by us through Medical Assistance (Medicaid) • Family Planning – open access service covered by us through Medical Assistance (Medicaid). For more information refer to Family Planning section.	

Services that are covered for you	**What you must pay** when you get these services
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs Additional benefits may be covered by us through Medical Assistance (Medicaid). We also offer supplemental routine foot care of one visit per month not related to a specific diagnosis already covered by Medicare.	$0
Post-discharge medication reconciliation Medication reconciliation is an important part of post-discharge care if you take prescription medications. We offer post-discharge medication reconciliation given by a pharmacist after discharge from an inpatient facility. They will review discharge instructions and medications with you to make sure you understand. They will also coordinate your discharge medications with the medications you were taking before your inpatient stay.	$0
Prostate cancer screening exams For men aged 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test Additional benefits may be covered by us through Medical Assistance (Medicaid).	There is no coinsurance, copayment, or deductible for an annual digital rectal exam and PSA test.

Services that are covered for you	**What you must pay** when you get these services
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – refer to "Vision Care" later in this section for more detail. Additional items covered by us through Medical Assistance (Medicaid) include: orthotics, wigs for people with alopecia areata and some shoes when a part of a leg brace or when custom molded.	$0
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	$0
Screening and counseling to reduce alcohol misuse We cover one annual alcohol misuse screening for adults with Medicare (including pregnant people) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

Services that are covered for you	**What you must pay** when you get these services
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are:** people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant people and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

Services that are covered for you	**What you must pay** when you get these services
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs (continued) provider and take place in a primary care setting, such as a doctor's office.	
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs."	$0

Services that are covered for you	**What you must pay** when you get these services
Skilled nursing facility (SNF) care for additional nursing facility care covered by us through Medical Assistance (Medicaid), refer to Nursing Home Services*	
(For a definition of "skilled nursing facility care," refer to Chapter 12 of this document. Skilled nursing facilities are sometimes called "SNFs.")	$0
No prior hospital stay is required. You are covered for up to 100 days each benefit period for inpatient services in a SNF, in accordance with Medicare guidelines.	
Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services	
Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to get your care from a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went	

Services that are covered for you	**What you must pay** when you get these services
Skilled nursing facility (SNF) care for additional nursing facility care covered by us through Medical Assistance (Medicaid), refer to Nursing Home Services* (continued) to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse is living at the time you leave the hospital	
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. Additional benefits may be covered by us through Medical Assistance (Medicaid).	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Resources to Quit Smoking or Vaping The Tobacco and Nicotine Quit Line helps members learn to live without tobacco or nicotine at no charge. Coaches offer personalized support and tools such as: • One-on-one phone coaching • A quit guide • Quit aids such as nicotine patches and gum • A Website and mobile app for online support, text tips and reminders • Resources and medication options that can help fight cravings	$0 Over-the-Counter (OTC) nicotine replacement therapy products (gum, lozenges, non-prescription patches) are available to members who participate in the Tobacco and Nicotine Quit Line.

Services that are covered for you	**What you must pay** when you get these services
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) (continued) Call the Tobacco and Nicotine Quit Line at 1-855-260-9713 (this call is free) to get started today. TTY users call 711. Or go to myquitforlife.com/ucare.	
Special Supplemental Benefits for the Chronically Ill • The plan covers up to one round-trip ride per day to an Alcoholics Anonymous or Narcotics Anonymous meeting for members assessed as having substance use disorder.* • The Plan covers a nutritional food allowance up to $30 per month for members with hypertension, diabetes or lipid disorders.	$0
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques	$0

Services that are covered for you	**What you must pay** when you get these services
Supervised Exercise Therapy (SET) (continued) SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	
Telemonitoring The use of technology to provide care and support to a member's complex health needs from a remote location such as in a member's home. Telemonitoring can track a member's vital signs using a device or equipment that sends the data electronically to their provider for review. Examples of vital signs that can be monitored remotely include heart rate, blood pressure, and blood glucose levels. Telemonitoring is covered for members with high-risk, medically complex conditions like congestive heart failure, chronic obstructive pulmonary disease (COPD) or diabetes (when medically neccessary).	$0
Transportation services If you need transportation to and from health services that we cover, call HealthRide at 612-676-6830 or 1-800-864-2157 (this call is free), TTY: 612-676-6810 or 1-800-688-2534 (this call is free). HealthRide hours are 7 am – 8 pm, Monday – Friday. We will provide the most appropriate and cost-effective transportation. The Plan is not required to provide transportation to your Primary Care Clinic if it is over 30 miles from your home or if you choose a Specialty provider that is more than 60 miles from your home. Call 612-676-6830 or 1-800-864-2157 (this call is free) if you do not have a primary care clinic that is available within 30 miles of your home and/or you do not have a specialty provider available within 60 miles of your home.	$0

Services that are covered for you	**What you must pay** when you get these services
Transportation services (continued) Covered services: – Volunteer driver transport – Unassisted transport (taxi or public transit) – Assisted transport – Lift-equipped/ramp transport – Protected transport – Stretcher transport Note: Our plan does not cover mileage reimbursement (for example, when you use your own car), meals, lodging, and parking also including out of state travel. These services are not covered under the Plan but may be available through the local county or tribal agency. Call your local county or tribal agency for more information. We also provide a supplemental benefit of: • **Transportation Services to Participating Fitness Centers** We offer up to three round trip rides per week to a participating fitness center. • **Transportation to Alcoholics Anonymous and Narcotics Anonymous meetings** We cover one round-trip ride per day to Alcoholics anonymous and/or Narcotics Anonymous meetings for members assessed as having substance use disorder.	
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but, given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. Examples of . urgently needed services that the plan must cover out-of-network are: 1) you need immediate care during the weekend, or 2) you are temporarily outside the service area	$0

Services that are covered for you	**What you must pay** when you get these services
Urgently needed services (continued) of the plan. Services must be immediately needed and medically necessary. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider then your plan will cover the urgently needed services from a provider out-of-network. This coverage is only available within the United States and its territories.	
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts, but they are covered by us through Medical Assistance (Medicaid). • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older and Hispanic Americans who are 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) The following are covered by us through Medical Assistance (Medicaid): Eye Exams • Initial eyeglasses, when medically necessary. Selection may be limited. • Replacement eyeglasses, when medically necessary.	$0

Services that are covered for you	**What you must pay** when you get these services
Vision care (continued) • Identical replacement of covered eyeglasses for loss, theft or damage beyond repair. • Repairs to frames and lenses for eyeglasses covered under the Plan • Tinted, photochromatic (such as Transition® lenses) or polarized lenses, when medically necessary • Contact lenses, when medically necessary **Note:** Our plan does not cover an extra pair of glasses, protective coating for plastic lenses, and contact lens supplies. We also provide a supplemental benefit of: • Anti-glare lens coating, once per year • Photochromic ("transition") lens tinting, once per year • Progressive (no-line) lenses, once once per year	
"Welcome to Medicare" preventive visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.

SECTION 3 What services are covered outside of UCare Connect + Medicare?

Section 3.1 Services *not* covered by UCare Connect + Medicare

The following services are not covered by UCare Connect + Medicare but are available through Medical Assistance (Medicaid):

Other Services

The following services are not covered by us under the plan but may be available through another source, such as the state, county, federal government, or tribe. To find out more about these services, call the Minnesota Health Care Programs Member Helpdesk at 651-431-2670 or 1-800-657-3739 (toll-free).

- Case management for people with developmental disabilities
- Child welfare targeted case management
- Consumer Support Grant (CGS)
- Day training and habilitation
- HIV services under the Ryan White Act
- Home Care Nursing
- Intermediate care facility for people who have a developmental disability (ICF/DD)
- Job training and educational services
- Medical Assistance (Medicaid) covered services provided by Federally Qualified Health Centers (FQHC)
- Mileage reimbursement (for example, when you use your own car), meals, lodging, and parking. Contact your county for more information.
- Nursing home stays for which our plan is not otherwise responsible. Refer to "Nursing Home Services" in the Benefits Chart
- Personal Care Assistant (PCA) services (Community First Services and Supports (CFSS) replaces PCA services when the State of Minnesota gets Federal approval to provide this service.)
- Relocation Service Coordination (RSC)
- Room and board associated with Intensive Residential Treatment Services (IRTS)
- Room and board for substance use disorder treatment as determined necessary by substance use disorder assessment
- Services provided by a state regional treatment center, a state-owned long-term care facility.
- Services provided by federal institutions
- Treatment at Rule 36 facilities that are not licensed as Intensive Residential Treatment Services (IRTS)
- Vulnerable Adult Protective Services
- Waiver services provided under Home and Community Based Services waivers

SECTION 4 What services are not covered by Medicare?

Section 4.1 Services *not* covered by Medicare (Medicare exclusions)

This section tells you what services are "excluded" by Medicare.

The chart below describes some services and items that aren't covered by Medicare under any conditions or are covered by Medicare only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you received the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 6.3 in this document.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture Additional acupuncture services may be covered by us through Medical Assistance (Medicaid)		✓ Available for people with chronic low back pain under certain circumstances.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Cosmetic surgery or procedures		✓ • Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care (Care that helps with activities of daily living that does not require professional skills or training, e.g. bathing and dressing.) Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing. Additional services may be covered by the Minnesota Department of Human Services through Medical Assistance (Medicaid). Refer to Home and Community Based Services	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Experimental medical and surgical procedures, equipment and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.		✓ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (Refer to Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household	✓	
Full-time nursing care in your home - Covered by Minnesota Department of Human Services through Medical Assistance (Medicaid) if you are assessed by a home care agency and found eligible to need this service.	✓	
Home-delivered meals Additional services may be covered by the Minnesota Department of Human Services through Medical Assistance (Medicaid). Refer to Home and Community Based Services.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Homemaker services include basic household assistance, such as light housekeeping or light meal preparation. Additional services may be covered by the Minnesota Department of Human Services through Medical Assistance (Medicaid). Refer to Home and Community Based Services	✓	
Naturopath services (uses natural or alternative treatments)	✓	
Non-routine dental care Additional services may be covered by us through Medical Assistance (Medicaid)		✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes or supportive devices for the feet Orthopedic shoes are covered by us through Medical Assistance (Medicaid) – refer to Prosthetic devices and related supplies section for coverage information.		✓ Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Private room in a hospital		✓ Covered only when medically necessary.
Reversal of sterilization procedures and or non-prescription contraceptive supplies Non-prescription contraceptive supplies are covered by us through Medical Assistance (Medicaid)	✓	
Routine chiropractic care		✓ Manual manipulation of the spine to correct a subluxation is covered.
Routine dental care, such as cleanings, fillings or dentures Routine dental services are covered by us through Medical Assistance (Medicaid) – refer to Dental Services section for coverage information.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids. Additional vision care services including some of those listed are covered by us through Medical Assistance (Medicaid).		✓ Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Routine foot care Additional services may be covered by us through Medical Assistance (Medicaid)		✓ Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).
Routine hearing exams, hearing aids, or exams to fit hearing aids. These are covered by us through Medical Assistance (Medicaid).	✓	
Services considered not reasonable and necessary, according to Original Medicare standards	✓	

CHAPTER 5
Using the plan's coverage for Part D prescription drugs

How can you get information about your drug costs?

Because you are eligible for Medical Assistance (Medicaid), you qualify for and are getting "Extra Help" from Medicare to pay for your prescription drug plan costs. Because you are in the "Extra Help" program, **some information in this *Evidence of Coverage* about the costs for Medicare Part D prescription drugs may not apply to you**. We sent you a separate insert, called the "*Evidence of Coverage* Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Customer Service and ask for the "LIS Rider." (Phone numbers for Customer Service are printed on the back cover of this document.)

SECTION 1 Introduction

This chapter **explains rules for using your coverage for Part D drugs.** Please see Chapter 4 for Medicare Part B drug benefits and hospice drug benefits. In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medical Assistance (Medicaid) benefits.

In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medical Assistance (Medicaid) benefits. The Drug List tells you how to find out about your Medical Assistance (Medicaid) drug coverage.

Section 1.1 Basic rules for the plan's Medicare Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist or other prescriber) write you a prescription which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (Refer to Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service*.)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (Refer to Section 3, *Your drugs need to be on the plan's "Drug List."*)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (Refer to Section 3 for more information about a medically accepted indication.)

SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service

Section 2.1 Use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (Refer to Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are on the plan's Drug List.

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Provider and Pharmacy Directory*, visit our website (**ucare.org/searchnetwork**) and/or call Customer Service.

You may go to any of our network pharmacies.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another pharmacy in your area, you can get help from Customer Service or use the *Provider and Pharmacy Directory*. You can also find information on our website at **ucare.org/searchnetwork**.

What if you need a specialized pharmacy?

Some prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy. A home infusion pharmacy supplies the drugs for home infusion therapy, but does not administer the therapy. Our plan will cover drugs for home infusion therapy if:
  - Your prescription drug is on the plan's Drug List or a formulary exception has been granted for your prescription drug.
  - Your prescription is written by an authorized prescriber.

  Please refer to your *Provider and Pharmacy Directory* to find a home infusion pharmacy in your area. For more information, contact Customer Service.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you are in an LTC

facility, we must ensure that you are able to routinely receive your Medicare Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Customer Service.

- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Provider and Pharmacy Directory* or call Customer Service.

Section 2.3 Using the plan's mail-order service

For certain kinds of drugs, you can use the plan's network mail-order service. Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition.

Our plan's mail-order service allows you to order **up to a 90-day supply**.

To get information about filling your prescriptions by mail, call Customer Service. If you use a mail-order pharmacy that is not in the plan network, your prescription will not be covered.

Usually, a mail-order pharmacy order will be delivered to you in no more than 14 days. However, sometimes your mail-order may be delayed. If your mail-order is delayed, call Customer Service to find out how to fill your prescription.

New prescriptions the pharmacy receives directly from your doctor's office.

The pharmacy will automatically fill and deliver new prescriptions it receives from health care providers, without checking with you first, if either:

- You used mail-order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You may request automatic delivery of all prescriptions at any time by calling Express Scripts Mail Order Pharmacy at 1-877-567-6320 (this call is free). TTY users call 1-800-716-3231 (this call is free).

If you receive a prescription automatically by mail that you do not want, and you were not contacted to find out if you wanted it before it shipped, you may be eligible for a refund.

If you used mail order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact Express Scripts Mail Order Pharmacy at 1-877-567-6320 (this call is free). TTY users call 1-800-716-3231 (this call is free).

If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to find out if you want the medication filled and shipped immediately. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or cancel the new prescription.

Section 2.4 How can you get a long-term supply of drugs?

The plan offers two ways to get a long-term supply (also called an "extended supply") of "maintenance" drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Provider and Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Service for more information.
2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. **Please check first with Customer Service** to see if there is a network pharmacy nearby. You will most likely be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

1. *In case of a medical emergency.*

   We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care.

2. *Other situations.*

   We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:

- If you are unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
- If you are trying to fill a covered prescription drug that is not regularly stocked at an eligible network retail or mail-order pharmacy. (These drugs include orphan drugs or other specialty pharmaceuticals.)
- If you are traveling within the U.S., but outside the service area, and you become ill, lose or run out of your prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules and a network pharmacy is not available. We cannot pay for any prescriptions that are filled outside the U.S., even for a medical emergency.

If the Governor of Minnesota, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to coverage. Please visit **ucare.org/important-coverage-information** for important information about coverage during a declared disaster.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

We do not allow UCare Connect + Medicare providers to bill you for services. We pay our providers directly, and we protect you from any charges. If you pay for a Medical Assistance (Medicaid)-covered drug, we cannot pay you back. The exception is if you pay for Medicare Part D prescription drugs. If you paid for a Medicare Part D prescription drug that you think we should have covered, contact Customer Service at the phone number printed on the back cover of this document.

SECTION 3 Your drugs need to be on the plan's "Drug List"

Section 3.1 The "Drug List" tells which Medicare Part D drugs are covered

The plan has a *"List of Covered Drugs (Formulary)."* In this *Evidence of Coverage*, **we call it the "Drug List" for short**.

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

The Drug List includes the drugs covered under Medicare Part D. In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medical

Assistance (Medicaid) benefits. The Drug List tells you how to find out about your Medical Assistance (Medicaid) drug coverage.

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is *either*:

- approved by the Food and Drug Administration for the diagnosis or condition for which it is being prescribed.
- -- *or* -- supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

The Drug List includes both brand name drugs, generic drugs, and biosimilars.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the drug list, when we refer to "drugs," this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or biological product and usually costs less. There are generic drug substitutes or biosimilar alternatives available for many brand name drugs and some biological products.

Over-the-Counter Drugs

Our plan also covers certain over-the-counter drugs. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. For more information, call Customer Service.

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, refer to Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the Drug List. In some cases, you may be able to obtain a drug that is not on the drug list. For more information, please see Chapter 9.

Section 3.2 There is one "cost-sharing tier" for drugs on the Drug List

Every drug on the plan's Drug List is in a cost-sharing tier. In general, what you pay for a drug depends on whether the drug is a generic or brand drug:

- Tier 1 Generic drugs have the lowest copay
- Tier 1 Brand drugs have a higher copay

To find out which cost sharing tier your drug is in, look it up in the plan's Drug List.

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6 (*What you pay for your Part D prescription drugs*).

Section 3.3 How can you find out if a specific drug is on the Drug List?

You have three ways to find out:

1. Check the most recent Drug List we provided electronically.
2. Visit the plan's website (**ucare.org/dsnp-druglist**). The Drug List on the website is always the most current.
3. Call Customer Service to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective ways. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. If a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option.

Please note that sometimes a drug may appear more than once on our drug list. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

The sections below tell you more about the types of restrictions we use for certain drugs.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. Contact Customer Service to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the

restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9)

Restricting brand name drugs when a generic version is available

Generally, a "generic" drug works the same as a brand name drug and usually costs less. **In most cases, when a generic version of a brand name drug is available, our network pharmacies will provide you the generic version instead of the brand name drug.** However, if your provider has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called "**prior authorization**." This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, and Drug A is less costly, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called "**step therapy**."

Quantity limits

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

There are situations where there is a prescription drug you are taking, or one that you and your provider think you should be taking, that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.

- The drug is covered, but there are extra rules or restrictions on coverage for that drug, as explained in Section 4.
- There are things you can do if your drug is not covered in the way that you'd like it to be covered.
- If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.

Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

If your drug is not on the Drug List or is restricted, here are options:

- You may be able to get a temporary supply of the drug.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change in coverage and decide what to do.

To be eligible for a temporary supply, the drug you have been taking **must no longer be on the plan's Drug List** OR **is now restricted in some way**.

- **If you are a new member,** we will cover a temporary supply of your drug during the first 90 days of your membership in the plan.
- **If you were in the plan last year,** we will cover a temporary supply of your drug during the first 90 days of the calendar year.
- This temporary supply will be for a maximum of 30 days at a retail pharmacy and 31 days from a long-term care (LTC) pharmacy. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 30 days at a retail pharmacy and 31 days from a long-term care (LTC) pharmacy of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in the plan for more than 90 days and reside in a long-term care facility and need a supply right away:**

We will cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.

- **For those who are a current member of the plan and transitioning to a different level of care:**

  We will cover one 31-day supply, or less if your prescription is written for fewer days. If you are a current member, admitted or discharged from a long-term care facility, you will be allowed "refill-too-soon" overrides to ensure that you have access to an adequate supply of your medications.

For questions about a temporary supply, call Customer Service.

During the time when you are using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have two options:

1) You can change to another drug

Talk with your provider about whether there is a different drug covered by the plan that may work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

2) You can ask for an exception

You and your provider can ask the plan to make an exception and cover the drug in the way you would like it covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you and your provider want to ask for an exception, Chapter 9, Section 7.4 tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan can make some changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List.**
- **Add or remove a restriction on coverage for a drug.**
- **Replace a brand name drug with a generic drug.**

We must follow Medicare requirements before we change the plan's Drug List.

Section 6.2 What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List on a regularly scheduled basis. Below we point out the times that you would get direct notice if changes are made to a drug that you are taking.

Changes to your drug coverage that affect you during the current plan year

- **A new generic drug replaces a brand name drug on the Drug List (or we change the cost-sharing tier or add new restrictions to the brand name drug or both)**
  - We may immediately remove a brand name drug on our Drug List if we are replacing it with a newly approved generic version of the same drug. The generic drug will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. We may decide to keep the brand name drug on our Drug List, but immediately move it to a higher cost-sharing tier or add new restrictions or both when the new generic is added.
  - We may not tell you in advance before we make that change—even if you are currently taking the brand name drug. If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s). This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.
  - You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, refer to Chapter 9.
- **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market**
  - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you are taking that drug, we will tell you right away.
  - Your prescriber will also know about this change, and can work with you to find another drug for your condition.
- **Other changes to drugs on the Drug List**
  - We may make other changes once the year has started that affect drugs you are taking. For example, we might add a generic drug that is not new to the market to

replace a brand name drug on the Drug List or change the cost-sharing tier or add new restrictions to the brand name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.

- For these changes, we must give you at least 30 days' advance notice of the change or give you notice of the change and a 30-day refill of the drug you are taking at a network pharmacy.
- After you receive notice of the change, you should work with your prescriber to switch to a different drug that we cover to satisfy any new restrictions on the drug you are taking.
- You or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, refer to Chapter 9.

Changes to the Drug List that do not affect you during this plan year

We may make certain changes to the Drug List that are not described above. In these cases, the change will not apply to you if you are taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that will not affect you during the current plan year are:

- We put a new restriction on your use of the drug.
- We remove your drug from the Drug List.

If any of these changes happen for a drug you are taking (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't find any increase in your payments or any added restrictions to your use of the drug.

We will not tell you about these types of changes directly during the current plan year. You will need to check the Drug List for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to the drugs you are taking that will impact you during the next plan year.

SECTION 7 What types of drugs are *not* covered by the plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means neither Medicare nor Medical Assistance (Medicaid) pays for these drugs.

If you appeal and the requested drug is found not to be excluded under Part D we will pay for or cover it. (For information about appealing a decision, go to Chapter 9.) If the drug excluded by our plan is also excluded by Medical Assistance (Medicaid), you must pay for it yourself.

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States or its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
  - Coverage for "off-label use" is allowed only when the use is supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

In addition, by law, the following categories of drugs listed below are not covered by Medicare or Medical Assistance (Medicaid).

- Drugs used to promote fertility
- Drugs used for cosmetic purposes or to promote hair growth
- Drugs used for the treatment of sexual or erectile dysfunction
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

SECTION 8 Filling a prescription

Section 8.1 Provide your membership information

To fill your prescription, provide your plan membership information, which can be found on your membership card, at the network pharmacy you choose. The network pharmacy will automatically bill the plan for *our* share of your drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

Section 8.2 What if you don't have your membership information with you?

If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then **ask us to reimburse you** for our share. Refer to Chapter 7, Section 2.1 for information about how to ask the plan for reimbursement.)

We do not allow UCare Connect + Medicare providers to bill you for services. We pay our providers directly, and we protect you from any charges. If you pay for a Medical Assistance (Medicaid)-covered drug, we cannot pay you back. The exception is if you pay for Medicare Part D prescription drugs. If you paid for a Medicare Part D prescription drug that you think we should have covered, contact Customer Service at the phone number printed on the back cover of this document.

SECTION 9 Medicare Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this Chapter.

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or uses a pharmacy that supplies drugs for all of its residents. If you are a resident of a LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it is part of our network.

Check your *Provider and Pharmacy Directory* to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Customer Service. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies.

What if you're a resident in a long-term care (LTC) facility and need a drug that is not on our Drug List or is restricted in some way?

Please refer to Section 5.2 about a temporary or emergency supply.

Section 9.3 What if you're also getting drug coverage from an employer or retiree group plan?

If you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact **that group's benefits administrator.** He or she can help you determine how your current prescription drug coverage will work with our plan.

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be *secondary* to your group coverage. That means your group coverage would pay first.

Special note about 'creditable coverage':

Each year your employer or retiree group should send you a notice that tells if your prescription drug coverage for the next calendar year is "creditable".

If the coverage from the group plan is "**creditable,**" it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

Keep this notice about creditable coverage because you may need it later. If you enroll in a Medicare plan that includes Medicare Part D drug coverage, you may need this notice to show that you have maintained creditable coverage. If you didn't get the creditable coverage notice, request a copy from your employer or retiree plan's benefits administrator or the employer or union.

Section 9.4 What if you're in Medicare-certified hospice?

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea, laxative, pain medication or antianxiety drugs) that are not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking
- Unsafe amounts of opioid pain medications

If we find a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain doctor(s)

- Limiting the amount of opioid or benzodiazepine medications we will cover for you

If we plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will explain the limitations we think should apply to you. You will have an opportunity to tell us which doctors or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our determination or with the limitation, you and your prescriber have the right to appeal. If you appeal, we will review your case and give you a decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 9 for information about how to ask for an appeal.

You will not be placed in our DMP if you have certain medical conditions, such as active cancer-related pain or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.3 Medication Therapy Management (MTM) and other programs to help members manage their medications

We have programs that can help our members with complex health needs. One program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the programs for us to help make sure that our members get the most benefit from the drugs they take.

Some members who take medications for different medical conditions and have high drug costs, or are in a DMP to help members use their opioids safely, may be able to get services through an MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about these programs, please contact Customer Service.

CHAPTER 6

What you pay for your Part D prescription drugs

How can you get information about your drug costs?

Because you are eligible for Medical Assistance (Medicaid), you qualify for and are getting "Extra Help" from Medicare to pay for your prescription drug plan costs. Because you are in the "Extra Help" program, **some information in this *Evidence of Coverage* about the costs for Medicare Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "*Evidence of Coverage* Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Customer Service and ask for the "LIS Rider."

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs – some drugs are excluded from Part D coverage by law. Some of the drugs excluded from Part D coverage are covered under Medicare Part A or Part B or under Medical Assistance (Medicaid).

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5, Sections 1 through 4 explain these rules.

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

There are different types of out-of-pocket costs for Part D drugs. The amount that you pay for a drug is called "cost sharing," and there are two ways you may be asked to pay.

- The "**deductible**" is the amount you must pay for drugs before our plan begins to pay its share.
- "**Copayment**" is a fixed amount you pay each time you fill a prescription.
- "**Coinsurance**" is a percentage of the total cost you pay each time you fill a prescription.

Section 1.3 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what does not count as your out-of-pocket costs.

Here are the rules we must follow to keep track of your out-of-pocket costs.

These payments are included in your out-of-pocket costs

Your out-of-pocket costs include the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5):

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $7,400 in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments are not included in your out-of-pocket costs

Your out-of-pocket costs, **do not include** any of these types of payments:

- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Non-Medicare Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.

- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and Veterans Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan by calling Customer Service.

How can you keep track of your out-of-pocket total?

- **We will help you.** The Part D EOB report you receive includes the current amount of your out-of-pocket costs. When this amount reaches $7,400, this report will tell you that you have left the Initial Coverage Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug

Section 2.1 What are the drug payment stages for UCare Connect + Medicare members?

There are four "drug payment stages" for your prescription drug coverage under UCare Connect + Medicare. How much you pay depends on what stage you are in when you get a prescription filled or refilled. Details of each stage are in Sections 4 through 7 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Coverage Gap Stage

Stage 4: Catastrophic Coverage Stage

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly summary called the "*Part D Explanation of Benefits*" (the "Part D EOB")

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your "**out-of-pocket**" cost.
- We keep track of your "**total drug costs.**" This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

If you have had one or more prescriptions filled through the plan during the previous month, we will send you a *Part D Explanation of Benefits* ("Part D EOB"). The Part D EOB includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1**. This is called "year-to-date" information. It shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This information will display the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other available drugs with lower cost sharing for each prescription claim.

Section 3.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card when you get a prescription filled.** This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep

track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of these receipts. Here are examples of when you should give us copies of your drug receipts:

- When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
- When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
- Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this go to Chapter 7, Section 2.

- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive the Part D EOB in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Customer Service. You may request to receive your Part D Explanation of Benefits (Part D EOB) reports online by logging into www.Express-Scripts.com. Be sure to keep these reports.

SECTION 4 There is no deductible for UCare Connect + Medicare

Section 4.1 You do not pay a deductible for your Medicare Part D drugs

There is no deductible for UCare Connect + Medicare. You begin in the Initial Coverage Stage when you fill your first prescription of the year. Refer to Section 5 for information about your coverage in the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has cost-sharing tiers

Every drug on the plan's Drug List is in a cost-sharing tier. In general, what you pay for a drug depends on whether the drug is a generic or brand drug:

- Tier 1 Generic drugs have the lowest copay
- Tier 1 Brand drugs have a higher copay

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A network retail pharmacy
- A pharmacy that is not in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 to find out when we will cover a prescription filled at an out-of-network pharmacy.
- The plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, refer to Chapter 5 and the plan's *Provider and Pharmacy Directory*.

Section 5.2 A table that shows your costs for a *one-month* supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

As shown in the table below, the amount of the copayment or coinsurance depends on the cost-sharing tier.

Sometimes the cost of the drug is lower than your copayment or coinsurance. In these cases, you pay the lower price for the drug instead of the copayment or coinsurance.

Your share of the cost when you get a *one-month* supply of a covered Medicare Part D prescription drug:

Tier	Standard retail cost sharing (in-network) (up to a 30-day supply)	Mail-order cost sharing (up to a 30-day supply)	Long-term care (LTC) cost sharing (up to a 31-day supply)	Out-of-network cost sharing (Coverage is limited to certain situations; refer to Chapter 5 for details.) (up to a 29-day supply)
Drugs in Tier 1 Generic* (Covered generic drugs)	$0/$1.45/$4.15	$0/$1.45/$4.15 depending on your income, institutional status, or if you are receiving Home and Community Based Services (disability waiver).	$0 depending on your income, institutional status, or if you are receiving Home and Community Based Services (disability waiver).	$0/$1.45/$4.15 depending on your income, institutional status, or if you are receiving Home and Community Based Services (disability waiver).
Drugs in Tier 1 Brand* (Covered brand drugs)	$0/$4.30/$10.35	$0/$4.30/$10.35 depending on your income, institutional status, or if you are receiving Home and Community Based Services (disability waiver).	$0 depending on your income, institutional status, or if you are receiving Home and Community Based Services (disability waiver).	$0/$4.30/$10.35 depending on your income, institutional status, or if you are receiving Home and Community Based Services (disability waiver).

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you are trying a medication for the first time). You can also ask your doctor

to prescribe, and your pharmacist to dispense, less than a full month's supply of your drugs, if this will help you better plan refill dates for different prescriptions.

If you receive less than a full month's supply of certain drugs, you will not have to pay for the full month's supply.

- If you are responsible for coinsurance, you pay a percentage of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you are responsible for a copayment for the drug, you will only pay for the number of days of the drug that you receive instead of a whole month. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.

Section 5.4 A table that shows your costs for a *long-term* (up to a 90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply"). A long-term supply is up to a 90-day supply.

The table below shows what you pay when you get a long-term supply of a drug.

Your share of the cost when you get a *long-term* supply of a covered Medicare Part D prescription drug:

Tier	**Standard retail cost sharing (in-network)** (up to a 90-day supply)	**Mail-order cost sharing** (up to a 90-day supply)
Drugs in Tier 1 Generic* (Covered generic drugs)	$0/$1.45/$4.15	$0/$1.45/$4.15
Drugs in Tier 1 Brand* (Covered brand drugs)	$0/$4.30/$10.35	$0/$4.30/$10.35

*Your copay depends upon your income level and institutional status.

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $7,400

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $7,400. You then move on to the Catastrophic Coverage Stage.

We offer additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will not count toward your total out-of-pocket costs.

The Part D EOB that you receive will help you keep track of how much you, the plan, and any third parties have spent on your behalf during the year. Many people do not reach the $7,400 limit in a year.

We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage. Refer to Section 1.3 on how Medicare calculates your out-of-pocket costs.

SECTION 6 There is no coverage gap for UCare Connect + Medicare

Section 6.1 You do not have a coverage gap for your Medicare Part D drugs

There is no coverage gap for UCare Connect + Medicare. Once you leave the Initial Coverage Stage, you move on to the Catastrophic Coverage Stage (refer to section 7).

SECTION 7 During the Catastrophic Coverage Stage, the plan pays all of the costs for your drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $7,400 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay all of the costs for your drugs.

SECTION 8 Part D vaccines. What you pay depends on how and where you get them

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of **the vaccine itself**.
- The second part of coverage is for the cost of **giving you the vaccine**. (This is sometimes called the "administration" of the vaccine.)

Your costs for a Part D vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for).
   - Some vaccines are considered medical benefits. (Refer to the *Medical Benefits Chart what is covered and what you pay* in Chapter 4).
   - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary)*.
2. **Where you get the vaccine**
   - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
3. **Who gives you the vaccine.**
   - A pharmacist may give the vaccine in the pharmacy or another provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccination can vary depending on the circumstances and what Drug Stage you are in.

- Sometimes when you get a vaccination, you have to pay the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get a vaccination, you will pay only your share of the cost under your Part D benefit.
- Remember, we do not allow UCare Connect + Medicare providers to bill you for services. We pay our providers directly, and we protect you from any charges. If you pay for a Medical Assistance (Medicaid)-covered drug, we cannot pay you back. The exception is if you pay for Medicare Part D prescription drugs. If you paid for a service that you think we should have covered, contact Customer Service at the phone number printed on the back cover of this document.

Below are three examples of ways you might get a Medicare Part D vaccine.

Situation 1: You get your vaccination at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to give vaccines.)

- You will have to pay the pharmacy your copayment for the vaccine itself which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccination at your doctor's office.

- When you get the vaccine, you will pay for the entire cost of the vaccine itself and the cost for the provider to give it to you..
- You can then ask our plan to our share of the cost by using the procedures that are described in Chapter 7
- You will be reimbursed the amount you paid less your normal copayment for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

Situation 3: You buy the Part D vaccine itself at your pharmacy, and then take it to your doctor's office where they give you the vaccine.

- You will have to pay the pharmacy your copayment for the vaccine itself.
- When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7 of this document.
- You will be reimbursed the amount charged by the doctor for administering the vaccine.

CHAPTER 7

Asking us to pay our share of a bill you have received for covered medical services or drugs

SECTION 1 Situations in which you should ask us to pay for your covered services or drugs

Section 1.1 If you pay for your covered services or drugs, or if you receive a bill, you can ask us for payment

Our network providers bill the plan directly for your covered services and drugs. If you get a bill for the full cost of medical care or drugs you have received, you should send this bill to us so that we can pay it. When you send us the bill, we will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

If you have already paid for a Medicare-only service or item covered by the plan such as a Medicare Part D drug, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

There may also be times when you get a bill from a provider for the full cost of medical care you have received or possibly for more than your share of cost sharing as discussed in the document., Send the bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly. If we decide not to pay it, we will notify the provider. You should never pay more than plan-allowed cost-sharing. If this provider is contracted you still have the right to treatment.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received.

1. **When you've received emergency or urgently needed medical care from a provider who is not in our plan's network**

   You can receive emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases, ask the provider to bill the plan.

   - If you pay the entire amount yourself at the time you receive the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.

   - We do not allow UCare Connect + Medicare providers to bill you for services. We pay our providers directly, and we protect you from any charges. If you pay for a Medical Assistance (Medicaid)-covered drug, we cannot pay you back. The exception is if you pay for Medicare Part D prescription drugs. If you paid for a service that you think we should have covered, contact Customer Service at the phone number printed on the back cover of this document.

- You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
  - If the provider is owed anything, we will pay the provider directly.
  - We do not allow UCare Connect + Medicare providers to bill you for services. We pay our providers directly, and we protect you from any charges. If you pay for a Medical Assistance (Medicaid)-covered drug, we cannot pay you back. The exception is if you pay for Medicare Part D prescription drugs. If you paid for a service that you think we should have covered, contact Customer Service at the phone number printed on the back cover of this booklet.

2. When a network provider sends you a bill you think you should not pay

Network providers should always bill the plan directly. But sometimes they make mistakes, and ask you to pay for your services.

- Whenever you get a bill from a network provider, send us the bill. We will contact the provider directly and resolve the billing problem.
- We do not allow UCare Connect + Medicare providers to bill you for services. We pay our providers directly, and we protect you from any charges. If you pay for a Medical Assistance (Medicaid)-covered drug, we cannot pay you back. The exception is if you pay for Medicare Part D prescription drugs. If you paid for a service that you think we should have covered, contact Customer Service at the phone number printed on the back cover of this document.

3. If you are retroactively enrolled in our plan

Sometimes a person's enrollment in the plan is retroactive. (This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your Medicare Part D covered services or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork such as receipts and bills for us to handle the reimbursement.

4. When you use an out-of-network pharmacy to get a prescription filled

If you use an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your Medicare Part D prescription. Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 5, Section 2.5 for a discussion of these circumstances.

5. When you pay the full cost for a Part D prescription because you don't have your plan membership card with you

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself. Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

6. When you pay the full cost for a Part D prescription in other situations

You may pay the full cost of the Part D prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.

- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost of the drug.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide it should be covered, we will pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 document has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or to pay a bill you have received

We do not allow UCare Connect + Medicare providers to bill you for services. We pay our providers directly, and we protect you from any charges. If you pay for a Medical Assistance (Medicaid)-covered drug, we cannot pay you back. The exception is if you pay for Medicare Part D prescription drugs. If you paid for a service that you think we should have covered, contact Customer Service at the phone number printed on the back cover of this document.

Mail your request for payment together with any bills or paid receipts to us at this address:

For medical payment requests:
Attn: DMR Department
UCare
PO Box 52
Minneapolis, MN 55440-0052

For Part D prescription drug payment requests:
Attn: Medicare Part D
Express Scripts
PO Box 14718

Lexington, KY 40512-4718

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to find out whether we should cover the service or drug and how much we owe

When we receive your request for payment for a Medicare Part D drug, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

We do not allow UCare Connect + Medicare providers to bill you for services. We pay our providers directly, and we protect you from any charges. If you pay for a Medical Assistance (Medicaid)-covered drug, we cannot pay you back. The exception is if you pay for Medicare Part D prescription drugs. If you paid for a service that you think we should have covered, contact Customer Service at the phone number printed on the back cover of this document.

- If we decide that the Medicare Part D drug is covered and you followed all the rules, we will pay for our share of the cost for the Medicare Part D drug. If you have already paid for the Medicare Part D drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider.
- If we decide that the Medicare Part D drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost of the Medicare Part D drug. We will send you a letter explaining the reasons why we are not sending the payment and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9 of this document.

CHAPTER 8
Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivites as a member of the plan

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in braille, in large print, or other alternate formats, etc.)

Your plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

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

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services. If providers in the plan's network for a specialty are not available, it is the plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, seeing a women's health specialists or finding a network specialist, please call to file a grievance with Customer Service. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Section 1.2 We must ensure that you get timely access to your covered services and drugs

You have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services. You have the right to choose where you get family planning services. You have the right to get a second opinion for medical, mental health and substance use disorder services. We do not require you to get referrals to use network providers.

You have the right to get appointments and covered services from the plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from

specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays. You have the right to get services you need 24 hours a day, seven days a week.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 tells what you can do.

Section 1.3 We must protect the privacy of your personal health information

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

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't access or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for you first*.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - We are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.
  - We and the health providers who take care of you have the right to look at information about your health care. When you enrolled in the Minnesota Health Care Program, you gave your consent for us to do this. We will keep this information private according to law.

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

You have the right to review your medical records held by the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

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

If you have questions or concerns about the privacy of your personal health information, please call Customer Service.

Section 1.4 We must give you information about the plan, its network of providers, your covered services and member rights and responsibilities

As a member of UCare Connect + Medicare, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Customer Service:

- **Information about our plan.** This includes, for example, information about the plan's financial condition. You have the right to get the results of an external quality review study from the State, if you ask for them.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network. You have the right to get the following from us, if you ask for it:
  - Whether we use a physician incentive plan that affects the use of referral services and the type(s) of incentive arrangements used;
  - Whether stop-loss protection is provided; and
  - Results of a member survey if one is required because of our physician incentive plan.
  - The professional qualifications of health care providers.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D prescription drug coverage.

- **Information about why something is not covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug is not covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.
- You have the right to make recommendations regarding the organization's member rights and responsibilities policy.

Section 1.5 We must support your right to make decisions about your care

You have the right to have a candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage. We must support your right to participate in decisions about your health care.

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

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

- **To know about all of your choices.** You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- To get help to identify services needed to help you stay in the least restrictive environment.
- To be free of restraints or seclusion used as a means of coercion, discipline, convenience or retaliation.

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

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

- Fill out a written form to **give someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "health care directives," "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. Chapter 2 tells how to find resources from the Senior LinkAge Line® at www.MinnesotaHelp.info.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital**.

- The hospital will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Office of Health Facility Complaints at 651-201-4200 or 1-800-369-7994 (this call is free). TTY users call 651-583-5090.

If you believe that a health plan did not follow the advance directive requirements, you may file a complaint with Managed Care at 651-201-5176 or 1-888-345-0823 (this call is free). TTY users call 711.

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made

You have the right to voice complaints or submit appeals about the organization for the care it provides.

If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly**.

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

You have the right to be treated with respect and dignity. If you feel that you are being treated unfairly or your rights are not being respected, there are actions you can take.

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

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, sexual orientation, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697 or call your local Office for Civil Rights.

Is it about something else?

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

- You can **call Customer Service.**
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- Or, you can **call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

- You can **call the Minnesota Department of Human Services**. For details about this agency and how to contact it, go to Chapter 2, Section 6.
- You can **call the Ombudperson for Public Managed Health Care Programs**. For details about this agency and how to contact it, go to Chapter 2, Section 6.

Section 1.8 How to get more information about your rights and responsibilities

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

- You can **call Customer Service**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- You can get help from the Minnesota Ombudsperson for Public Managed Health Care Programs for all managed care services. You can also get help from Ombudsman for Long Term Care related to long term care services, and The Office of Ombudsman for Mental Health and Developmental Disabilities regarding mental health and developmental disabilities. Contact information is in Chapter 2, Section 6 of this document.
- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

SECTION 2 You have some responsibilities as a member of the plan

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* document to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services.
  - Chapters 5 and 6 give the details aboutPart D prescription drug coverage.

- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card and your Medical Assistance (Medicaid) card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Learn as much as you can about your health problems so you can participate in developing mutually agreed upon treatment goals with your provider.
  - Establish a relationship with a Plan network primary care doctor before you become ill. This helps you and your primary care doctor understand your total health condition.
  - Establish a relationship with your care coordinator so they can assist you with getting your health care needs met.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask and get an answer you can understand.
  - Practice preventative health care. Have tests, exams, and shots recommended for you based on your age and gender.
  - Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You must continue to pay your Medicare premiums to remain a member of this plan.
  - For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug.

  - If you are required to pay the extra amount for Part D because of your higher income (as reported on your last tax return), you must continue to pay the extra amount directly to the government to remain a member of the plan.

- **If you move *within* our service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 9

What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on the type of problem you are having:

- For some problems, you need to use the **process for coverage decisions and appeals.**
- For other problems, you need to use the **process for making complaints;** also called grievances.

Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the legal terms?

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand. to make things easier, this chapter:

- Uses simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination,” or “coverage determination” or “at-risk determination,” and “independent review organization” instead of “Independent Review Entity.”
- It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to

customer service for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers and website URLs in Chapter 2, Section 3 of this document.

Medicare

You can also contact Medicare to get help. To contact Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can also visit the Medicare website (www.medicare.gov).

You can also get help and information from Medicaid

You are enrolled in Medicare and in Medicaid. If you have questions about the help you get from Medicaid, call the Minnesota Department of Human Services.

CALL
651-431-2000 (Twin Cities Metro area)
or 1-800-657-3739 (Outside the Twin Cities Metro area)

TTY
1-800-627-3529 or 711

These numbers are for people who have hearing or speaking problems. You must have special telephone equipment to call them.

WRITE
Department of Human Services of Minnesota
PO Box 64976
St. Paul, MN 55164-0976

WEBSITE
https://mn.gov/dhs

The Ombudsperson for Public Managed Health Care Programs, at the Minnesota Department of Human Services can help you file a complaint or appeal with our plan. The Ombudsperson can also help you request a State Appeal (Medicaid Fair Hearing with the state). The Ombudsperson for Long Term care can assist with long term care service issues. The Office of Ombudsman for Mental Health and Developmental Disabilities can also assist with mental

health and developmental disability related concerns. You will find the phone number for the Ombudsman in Chapter 2, Section 6 of this document.

SECTION 3 Understanding Medicare and Medical Assistance (Medicaid) complaints and appeals in our plan

You have Medicare and get assistance from Medical Assistance (Medicaid). Information in this chapter applies to **all** of your Medicare and Medical Assistance (Medicaid) benefits. This is sometimes called an "integrated process" because it combines, or integrates, Medicare and Medical Assistance (Medicaid) processes.

Sometimes the Medicare and Medical Assistance (Medicaid) processes are not combined. In those situations, you use a Medicare process for a benefit covered by Medicare and a Medical Assistance (Medicaid) process for a benefit covered by Medical Assistance (Medicaid). These situations are explained in **Section 6.4** of this chapter, "Step-by-step: How a Level 2 appeal is done."

PROBLEMS ABOUT YOUR BENEFITS

SECTION 4 Coverage decisions and appeals

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The information below will help you find the right section of this chapter for problems or complaints about **benefits covered by Medicare or Medical Assistance (Medicaid)**.

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care or prescription drugs are covered or not, the way they are covered, and problems related to payment for medical care or prescription drugs.

Yes.

Go on to the next section of this chapter, **Section 5, "A guide to the basics of coverage decisions and making appeals."**

No.

Skip ahead to **Section 11** at the end of this chapter, "**How to make a complaint about quality of care, waiting times, customer service, or other concerns.**"

SECTION 5 A guide to the basics of coverage decisions and appeals

Section 5.1 Asking for coverage decisions and making appeals: the big picture

Coverage decisions and making appeals deal with problems related to your benefits and coverage, including payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions prior to receiving services

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. We are making a coverage decision whenenver we decide what is covered for you and how much we pay. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

In some cases, we might decide a service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after a service is received, and you are not satisfied, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or "fast appeal" of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision.

In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will

send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we do not dismiss your case but say no to all or part of your Level 1 appeal, you can go on to a Level 2 appeal. The Level 2 appeal is conducted by an independent review organization that is not connected to us. (Appeals for medical services and Part B drugs will be automatically sent to the independent review organization for a Level 2 appeal – you do not need to do anything. For Part D drug appeals, if we say no to all or part of your appeal you will need to ask for a Level 2 appeal. Part D appeals are discussed further in Section 6 of this chapter). If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 9 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 5.2 How to get help when you are asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- Y**ou can call us at Customer Service**.
- **You can get free help** from your State Health Insurance Assistance Program. You may also contact the Minnesota Ombudsperson for Public Managed Health Care Programs, Ombudsman for Long Term Care, or The Office of Ombudsman for Mental Health and Developmental Disabilities for Medical Assistance (Medicaid) services. If you would like help deciding whether your problem is about Medicare benefits or Medical Assistance (Medicaid) benefits, please contact Customer Service.
- **Your doctor or other health care provider can make a request for you.** If your doctor helps with an appeal past Level 2,they will need to be appointed as your representative. Please call Customer Service and ask for the "Appointment of Representative" form. (The form is also available on Medicare'es website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf
  - For medical care, your doctor or other health care provider can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
  - If your doctor or other health provider asks that a service or item that you are already getting be continued during your appeal, you **may** need to name your doctor or other prescriber as your representative to act on your behalf.
  - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.

- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or another person to be your representative, call Customer Service and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at **ucare.org/formembers**. The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
  - While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 5.3 Which section of this chapter gives the details for your situation?

There are four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 6** of this chapter: "Your medical care: How to ask for a coverage decision or make an appeal"
- **Section 7** of this chapter: "Your Medicare Part D prescription drugs: How to ask for a coverage decision or make an appeal"
- **Section 8** of this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon"
- **Section 9** of this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (This section applies to these services only*:* home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call Customer Service (phone numbers are printed on the back cover of this booklet). You can also get help or information from government organizations such as the Minnesota Ombudsman for Public Managed Health Care Programs, Ombudsman for Long Term Care, The Office of Ombudsman for Mental Health and Developmental Disabilities or your State Health Insurance Assistance Program (Chapter 2, Section 3, of this booklet has the phone numbers for these programs).

SECTION 6 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision

Section 6.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered)*. To keep things simple, we generally refer to "medical care coverage" or "medical care" includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan. **Ask for a coverage decision. Section 6.2.**
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan. **Ask for a coverage decision. Section 6.2.**
3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care. **Make an appeal. Section 6.3.**
4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 6.5.**

   NOTE: We do not allow UCare Connect + Medicare providers to bill you for services. We pay our providers directly, and we protect you from any charges. If you pay for a Medical Assistance (Medicaid)-covered drug, we cannot pay you back. The exception is if you pay for Medicare Part D prescription drugs. If you paid for a service that you think we should have covered, contact Customer Service at the phone number printed on the back cover of this document.

5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 6.3.**

NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read Sections 8 and 9 of this chapter. Special rules apply to these types of care.

Section 6.2 Step-by-step: How to ask for a coverage decision

Legal Terms
When a coverage decision involves your medical care, it is called an "**organization determination**." A "fast coverage decision" is called an "**expedited determination.**"

Step 1: Decide if you need a "standard coverage decision" or a "fast coverage decision."

A "standard coverage decision" is usually made within 14 days or 72 hours for Part B drugs. A "fast coverage decision" is generally made within 72 hours for medical services, 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

- You may *only ask* for coverage for medical care *you have not yet received*.
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines
  - Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision
  - Explains that you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

Step 2: Ask our plan to make a coverage decision or fast coverage decision.

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions we use the standard deadlines.

This means we will give you an answer within 14 calendar days after we receive your request for a medical item or service. If your request is for a **Medicare Part B prescription drug**, we will give you an answer within 72 hours after we receive your request.

- **However,** if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- If you believe we should not take extra days, you can file a "fast complaint." We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Refer to Section 10 of this chapter for information on complaints.)

For Fast Coverage decisions we use an expedited timeframe

A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.

- **However,** if you ask for more time, or if we need more that may benefit you **we can take up to 14 more days**. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- If you believe we should not take extra days, you can file a "fast complaint". (Refer to Section 10 of this chapter for information on complaints.) We will call you as soon as we make the decision.

- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 6.3 Step-by-step: How to make a Level 1 appeal

Legal Terms
An appeal to the plan about a medical care coverage decision is called a plan "**reconsideration.**" A "fast appeal" is also called an "**expedited reconsideration.**"

Step 1: Decide if you need a "standard appeal" or a "fast appeal."

A "standard appeal" is usually made within 30 days. A "fast appeal" is generally made within 72 hours.

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor or health care provider will need to decide if you need a "fast appeal." If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.2 of this chapter.

Step 2: Ask our plan for an appeal or a fast appeal

- **If you are asking for a standard appeal, submit your standard appeal in writing.**
- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a free copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

If we told you we were going to stop or reduce services or items that you were already getting, you may be able to keep those services or items during your appeal.

- If we decided to change or stop coverage for a service or item that you currently get, we will send you a notice before taking the proposed action.
- If you disagree with the action, you can file a Level 1 appeal. We will continue covering the service or item if you ask for a Level 1 appeal within 10 calendar days of the

postmark date on our letter or by the intended effective date of the action, whichever is later.

- If you meet this deadline, you can keep getting the service or item with no changes while your Level 1 appeal is pending. You will also keep getting all other services or items (that are not the subject of your appeal) with no changes.

Step 3: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed, possibly contacting you or your doctor.

Deadlines for a "fast appeal"

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
  - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a "standard" appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item

or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- If you believe we should **not** take extra days, you can file a "fast complaint." When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, refer to **Section 11** of this chapter.)

- If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal where an independent review organization will review the appeal. Section 6.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage within 3**0 calendar days**, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug, after we receive your appeal.

- **If our plan says no to part or all of your appeal, you have additional appeal rights.**

- If we say no to part or all of what you asked for, we will send you a letter.

  - If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the independent review organization for a Level 2 appeal.

  - If your problem is about coverage of a Medicaid service or item, the letter will tell you how to file a Level 2 appeal yourself.

Section 6.4 Step-by-step: How a Level 2 appeal is done

Legal Terms
The formal name for the "Independent Review Organization" is the "**Independent Review Entity.**" It is sometimes called the "**IRE.**"

The **independent review organization is an independent organization hired by Medicare**. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

- If your problem is about a service or item that is usually **covered by Medicare**, we will automatically send your case to Level 2 of the appeals process as soon as the Level 1 appeal is complete.

- If your problem is about a service or item that is usually **covered by Medicaid**, you can file a Level 2 appeal yourself. The letter will tell you how to do this. Information is also below.

- If your problem is about a service or item that could be **covered by both Medicare and Medicaid**, you will automatically get a Level 2 appeal with the independent review organization. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Go to page 196 for information about continuing your benefits during Level 1 appeals.

- If your problem is about a service that is usually covered by Medicare only, your benefits for that service will not continue during the Level 2 appeals process with the independent review organization.

- If your problem is about a service that is usually covered by Medicaid, your benefits for that service will continue if you submit a Level 2 appeal within 10 calendar days after receiving the plan's decision letter.

If your problem is about a service or item Medicare usually covers:

Step 1: The independent review organization reviews your appeal.

- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a free copy of your case file.**

- You have a right to give the independent review organization additional information to support your appeal.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

If you had a "fast" appeal at Level 1, you will also have a "fast" appeal at Level 2

- For the "fast appeal" the review organization must give you an answer to your Level 2 appeal **within 72** hours of when it receives your appeal.

- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

If you had a "standard" appeal at Level 1, you will also have a "standard" appeal at Level 2

- For the "standard appeal" if your request is for a medical item or service, the review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it receives your appeal.

- If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it receives your appeal.

- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

Step 2: The independent review organization gives you their answer.

The independent review organization will tell you its decision in writing and explain the reasons for it.

- **If the independent review organization says yes to part or all of a request for a medical item or service**, we must authorize the medical care coverage **within 72 hours** or provide the service within **14 calendar days** after we receive the independent review organization's decision for **standard requests** or provide the service **within 72 hours** from the date we receive the independent review organization's decision for **expedited requests**.

- **If the independent review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Medicare Part B prescription drug **within 72** hours after we receive the independent review organization's decision for **standard requests** or **within 24 hours** from the date we receive the independent review organization's decision for **expedited requests**.

- **If this organization says no to part or all of your appeal**, it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision" or "turning down your appeal.") In this case, the independent review organization will send you a letter:

  - Explaining its decision.

  - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.

  - Telling you how to file a Level 3 appeal.

- If your Level 2 appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you get after your Level 2 appeal.

  - The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** in this chapter explains the process for Level 3, 4, and 5 appeals.

If your problem is about a service or item Medical Assistance (Medicaid) usually covers:

Step 1: You can ask for a State Appeal (Medicaid Fair Hearing).

- Level 2 of the appeals process for services that are usually covered by Medical Assistance (Medicaid) is a State Appeal (Medicaid Fair Hearing). You must ask for a State Appeal Medicaid (Fair Hearing)in writing or over the phone **within 120 calendar days** of the date that we sent the decision letter on your Level 1 appeal. The letter you get from us will tell you where to submit your hearing request.

If you disagree with a decision or have a complaint regarding a Medical Assistance (Medicaid) covered service, you can do any of the following:

- You can call our plan to file an appeal
- You can write to our plan to file an appeal

You can write to the Minnesota Department of Human Services to request a State Appeal (Medicaid Fair Hearing). Please include:

- Your name
- Address
- Member number
- Phone number
- Date of birth
- Reasons for appealing
- Any information you want us to review, such as medical records, doctors, providers' letters, or other information that explains why you need the item or service. Call your doctor or provider if you need this information.

State Appeal (Medicaid Fair Hearing) Process

A State Appeal (Medicaid Fair Hearing) is a hearing at the State to review a decision made by us for Medical Assistance (Medicaid) covered services. You must request a hearing in writing. You may ask for a hearing if you disagree with:

- the delivery of health services;
- enrollment in the plan;
- denial in full or part of a claim or service;
- our failure to act within required timelines for service authorizations and appeals; or

- any other action.

You must ask for a State Appeal (Medicaid Fair Hearing) **within 120 days** of the date of the health plan decision to deny, reduce, or stop services.

Write to:

Minnesota Department of Human Services
Appeals Office
PO Box 64941
St. Paul, MN 55164-0941

Or fax to: 651- 431-7523

Or complete an Appeal to State Agency online at:
https://edocs.dhs.state.mn.us/lfserver/Public/DHS-0033-ENG

1. A Human Services Judge from the State Appeals Office will hold a hearing. Your meeting will be by telephone unless you ask for a face-to-face meeting.
2. Tell the State why you disagree with the decision made by us.
3. You can ask a friend, relative, advocate, provider, or lawyer to help you.
4. he process can take between 30 and 90 days. If your hearing is about an urgently needed service, tell the State Appeals Office **when you file your hearing request** (refer to contact information above) or the Minnesota Ombudsperson for Public Managed Health Care Programs when you call or write to them. Refer to Chapter 2 for contact information.
5. If your hearing is about a medical necessity denial, you may ask for an expert medical opinion. This will be from an outside reviewer. There is no cost to you.

Step 2: The State Appeal (Medicaid Fair Hearing) office gives you their answer.

The State Appeal (Medicaid Fair Hearing) office will tell you their decision in writing and explain the reasons for it.

- **If the State Appeal (Medicaid Fair Hearing) office says yes to part or all of a request for a medical item or service**, we must authorize or provide the service or item within 72 hours after we receive the decision from the Fair Hearing office.

- **If the State Appeal (Medicaid Fair Hearing) office says no to part or all of your appeal**, they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called “upholding the decision” or “turning down your appeal.”)

If the decision is no for all or part of what I asked for, can I make another appeal?

If the independent review organization or State Appeal (Medicaid Fair Hearing) office decision is no for all or part of what you asked for, you have **additional appeal rights**.

The letter you get from the State Appeal (Medicaid Fair Hearing) office will describe this next appeal option.

Refer to **Section 10** of this chapter for more information on your appeal rights after Level 2.

Section 6.5 What if you are asking us to pay you back for a bill you have received for medical care?

We can't reimburse you directly for a Medical Assistance (Medicaid) service or item. If you get a bill for Medicaid-covered services and items, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the problem. But if you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting the service or item.

Asking to be paid back for something you have already paid for:

If you send us the paperwork asking reimbursement, you are asking for a coverage decision. We can't reimburse you directly for a **Medicaid** service or item. If you get a bill for Medicaid covered services and items, send the bill to us. **You should not pay the bill yourself**. We will contact the health care provider directly and take care of the problem. But if you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting services or item.

If you want us to reimburse you for a **Medicare** service or item or you are asking us to pay a health care provider for a Medical Assistance (Medicaid) service or item you paid for, you will ask us to make this coverage decision. We will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care.

- If the Medicare medical care is covered, we will send you the payment for the cost within 60 calendar days after we receive your request.
  - If the Medicaid care that you paid a health care provider for is covered and you think we should pay the health care provider instead, we will send your health care provider the payment for our share of the cost within 60 calendar days after we receive your request.
  - Then you will need to contact your health care provider to get them to pay you back. If you haven't paid for the services, we will send the payment directly to the health care provider. When we send the payment, it's the same as saying yes to your request for a coverage decision.

- **If we say no to your request:** If the medical care is *not* covered, or you *did* not follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why.

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 5.3. For appeals concerning reimbursement, please note:

- We must give you our answer within 30 calendar days after we receive your appeal. If you are asking us to pay you back for medical care you have already received and paid for, you are not allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the health care provider within 60 calendar days.

SECTION 7 Your Medicare Part D prescription drugs: How to ask for a coverage decision or make an appeal

Section 7.1 This section tells you what to do if you have problems getting a Medicare Part D drug or you want us to pay you back for a Medicare Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (Refer to Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please refer to Chapters 5 and 6.

- **This section is about your Part D drugs only.** To keep things simple, we generally say “drug” in the rest of this section, instead of repeating “covered outpatient prescription drug” or “Medicare Part D drug” every time. We also use the term “drug list” instead of “List of Covered Drugs” or “Formulary.”
- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Terms
An initial coverage decision about your Part D drugs is called a "**coverage determination**."

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that is not on the plan's *List of Covered Drugs*. **Ask for an exception. Section 7.2.**
- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get). **Ask for an exception. Section 7.2.**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 7.4.**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 7.4.**

If you disagree with a coverage decision we have made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 7.2 What is an exception?

Legal Terms
Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a "**formulary exception.**" Asking for removal of a restriction on coverage for a drug is sometimes called asking for a "**formulary exception.**" Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a "**tiering exception.**"

If a drug is not covered in the way you would like it to be covered, you can ask us to make an "exception." An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are two examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our Drug List.** If we agree to cover a drug not on the Drug List, you will need to pay the cost-sharing amount that applies to Tier 1 for brand name drugs or Tier 1 for generic drugs. You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug
2. **Removing a restriction for a covered drug**. Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

Section 7.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally not approve your request for an exception.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for another review of our decision by making an appeal.

Section 7.4 Step-by-step: How to ask for a coverage decision, including an exception

Legal Terms
A "fast coverage decision" is called an "**expedited coverage determination.**"

Step 1: Decide if you need a "standard coverage decision" or a "fast coverage decision."

"**Standard coverage decisions**" are made within **72 hours** after we receive your doctor's statement. "**Fast coverage decisions**" are made within **24 hours** after we receive your doctor's statement.

If your health requires it, ask us to give you a "fast coverage decision." **To get a fast coverage decision, you must meet two requirements:**

- You must be asking for a drug you have not yet received. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically give you a fast coverage decision.
- If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision. If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Tells you how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

Step 2: Request a "standard coverage decision" or a "fast coverage decision."

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form which is available on our website. Chapter 2 has contact information.

You may submit an appeal or grievance by logging in to the UCare member portal on UCare's website. To submit an appeal or grievance:

- Visit our home page at ucare.org.
- Click "Log in" near the upper, right-hand corner of the page.
- Under "member login," enter your email and password and click "Sign In."
- Choose "Message Center" from the menu bar at the top of the page.
- Click "Create New Customer Services Message."
- Select "Appeal" or "Grievance" (or "Appeal Part D" for eligible Medicare members) in the subject line.

- Type your appeal or grievance details in the text box.
- Click "Send Message" when you're ready to send your appeal or grievance to UCare.

To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you are requesting an exception, provide the "supporting statement**, which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

Step 3: We consider your request and give you our answer.

Deadlines for a "fast coverage decision"

- We must generally give you our answer **within 24 hours** after we receive your request.
  - For exceptions, we will give you our answer within 24 hours after we receive your doctor'ssupporting statement. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a "standard coverage decision" about a drug you have not yet received

- We must give you our answer **within 72 hours** after we receive your request.
  - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you requested** we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a "standard coverage decision" about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can to make an appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking us again to get the drug coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 7.5 Step-by-step: How to make a Level 1 appeal

Legal Terms
An appeal to the plan about a Medicare Part D drug coverage decision is called a plan "**redetermination**." A "fast appeal" is also called an "**expedited redetermination.**"

Step 1: Decide if you need a "standard appeal" or a "fast appeal."

A "standard appeal" is usually made within 7 days. A "fast appeal" is generally made within 72 hours. If your health requires it, ask for a "fast appeal"

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."

- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.4 of this chapter.

Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a "fast appeal."

- **For standard appeals, submit a written request or call us.** Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at** 612-676-6841 or 1-877-523-1517 (this call is free). TTY call 612-676-6810 or 1-800-688-2534 (this call is free). Chapter 2 has contact information.
- W**e must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- Y**ou must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- Y**ou can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

Step 3: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a "fast appeal"

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires us to.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. **Section 7.6** explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.

- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a "standard appeal" for a drug you have not yet received

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
  - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. **Section 7.6** explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a "standard appeal" about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you **within 30 calendar days** after we receive your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 7.6 Step-by-step: How to make a Level 2 appeal

Legal Terms
The formal name for the "independent review organization" is the "**Independent Review Entity**." It is sometimes called the "**IRE**."

The independent review organization is an independent organization hired by Medicare. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding "at-risk" determination under our drug management program, we will automatically forward your claim to the IRE.
- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

Deadlines for "fast appeal"

- If your health requires it, ask the independent review organization for a "fast appeal."
- If the organization agrees to give you a "fast appeal," the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for "standard appeal"

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already

bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

Step 3: The independent review organization gives you their answer.

For "fast appeals":

- **If the independent review organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

For "standard appeals":

- **If the independent review organization says yes to part or all of your request for coverage,** we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to **part or all** of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called "upholding the decision." It is also called "turning down your appeal."). In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If you want to go on to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal decision.

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will help arrange for care you may need after you leave.

- The day you leave the hospital is called your "**discharge date**."
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

Section 8.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

Within two days of being admitted to the hospital, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, please call Customer Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you about:
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay.
   - Where to report any concerns you have about the quality of your hospital care.
   - Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.
2. **You will be asked to sign the written notice to show that you received it and understand your rights.**

- You or someone who is acting on your behalf will be asked to sign the notice.
- Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. **Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
   - If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call Customer Service or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also refer to the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Section 8.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are:

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service. Or call your SHIP, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to find out if your planned discharge date is medically appropriate for you.

The **Quality Improvement Organization i**s a group of doctors and other health care professionals paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you received *(An Important Message from Medicare About Your Rights)* tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge**.
  - **If you meet this deadline,** you may stay in the hospital *after* your discharge date w*ithout paying for it* while you wait to get the decision from the Quality Improvement Organization.
  - **If you do *not* meet this deadline,** and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, refer to **Section 8.4** of this chapter
- Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted, we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Customer Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization ("the reviewers") will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers tell us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the review organization says *no*, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Section 8.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8.4 What if you miss the deadline for making your Level 1 Appeal?

Legal Terms
A "fast review" (or "fast appeal") is also called an "**expedited appeal**."

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge. If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal.

If you use this other way of making your appeal, t*he first two levels of appeal are different*.

Step-by-Step: How to make a Level 1 *Alternate* appeal

Step 1: Contact us and ask for a "fast review."

- **Ask for a "fast review."** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines. Chapter 2 has contact information.

Step 2: We do a "fast review" of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We see if the decision about when you should leave the hospital was fair and followed all the rules.

Step 3: We give you our decision within 72 hours after you ask for a "fast review".

- **If we say *yes* to your appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If we say *no* to your appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.

  - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say *no* to your appeal, your case will *automatically* be sent on to the next level of the appeals process.

Step-by-Step: Level 2 *Alternat*e appeal Process

Legal Terms
The formal name for the "independent review organization" is the "**Independent Review Entity.**" It is sometimes called the "**IRE.**"

The independent review organization is an independent organization hired by Medicare. It is not connected with our plan and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: We will automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. **Section 11** of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says yes to your appeal**, then we must pay you back for our share of the costs of hospital care you received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal**, it means they agree that your planned hospital discharge date was medically appropriate.
  - The written notice you get from the independent review organization will tell how to start a Level 3 appeal with the review process, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the independent review organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal.
- **Section 10** in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 9.1 *This section is only about three services:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

When you are getting **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility),** you have the right to keep getting your

covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying for your care*.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 9.2 We will tell you in advance when your coverage will be ending

Legal Term
"**Notice of Medicare Non-Coverage.**" It tells you how you can request a "**fast-track appeal.**" Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.

1. **You receive a notice in writing** at least two days before our plan is going to stop covering your care. The notice tells you:
   - The date when we will stop covering the care for you.
   - How to request a "fast track appeal" to request us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it.** Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does <u>not</u> mean you agree** with the plan's decision to stop care.

Section 9.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**

- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate.

The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a *fast-track appeal*. You must act quickly.

How can you contact this organization?

- The written notice you received (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.

Your deadline for contacting this organization.

- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, refer to **Section 9.5** of this chapter.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Term
"**Detailed Explanation of Non-Coverage.**" Notice that provides details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization ("the reviewers") will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.

- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers tell us of your appeal, you will get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes?

- If the reviewers say **yes** to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say **no**, then **your coverage will end on the date we have told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 9.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is *no*, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 9.5 What if you miss the deadline for making your Level 1 appeal?

You can appeal to us instead

As explained above, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* appeal

Legal Terms
A "fast review" (or "fast appeal") is also called an "**expedited appeal**."

Step 1: Contact us and ask for a "fast review."

- **Ask for a "fast review."** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines. Chapter 2 has contact information.

Step 2: We do a "fast review" of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to find out if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.

Step 3: We give you our decision within 72 hours after you ask for a "fast review"

- **If we say yes to your appeal,** it means we have agreed with you that you need services longer, and we will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care.

Step 4: If we say no to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

Legal Term
The formal name for the "independent review organization" is the "**Independent Review Entity.**" It is sometimes called the "**IRE.**"

Step-by-Step: Level 2 *Alternate* Appeal Process

During the Level 2 appeal, the **independent review organization** reviews the decision we made to your "fast appeal." This organization decides whether the decision should be changed. **The independent review organization is an independent organization that is hired by**

Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the independent review organization. Medicare oversees its work.

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. **Section 11** of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then we must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
  - The notice you get from the independent review organization will tell you in writing what you can do if you wish to go on to a Level 3 appeal.

Step 3: If the independent review organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- A Level 3 appeal is reviewed by an Administrative Law Judge or attouney adjudicator. **Section 10** of this chapter tells more about the process for Level 3, 4, and 5 appeals.

SECTION 10 Taking your appeal to Level 3 and beyond

Section 10.1 Appeal Levels 3, 4 and 5 for Medical Service Requests Covered by Medicare

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain how to make a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal	**An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over** - Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal it will go to a Level 4 appeal.
  - If we decide *not* to appeal, we must authorize or provide you with the service within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process.The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal The Medicare **Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over** - Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide yes or no to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 10.2 Additional Medicaid appeals

You also have other appeal rights if your appeal is about services or items that Medicaid usually covers. The letter you get from the Fair Hearing office will tell you what to do if you wish to continue the appeals process.

Section 10.3 Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The

written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal	**An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal	The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage that was approved by the Council within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 appeal A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 11.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Customer Service? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Service or other staff at the plan? – Examples include waiting too long on the phone, in the waiting room or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

Complaint	Example
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a "fast coverage decision" or a "fast appeal," and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for giving you a coverage decision or appeals; you can make a complaint. • You beileve we are not meeting the deadlines for covering or reimbursing you for certain medical services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 11.2 How to make a complaint

Legal Terms
• A "**complaint**" is also called a "**grievance**." • "**Making a complaint**" is also called "**filing a grievance**." • "**Using the process for complaints**" is also called "**using the process for filing a grievance**." • A "**fast complaint**" is also called an "**expedited grievance**."

Section 11.3 Step-by-step: Making a complaint

<u>Step 1:</u> Contact us promptly – either by phone or in writing.

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.

- Our complaint procedure includes both oral and written complaint processes as described below.

  Oral complaint

  - If we are not able to resolve your oral complaint right away over the phone, we will look into your complaint and give you a response as quickly as your situation requires based on your health status, but no later than 10 calendar days from the date you called us.

  - We will call and tell you what we can do about your complaint or tell you our decision. If you request a written response to your oral complaint, we will respond in writing to you.

  - We may extend the timeframe for resolving your oral complaint by an additional 14 calendar days if you request the extension or if we justify a need for additional information and the delay is in your best interest. If we extend the deadline, we must immediately notify you in writing of the reason(s) for the delay.

  - If we cannot resolve your oral complaint over the phone, or if you do not agree or are dissatisfied with our response, we have a formal procedure where you can file a written grievance.

  Written grievance

  - You can **write** us about your complaint. Mail your written complaint letter to:

    Attn: Member Appeals and Grievances
    UCare
    PO Box 52
    Minneapolis, MN 55440-0052

  - Or **email** us at cag@ucare.org.

    If you prefer to deliver your written complaint to us, our street address is:
    500 Stinson Blvd. NE
    Minneapolis, MN 55413

  - You can also **fax** your written complaint to us at 612-884-2021 or 1-866-283-8015.

  - We can help you put your complaint in writing. If you need help, call Customer Service.

  - We will notify you within ten (10) calendar days that we have received your written complaint.

  - Within 30 days we will send you a letter about our findings or decision.

- We may extend the time frame for resolving your written complaint by an additional 14 calendar days if you request the extension or if we justify a need for additional information and the delay is in your best interest. If we extend the deadline, we must immediately notify you in writing of the reason(s) for the delay.

If your grievance is about our denial of an expedited reconsideration, organization determination, or coverage determination, we'll give you a decision within 24 hours.

- **Whether you call or write, you should contact Customer Service right away.** You can make the complaint at any time after you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint cause we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint."** If you have a "fast complaint," it means we will give you **an answer within 24 hours.**
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

Section 11.4 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

  Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 11.5 You can also tell Medicare about your complaint

You can submit a complaint about UCare Connect + Medicare directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 10
Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in UCare Connect + Medicare may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and prescription drugs and you will continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You may be able to end your membership because you have Medicare and Medicaid

Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you may be able to end your membership in our plan or switch to a different plan one time during each of the following Special Enrollment Periods:

- January to March
- April to June
- July to September

If you joined our plan during one of these periods, you'll have to wait for the next period to end your membership or switch to a different plan. You can't use this Special Enrollment Period to end your membership in our plan between October and December. However, all people with Medicare can make changes from October 15 – December 7 during the Annual Enrollment Period. Section 2.2 tells you more about the Annual Enrollment Period.

- Choose any of the following types of Medicare plans:
  - Another Medicare health plan with or without prescription drugs coverage
  - Original Medicare *with* a separate Medicare prescription drug plan
  - Original Medicare without a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan
    - If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

> **Note:** If you disenroll from Medicare prescription drug coverage and go without "creditable" prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.
>
> Contact your State Medicaid Office to learn about your Medicaid plan options (telephone numbers are in Chapter 2, Section 6 of this document).

If you choose to leave our plan, the way you get your Medical Assistance (Medicaid) when you disenroll depends on your situation.

- If you are under age 65 with a disability basis for eligibility, you will be moved to the Medical Assistance (Medicaid) only version of SNBC. If you want your Medical Assistance to be provided fee-for-service, you must ask for that in your disenrollment request.
- If you are under age 65 and do not have a disability basis for eligibility, you will be automatically enrolled in our Families and Children health plan, if our Families and Children health plan is offered in your county. You can ask in writing to be enrolled in a different Families and Children health plan. If we do not have a Families and Children health plan in your county, you will be enrolled in a Families and Children health plan that is available in your county. Call your county worker for details.
- If you are 65 years or older, you will be automatically enrolled in our plan's Minnesota Senior Care Plus (MSC+) plan for your Medical Assistance (Medicaid) services if our MSC+ plan is offered in your county. If our plan does not have an MSC+ plan in your county, you will be enrolled in the MSC+ plan that is available in your county. You can also request to enroll into Minnesota Senior Health Options (MSHO), which combines your Medicare and Medical Assistance (Medicaid) into one plan like your current SNBC plan. Contact your county financial worker if you have questions.

If you currently have a medical spenddown and you choose to leave our plan, your Medical Assistance (Medicaid) will be provided fee-for-service. You will not be enrolled in another health plan for Medical Assistance (Medicaid) services unless you choose to enroll directly into MSHO from SNBC when you turn 65.

When will your membership end? Your membership will usually end on the first day of the month after we receive your request to change your plans. Your enrollment in your new plan will also begin on this day.

Section 2.2 You can end your membership during the Annual Enrollment Period

You can end your membership during the **Annual Enrollment Period** (also known as the "Annual Open Enrollment Period"). During this time, review your health and drug coverage and decide about your coverage for the upcoming year.

- **The Annual Enrollment Period** is from **October 15 to December 7.**
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan with or without prescription drug coverage
  - Original Medicare *with* a separate Medicare prescription drug plan.
  - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

If you receive "Extra Help" from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

> **Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Section 2.3 You can end your membership during the Medicare Advantage Open Enrollment Period

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31.
- **During the annual Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
  - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.4 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, you may be eligible to end your membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):

- Usually, when you have moved.
- If you have Medical Assistance (Medicaid).
- If you are eligible for "Extra Help" with paying for your Medicare prescriptions.
- If we violate our contract with you.
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.

  Note: If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

  Note: Section 2.1 tells you more about the special enrollment period for people with Medicaid.

The enrollment time periods vary depending on your situation.

To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare health plan with or without prescription drug coverage.
- Original Medicare *with* a separate Medicare prescription drug plan.

  OR

- Original Medicare *without* a separate Medicare prescription drug plan.

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

If you receive "Extra Help" from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Your membership will usually end on the first day of the month after your request to change your plan is received.

Note: Sections 2.1 and 2.2 tell you more about the special enrollment period for people with Medicaid and Extra Help.

Section 2.5 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership, you can:

- **Call Customer Service.**
- You can find the information in the ***Medicare & You 2023*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

SECTION 3 How do you end your membership in our plan?

The table below explains how you should end your membership in our plan. It only describes your Medicare coverage.

If you choose to leave our plan, the way you get your Medical Assistance (Medicaid) when you disenroll depends on your situation.

- If you are under age 65 with a disability basis for eligibility, you will be moved to the Medical Assistance (Medicaid) only version of SNBC. If you want your Medical Assistance to be provided fee-for-service, you must ask for that in your disenrollment request.
- If you are under age 65 and do not have a disability basis for eligibility, you will be automatically enrolled in our Families and Children program, if our Families and Children health plan is offered in your county. You can ask in writing to be enrolled in a different Families and Children health plan. If we do not have a Families and Children health plan in your county, you will be enrolled in a Families and Children health plan that is available in your county. Call your county worker for details.
- If you are 65 years or older, you will be automatically enrolled in our plan's Minnesota Senior Care Plus (MSC+) plan for your Medical Assistance (Medicaid) services if our MSC+ plan is offered in your county. If our plan does not have an MSC+ plan in your county, you will be enrolled in the MSC+ plan that is available in your county. You can also request to enroll into Minnesota Senior Health Options (MSHO), which combines

your Medicare and Medical Assistance (Medicaid) into one plan like your current SNBC plan. Contact your county financial worker if you have questions.

If you currently have a medical spenddown and you choose to leave our plan, your Medical Assistance (Medicaid) will be provided fee-for-service. You will not be enrolled in another health plan for Medical Assistance (Medicaid) services unless you choose to enroll directly into MSHO from SNBC when you turn 65.

If you would like to switch from our plan to:	**This is what you should do:**
Another Medicare health plan.	• Enroll in the new Medicare health plan. The new start date for new coverage will depend on your available election periods. Refer to Section 2 of this chapter for more information. • You will automatically be disenrolled from UCare Connect + Medicare when your new plan's coverage begins.
Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare health plan. The new start date for coverage will depend on your available election periods. Refer to Section 2 of this chapter for more information. You will automatically be disenrolled from UCare Connect + Medicare when your new plan's coverage begins.
Original Medicare *without* a separate Medicare prescription drug plan. – If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment. – If you disenroll from Medicare prescription drug coverage and go 63 days or more in a row without	• **Send us a written request to disenroll.** Contact Customer Service if you need more information on how to do this. • You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from UCare Connect + Medicare when your coverage in Original Medicare begins.

creditable prescription drug coverage, you may have to pay a late enrollment penalty if you join a Medicare drug plan later.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

For questions about your Minnesota Medical Assistance (Medicaid) benefits, contact the Minnesota Department of Human Services at 1-800-657-3739. TTY users should call 1-800-627-3429 or 711, or use your preferred relay service. These calls are free.

Ask how joining another plan or returning to Original Medicare affects how you get your Minnesota Medical Assistance (Medicaid) coverage.

SECTION 4 Until your membership ends, you must keep getting your medical services and drugs through our plan

Until your membership UCare Connect + Medicare ends, and your new Medicare and Medical Assistance (Medicaid) coverage begins, you must continue to get your medical care and prescription drugs through our plan.

- **Continue to use our network providers to receive medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled**
- **If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 UCare Connect + Medicare must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

UCare Connect + Medicare must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.

- If you are no longer eligible for Medical Assistance (Medicaid). As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and Medical Assistance (Medicaid). If you have Medicare and lose eligibility for Medical Assistance (Medicaid), our plan will continue to provide Medicare Advantage plan covered benefits for up to three months. If after three months you have not regained Medical Assistance (Medicaid), coverage with our plan will end. You will need to choose a new Medicare Part D plan in order to continue getting coverage for Medicare-covered drugs. If you need help, you can call the Senior LinkAge Line® at 1-866-333-2433.
- If you do not pay your medical spenddown, if applicable
- If you turn 65
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - If you move or take a long trip, call Customer Service to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan.

Where can you get more information?

If you have questions or would like more information on when we can end your membership, call Customer Service.

Section 5.2 We cannot ask you to leave our plan for any health-related reason

UCare Connect + Medicare is not allowed to ask you to leave our plan for any health-related reasons.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 11
Legal Notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

SECTION 2 Notice about non-discrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, geographic location within the service area, medical condition, receipt of health services, marital status, political beliefs, sexual orientation, creed, or public assistance status. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at https://www.hhs.gov/ocr/index.

If you have a disability and need help with access to care, please call Customer Service. If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, UCare Connect + Medicare, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Medical Assistance (Medicaid) subrogation or other claims

You may have other sources of payment for your medical care. They might be from another person, group, insurance company or other organization. Federal and State laws provide that Medical Assistance (Medicaid) benefits pay only if no other source of payment exists. If you have a claim against another source for injuries, we will make a separate claim for medical care we covered for you. The laws require you to help us do this. The claim may be recovered from any source that may be responsible for payment of the medical care we covered for you. The amount of the claim will not be more than Federal and State laws allow.

CHAPTER 12
Definitions of important words

Chapter 12. Definitions of important words

Introduction

This chapter includes key terms used throughout the *Evidence of Coverage* with their definitions. These terms may also be used in other member documents. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Customer Service.

Action – This includes:

- denial or limited authorization of the type or level of service
- reduction, suspension, or stopping of a service that was approved before
- denial of all or part of payment or service
- not providing services in a reasonable amount of time
- not acting within required time frames for grievances or appeals
- denial of a member's request to get services out of network for members living in a rural area with only one health plan.

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Anesthesia – Drugs that make you fall asleep for an operation.

Appeal – A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing a written or oral appeal.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of UCare Connect + Medicare, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost sharing your plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Care Coordinator – A nurse or social worker who is available to help you with your health care and social service needs. Your case manager will work with you in partnership to create a care plan to help keep you healthy and safe in your home.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay no copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $7,400 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare.

Chronic-Care Special Needs Plan – C-SNPs are SNPs that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions, defined in 42 CFR 422.2. A C-SNP must have specific attributes that go beyond the provision of basic Medicare Parts A and B services and care coordination that is required of all Medicare Advantage Coordinated Care Plans, in order to receive the special designation and marketing and enrollment accommodations provided to C-SNPs.

Clinical Trial – A qualified medical study test that is: subject to a defined peer review; sponsored by a clinical research program that meets federal and state rules and approved standards; and whose true results are reported.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs.

Complaint –The formal name for "making a complaint" is "filing a grievance." The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or "copay") – A fixed amount you may pay as your share of the cost each time you get prescription drugs. Copays are usually paid at the time prescription drugs are provided. Refer to Chapter 6 for copay amounts.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when drugs are received. Cost sharing includes any fixed "copayment" amount that a plan requires when a drug is received.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to

ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this document.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Covered Services – The term we use to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Cultural competency training – Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care, provided by people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Customer Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Daily cost-sharing rate – A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is $1 per day.

Direct Access Services – You can go to any provider in our plan's network to get these services. You do not need a referral or service authorization before getting services.

Disenroll or Disenrollment – The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll individuals who are entitled to both Medicare (title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

Dual Eligible Individual – A person who qualifies for Medicare and Medicaid coverage.

Durable Medical Equipment (DME) – Durable Medical Equipment (DME): Certain medical equipment that is ordered by your doctor for use at home. Examples are walkers, wheelchairs, oxygen equipment and supplies.

Emergency – A medical emergency is when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of function of a body part or could cause serious physical or mental harm. The medical symptoms may be a serious injury or severe pain. This is also called Emergency Medical Condition.

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Emergency Medical Transportation – Ambulance services, including ground and air transportation for an emergency medical condition

Evidence of Coverage **(EOC) and Disclosure Information** – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

E-visit – Secure, encrypted web access via remote technology, providing online exchange of non-urgent medical information between a health care provider and an established patient. E-visits follow established medical protocols and the prescribing and/or treatment recommendations follow state laws and are within the provider's scope of practice.

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Excluded Services – Services the plan does not pay for. Medical Assistance (Medicaid) will not pay for them either.

External Quality Review Study – A study about how quality, timeliness and access of care are provided by us. This study is external and independent.

Extra Help – A Medicare or State program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Family Planning – Information, services, and supplies that help a person decide about having children. These decisions include choosing to have a child, when to have a child, or not to have a child.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

Health Plan – An organization that has a network of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all your providers and services. They all work together to provide the care you need.

Home and Community Based Services – Additional services that are provided to help you remain in your home.

Home Health Aide – A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Home Health Care – Health care services for an illness or injury given in the home or in the community where normal life activities take the member.

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay/Hospitalization – Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care – Care in a hospital that usually doesn't require an overnight stay. An overnight stay for observation could be outpatient care.

Housing Stabilization Services – Services to help people with disabilities, including mental illness and substance use disorder, and seniors find and keep housing. The purpose of these services is to support a person's transition into housing, increase long-term stability in housing in the community, and avoid future periods of homelessness or institutionalization.

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached $7,400.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn

65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan.

Low Income Subsidy (LIS) – Refer to "Extra Help."

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. Amounts you pay for your Medicare Part A and Part B premiums and prescription drugs do not count toward the maximum out-of-pocket amount. (Note: Because our members also get assistance from Medical Assistance (Medicaid), very few members ever reach this out-of-pocket maximum.) Refer to Chapter 4, Section 1.2 for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

Medically Necessary – Services, supplies, or drugs you need to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice. Medically necessary care is appropriate for your condition. This includes care related to physical conditions and behavioral health (including Mental Health and Substance Use Disorder services). It includes the kind and level of services. It includes the number of treatments. It also includes where you get the services and how long they continue. Medically necessary services must:

- be the services, supplies and prescription drugs other providers would usually order.
- help you get better or stay as well as you are.
- help stop your condition from getting worse.
- help prevent and find health problems.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period – The time period from January 1 until March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Medicare Part D brand name drugs to Medicare Part D members who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the Federal government and certain drug manufacturers.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Part A – The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B – The Medicare program that covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C – The Medicare program that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

Medicare Part D – The Medicare prescription drug benefit program. Medicare Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Medicaid. UCare Connect + Medicare includes Medicare Part D.

Medicare Part D drugs – Drugs that can be covered under Medicare Part D. Congress specifically excluded certain categories of drugs from coverage as Medicare Part D drugs. Medicaid may cover some of these drugs.

Medicare Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Medicare Part D plan. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive "Extra Help" from Medicare to pay your prescription drug plan costs, you will not pay a late enrollment penalty. If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Medicare Part D or other creditable prescription drug coverage.

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Minnesota Senior Care Plus (MSC+) – A program in which the State contracts with health plans to cover and manage health care and Elderly Waiver services for Medical Assistance (Medicaid) enrollees age 65 and over.

Minnesota Senior Health Options (MSHO) – A program offered by the Minnesota Department of Human Services and health plans, including our Plan, for enrollees age 65 and over, eligible for both Medicare and Medical Assistance (Medicaid).

Network – Our contracted health care providers for the Plan.

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – "Provider" is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services."**Network providers**" have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called "plan providers" or participating providers.

Nursing home or facility – A place that provides care for people who cannot get their care at home but who do not need to be in the hospital.

Nursing Home Certifiable – A decision that you need a nursing home level of care.

Ombudsman – An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsman's services are free. You can find more information about the ombudsman in Chapters 2 and 9 of this handbook.

Open Access Services – Federal and state law allow you to choose any qualified health care provider, clinic, hospital, pharmacy, or family planning agency - even if not in the Plan's network - to get these services

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this document.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can go to any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

Out-of-Pocket Costs – Refer to the definition for "cost sharing" above. A member's cost-sharing requirement to pay for a portion of drugs received is also referred to as the member's "out-of-pocket" cost requirement.

Over-the-counter (OTC) drugs – Over-the-counter drugs refers to any drug or medicine that a person can buy without a prescription from a healthcare professional.

Palliative Care – Palliative Care helps people with serious illnesses feel better. It prevents or treats symptoms and side effects of disease and treatment. Palliative care also treats emotional, social, practical, and spiritual problems that illnesses can bring up. Palliative care can be given at the same time as treatments meant to cure or treat the disease. Palliative care may be given when the illness is diagnosed, throughout treatment, during follow-up, and at the end of life.

Part A – Refer to "Medicare Part A."

Part B – Refer to "Medicare Part B."

Part C – Refer to "Medicare Part C."

Part D – Refer to "Medicare Part D."

Part D Drugs – Refer to "Medicare Part D drugs."

People with Disabilities – People who are deemed disabled by the federal Social Security Administration or who are certified as such by the State Medical Review Team or deemed by the Local Agency to have a Developmental Disability for purposes of the Developmental Disability (DD) Waiver.

Personal Care Assistance (PCA) Services – A service option that offers a range of assistive and support services. They are provided in the person's home and community. Contact your county if you need these services.

Personal health information (also called Protected health information) (PHI) – Information about you and your health, such as your name, address, social security number, physician visits and medical history. Refer to UCare Connect + Medicare's Notice of Privacy Practices for more information about how UCare Connect + Medicare protects, uses, and discloses your PHI, as well as your rights with respect to your PHI.

Physicians Services – services provided by an individual licensed under state law to practice medicine or osteopathy. Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Prescription Drug Benefit Manager – A company under contract with UCare that manages specific delegated aspects of the pharmacy benefit, including claims processing and coverage determinations.

Prescription drug coverage – Refer to "Medicare Part D drugs." Or Health plan that helps pay for prescription drugs and medications.

Prescription Drugs – Drugs that can be dispensed only with an order given by a properly authorized person OR Drugs and medications that, by law, require a prescription.

Preventive Services – Services that help you stay healthy, such as routine physicals, immunizations and well-person care. These services help find and prevent health problems. Follow-up on conditions that have been diagnosed (like diabetes checkup) are not preventive.

Primary Care Clinic (PCC) – The facility where you get most of the health care services you need, such as annual checkups, and helps coordinate your care. You may need to choose a primary care clinic when you enroll in our plan.

Primary Care Provider (PCP) – The doctor or other provider you go to first for most health problems. In many Medicare health plans, you must go to your primary care provider before you go to any other health care provider.

Prior Authorization – Approval in advance to get services or certain drugs. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics – Medical devices including, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Provider – A qualified health care professional or facility approved under state law to provide health care.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

Quality of Care Complaint – For purposes of this *Evidence of Coverage*, "quality of care complaint" means an expressed dissatisfaction regarding health care services resulting in potential or actual harm to a member. Quality of care complaints may include: access; provider and staff competence; clinical appropriateness of care; communications; behavior; facility and environmental considerations; and other factors that could impact the quality of health care services.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Rehabilitation Services and Devices – Treatment and equipment you get to help you recover from an illness, accident or major operation. These services include physical therapy, speech and language therapy, and occupational therapy.

Restricted Recipient Program – A program for members who have received medical care and have not followed the rules or have misused services. If you are in this program, you must get health services from one designated primary care provider, one clinic, one hospital used by the primary care provider, and one pharmacy. UCare may designate other health care providers. You must do this for at least 24 months of eligibility for Minnesota Health Care Programs.

Members in this program who fail to follow program rules will be required to continue in the program for an additional 36 months.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan must disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Care – Care or treatment that can only be done by licensed nurses.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Specialist – A doctor who provides health care for a specific disease or part of the body.

Special Needs BasicCare (SNBC) – A voluntary managed care program for people with disabilities. SNBC is for people who have Medical Assistance and are under 65. SNBC covers the basic Medical Assistance services, except for personal care assistance and home care nursing. People on the SNBC – SNP program who have Medicare, will receive their Medicare services, including Medicare Part D, through the SNBC – SNP.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

State Appeal (Medicaid Fair Hearing with the state) – A hearing at the state to review a decision made by our Plan. You must request a hearing in writing. You may ask for a hearing if you disagree with any of the following:

- a denial, termination or reduction of service
- enrollment in the Plan
- denial in full or part of a claim or service
- our failure to act within required timelines for service authorizations, and appeals
- any other action

State Medicaid agency – In Minnesota, this agency is the Minnesota Department of Human Services.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Subrogation – Our right to collect money in your name from another person, group, or insurance company. We have this right when you get medical coverage under this plan for a service that is covered by another source or third party payer.

Substance Use Disorder – Using alcohol or drugs in a way that harms you.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Telehealth Services – Interactive, real-time virtual visits that allow providers to evaluate, diagnose and treat you without an in-person office visit. They are often used for follow-up visits, to manage chronic conditions and medications, to consult with specialists, and other clinical services.

Urgently Needed Services – Care you get for an illness, injury, or condition that is not an emergency but needs care right away. Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

UCare Connect + Medicare Customer Service

Method	Customer Service - Contact Information
CALL	612-676-3310 1-855-260-9707 (Calls to this number are free.) 8 am – 8 pm, seven days a week Customer Service also has free language interpreter services available for non-English speakers.
TTY	612-676-6810 1-800-688-2534 (Calls to this number are free.) 8 am – 8 pm, seven days a week These numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.
FAX	612-676-6501 1-866-457-7145
WRITE	**Attn: Customer Service** UCare PO Box 52 Minneapolis, MN 55440-0052
WEBSITE	**ucare.org**

Senior LinkAge Line® (Minnesota SHIP)

Senior LinkAge Line® is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	1-800-333-2433 (Calls to this number are free.)
TTY	Call the Minnesota Relay Service at 711 or use your preferred relay service. (Calls to this number are free.)
WRITE	Minnesota Board on Aging PO Box 64976 St. Paul, MN 55164-0976
WEBSITE	www.seniorlinkageline.com

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